Training U.S. Correctional Officers in Mental Health Emergency Response Using the Memphis Crisis Intervention Team Model

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Abstract

American correctional officers are ill-prepared to deal with the concentrated population of mentally ill offenders for whom they are ultimately responsible. In federal fiscal year 2011, the National Institute of Corrections (NIC) undertook a pilot program designed to introduce multidisciplinary leadership teams from around the country to the Crisis Intervention Teams (CIT) model of specialized mental health training and response, in the hopes that these teams would implement the processes needed to create sustainable CIT programs in their home institutions. In this paper, the author explores the background and significance of this problem, establishes the purpose of the extant investigation, provides a multi-factor analysis, and puts forth a strategic management and implementation plan for the proposed solution.
Although American correctional officers are charged with the safety and welfare of a highly concentrated population of mentally ill inmates, they have historically received little or no training to prepare them for this challenging work (Earley, 2006; Torrey, Kennard, Enslinger, Lamb, & Pavle, 2011). Consequently, the conditions of confinement faced by inmates with serious mental illnesses are frequently adverse to their recovery, and sometimes border on the inhumane. Crisis Intervention Teams (CIT) training, which was originally developed as a patrol-based model of law enforcement response to mental health crises, has been successfully integrated into a smattering of local jails and a few state correctional facilities, with largely positive results (Cattabriga, Deprez, Kinner, Louie, & Lumb, 2007; Parker, 2009). The proposed solution to this problem is to expand the initiative undertaken in federal fiscal year 2011 by the National Institute of Corrections (NIC) to train multidisciplinary leadership teams from around the country to develop and implement locally managed CIT programs within their home institutions (Dooley, 2010; National Institute of Corrections, 2011). In this paper, the author will explore the background and significance of this problem, establish the purpose of the extant investigation, provide a multi-factor analysis, and put forth a strategic management and implementation plan for the proposed solution.

**Background.**

**Historical overview.** Caring for the roughly five percent of U.S. adults who suffer from serious and persistent mental illness has vexed public policymakers since the earliest days of the union (Torrey, Kennard, Enslinger, Lamb, & Pavle, 2011; Magaletta, Diamond, Faust, Daggett, & Camp, 2009; U.S. Department of Health and Human Services, 2010). Lacking more suitable alternatives, the earliest governmental response
to people with mental illnesses whose behaviors deviated substantially from social norms was to lock them away in jails and prisons (Magaletta et al., 2009; Torrey et al., 2011).

In the mid-1820s, Louis Dwight, a Congregationalist minister who delivered Bibles to Massachusetts jail inmates, was appalled by the treatment of incarcerated “lunatics” he observed during his visits (Torrey et al., 2011, p. 2). Dwight protested to the Massachusetts state legislature, which appointed a committee to study the problem (Torrey et al., 2011). Shortly thereafter, the state constructed the State Lunatic Asylum at Worcester, which would serve as an alternative to incarceration for 120 patients (Torrey et al., 2011).

Fifteen years later, Dorothea Dix, also of Massachusetts, visited every jail in her state and documented continued maltreatment of mentally ill inmates (Torrey et al., 2011). By 1847, Dix had expanded the scope of her crusade to 18 states, visiting over 300 correctional institutions (Torrey et al., 2011). Dix’s investigation found the maltreatment of inmates with mental illnesses to be a pervasive national problem, and her impassioned advocacy led to the establishment of several state mental hospitals (Torrey et al., 2011). At the time of Dix’s pioneering advocacy for the decriminalization of mental illness, there existed approximately one public inpatient psychiatric bed for every 5,000 people in America, and less than one percent of the incarcerated population was classified as insane (Torrey et al., 2011).

**The deinstitutionalization movement.** By 1955, at the height of psychiatric hospital utilization in the U.S., an astounding 558,239 public psychiatric hospital beds were available, equating to roughly one bed for every 295 people in America (Torrey et al., 2008; Torrey et al., 2011). Living conditions in psychiatric hospitals of the day were
clearly inadequate – indeed, often inhumane – largely because few effective medical interventions had been developed (Earley, 2006; Torrey et al., 2011). Over the next two decades, the confluence of four primary factors resulted in the wholesale emptying of psychiatric hospitals across the country, which has come to be known as the deinstitutionalization movement: (1) the advent of Thorazine, the first widely effective, albeit debilitating, antipsychotic medication; (2) the enactment of Medicaid, which was supposed to provide federal funding to community mental health centers for the treatment of those disabled by mental illness; (3) a groundswell of social consciousness surrounding the substandard care being doled out in state mental hospitals; and (4) the rise of fiscal conservatism in state legislatures across the country, which created a climate bent on closing state hospitals in favor of shifting the cost of caring for the chronically mentally ill to the federal government through the new Medicaid entitlement (Earley, 2006; Torrey et al., 2011). In retrospect, Torrey and his colleagues (2011) characterized the deinstitutionalization movement as “one of the most well-meaning but poorly planned social changes ever carried out in the United States” (pp. 2-3).

If the only measure of success surrounding deinstitutionalization was the reduction of psychiatric hospitalization, then the movement could be said to be wildly successful. By 2005, approximately 95 percent of the nation’s public psychiatric bed capacity had been eliminated (Torrey et al., 2008). The Treatment Advocacy Center (as cited in Torrey et al., 2008) surveyed mental health experts across the country and found that in order to provide a minimum level of effective psychiatric care, one inpatient hospital bed would be needed for every 2,000 Americans. Yet, even if private psychiatric bed capacity were factored into the 2005 census, only one bed existed for every 3,000
people, meaning that the existing capacity to treat those with serious mental illnesses fell nearly 96,000 beds short of the minimum need (Torrey et al., 2008). Yet, the problem with using inpatient bed capacity as the singular measure of deinstitutionalization’s success is that it fails to take into account an axiom originally penned by British psychiatrist Lionel Penrose in 1939, which still holds true today:

Penrose published a paper on the relationship between the population of psychiatric hospitals and that of prisons. He postulated that the two populations were inversely correlated: As one decreases, the other increases. It has come to be known as the balloon theory – push in on one side and the other side bulges out. (Torrey et al., 2011, p. 2)

The intersection of law enforcement and the mentally ill. As Penrose postulated, emptying the nation’s psychiatric hospitals simply shifted the problem of dealing with the nation’s seriously and persistently mentally ill to the criminal justice system, as Torrey and his colleagues (2011) noted:

Emptying America’s mental hospitals without ensuring that the discharged patients received appropriate treatment in the community has been an egregious mistake. For the approximately half of discharged patients who have ended up homeless or in jails and prisons, it has been a personal tragedy. (p. 11)

When people afflicted with brain disorders find themselves in crisis or run afoul of the law, their first point of official contact is often with law enforcement. In fact, Hails and Borum (2003) estimated that between 7 and 10 percent of all U.S. law enforcement contacts involved a person with mental illness. Yet, despite the prevalence of such interactions, the average law enforcement officer in 2003 received only 6.5 hours of
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academy training – and less than one hour of annual refresher training – in handling psychiatric emergencies (Hails & Borum, 2003). Not surprisingly, expecting police officers to serve as the first line of defense for people experiencing mental health issues and providing them almost no training on the topic has proven to be a recipe for disaster (Earley, 2006; Hails & Borum, 2003).

Such was the case in 1987, when Memphis, Tennessee, police officers fatally shot a knife-wielding man with severe mental illness, sparking community outrage over the apparent lack of police alternatives to physical force in resolving crisis calls (Compton, Bahora, Watson, & Oliva, 2008). One positive outcome of this tragic event was that it became the catalyst for the formation of a paradigm-changing collaboration among law enforcement, mental healthcare providers, hospitals, academics, and advocates for people with mental illness (Compton et al., 2008). This collaboration led to the development of a groundbreaking 40-hour police training curriculum known as Crisis Intervention Team (CIT) training (Compton et al., 2008; Reuland, Draper, & Norton, 2010). At the time of CIT’s development, its model of training specially trained police officers to deal head-on with psychiatric emergencies – a model known as police-based specialized police response – was the least utilized mental health emergency response model in the nation (Compton et al., 2008; Reuland et al., 2010; Schwarzfeld, Reuland, & Plotkin, 2008). Since then, CIT has grown to become the predominant mental health emergency response model for law enforcement not only in the U.S., but around the world (Compton et al., 2008; Reuland et al., 2010; Schawzfeld et al., 2008).

The intersection of corrections and the mentally ill. Unfortunately, translating CIT – or any mental health-related training, for that matter – into correctional settings has
not been as seamless as one might expect (Earley, 2006; Magaletta, Diamond, Faust, Daggett, & Camp, 2009; Parker, 2009). Notwithstanding the fact that correctional officers are at least three times more likely to encounter people with serious mental illnesses than their patrol officer counterparts, there continues to exist a dearth of formalized training for correctional officers in how to deal effectively with this population (Earley, 2006; Parker, 2009; Torrey et al., 2011). Torrey and his colleagues (2011) summarized the problem thusly:

Men and women who work as correctional officers in jails and prisons apply for the job expecting to work with criminals, not individuals with serious mental illnesses. Many of the correctional officers do not understand, and have little or no training in, how to work with mentally ill inmates. (p. 11)

Compounding the situation are the facts that mentally ill inmates remain incarcerated far longer than similarly charged inmates without such illnesses, and that while they are incarcerated, “mentally ill inmates are often major management problems” (Torrey et al., 2011, p. 10). According to Parker (2009), inmates with mental illnesses are more likely than those without to be written up for institutional rule violations, are more likely to be charged with assaults occurring in the institution, and are more likely to be housed in restrictive settings. Once placed in restrictive environments, mentally ill inmates “typically do not do well clinically,” (Parker, 2009, p. 641) leading to behaviors that are even more difficult to effectively manage (Cloyes, Wong, Latimer, & Abarca, 2010; Parker, 2009).

Problem.
By any measure, then, the American criminal justice system is no better off today in terms of the criminalization of mental illness than it was a century-and-a-half ago; indeed, one could convincingly argue that the situation has grown direr. At the same time, the treatment of mentally ill offenders who occupy our jails and prisons, while perhaps less barbaric than would have been encountered in the 19th century, is still characterized by institutional abuse, reflecting a conspicuous absence of mental health-related training among correctional institution staffs across the country (Earley, 2006; Parker, 2009; Torrey et al., 2011). As a result of this lack of training, correctional officers often report feeling unprepared to manage incarcerated people with mental health issues (Earley, 2006; Parker, 2009; Torrey et al., 2011). Not surprisingly, when specialized mental health training has been implemented in correctional institutions, reported outcomes have included decreased use of force by staff, decreased assaults on staff by inmates, and improved collaboration between correctional staff and institutional mental healthcare providers (Compton et al., 2008; Parker, 2009).

Purpose.

While the CIT model remains largely unknown in the world of corrections, it has been successfully implemented in a small number of penal institutions in localities such as Maine, Utah, Colorado, and Florida (Cattabriga et al., 2007; Denes & Ramirez-Romero, 2011; Dooley, 2010). The positive impact of CIT training for correctional officers was summarized by Cattabriga and his colleagues (2007) thusly:

Before attending CIT training, Maine correctional officers generally did not feel they had received adequate training in crisis intervention. . . . After attending the training, corrections officers reported a higher degree of comfort when
encountering people with signs of mental illness, more confidence in their own ability to recognize maladaptive behaviors (including aggression) caused by mental illness, and more confidence to defuse or de-escalate situations as they arose. Officers also reported increased preparedness to handle people with mental illness in crisis, including those threatening to commit suicide. They were also more positive about their department’s role in addressing mental health crises and had become more familiar with community resources. (pp. 4-5)

CIT training is able to produce these types of outcomes because it incorporates a broad range of evidence-based adult learning principles to achieve a high degree of knowledge retention and transference to the workplace (Compton, Bahora, Watson, & Oliva, 2008; Sayre & Brodie, 2010).

In late 2010 (federal fiscal year 2011), the National Institute of Corrections (NIC) undertook a pilot program “designed to prepare three-person teams [representing the correctional, mental health, and consumer advocacy disciplines] to develop and implement CIT in their local jails and state prison systems” (Dooley, 2010, p. 1). Such national leadership focused on developing standardized state and local CIT initiatives is consistent with the recommendations of Cattabriga and his colleagues (2007), which stressed the importance of “work[ing] with state agencies to make CIT a permanent component of corrections training . . . with sustained funding and [administrative] commitment” (p. 38).

The purpose of this investigation, then, is to propose a nationally led and locally implemented training initiative geared toward improving U.S. correctional officers’ abilities to manage inmates with mental health problems.
Significance of Problem.

Over the past half-century, American jails and prisons have become vast repositories of the nation’s mentally ill (Magaletta, Diamond, Faust, Daggett, & Camp, 2009; Torrey, Kennard, Enslinger, Lamb, & Pavle, 2011). As of midyear 2010, the aggregate inmate population in federal, state, and local correctional institutions throughout the U.S. was roughly 2,361,000 (Minton, 2011; Pew Center on the States, 2010). Estimates of the incidence of mental illness in American jails and prisons have ranged from 15-20 percent to as high as 80-90 percent of the inmate population (Bazelon Center for Mental Health Law, 2006; Magaletta et al., 2009; Torrey et al., 2011). Roughly 454,500 correctional officers working in federal, state, and local facilities are responsible for the care and safety of this burgeoning high-need population (Bureau of Labor Statistics, 2011). Most of these officers receive little or no training in the management of people with mental illnesses (Cattabriga, Deprez, Kinner, Louis, & Lumb, 2007; Earley, 2006; Parker, 2009).

Integrating CIT training into jails and prisons across the United States would be a quantum leap forward in providing correctional officers with the skills needed to manage the most challenging inmates in their institutions. At the same time, it would also represent a significant investment of public resources into a new and largely untried method of doing business in profoundly adversarial and dangerous environments. As such, prudence requires that all aspects of this undertaking, including its ethical, legal, and economic implications, be evaluated before proceeding.

Ethical issues. From a broad theoretical perspective, the ethical foundations of the CIT model are congruent with both deontological and teleological ethics (Carroll &
From the deontological perspective, the Kantian universal imperative holds that conduct is ethical if it is righteous under all conditions, without regard to the people or physical circumstances involved (Carroll & Buchholtz, 2006). Clearly, treating mentally ill inmates with dignity and beneficence is morally right regardless of the circumstances. The teleological, or utilitarian, ethicist would likewise condone the practices of CIT because the greatest good for the greatest number of people would be realized by improving the plight of mentally ill inmates, who would thus be more likely to remain engaged in mental health treatment both inside and outside of correctional institutions, thereby consuming fewer correctional tax dollars in the future (Carroll & Buchholtz, 2006).

Looking beyond the theoretical, several practical aspects of CIT could pose ethical concerns for correctional officers, including the need to limit the scope of their services, avoiding boundary violations and role conflicts, and recognizing the limits of confidentiality (Bonner & Vandecreek, 2006; Haag, 2006; Williams, n.d.). There is both ethical and legal jeopardy, for example, in CIT officers failing to confine the scope of their roles to resolving the immediate crisis, venturing instead into the provision of psychological services for which they lack professional credentials (Williams, n.d.). Similarly, CIT officers must guard against the well-intentioned but ill-advised blurring of professional boundaries, which particularly in correctional settings can make officers vulnerable to manipulation and extortion (Bonner & Vandecreek, 2006; Haag, 2006). Another way that role conflicts can occur is when officers improperly use information revealed by inmates during CIT contacts, the disclosure of which would not be compelled by law or institutional regulations, against the inmates in disciplinary proceedings.
(Bonner & Vandecreek, 2006; Haag, 2006). Yet, it is equally important that CIT officers recognize that client confidentiality does not exist in correctional CIT work as it would in traditional psychotherapy (Bonner & Vandecreek, 2006; Haag, 2006). Obviously, the safety and security of the institution, staff, and inmates trump any conventional notions of confidentiality (Bonner & Vandecreek, 2006; Haag, 2006).

**Legal issues.** The two primary sources of liability stemming from the practice of CIT in correctional institutions stem from an expansion of the concept of psychological malpractice, and from the fact that “the stressful environment of a correctional facility, even in the short term, is harmful for persons who are themselves in crisis” (Alarid, 2010, p. 745; Williams, n.d.). Williams (n.d.) addressed the first issue by noting that a CIT officer would be “responsible for harm only if the failure to exercise reasonable care increased the risk of harm to another [or] if that failure increased the risk of harm or left the person in worse condition than before the intervention” (p. 1). Federal courts have dealt with the latter issue through several pivotal cases such as *Farmer v. Brennan* (511 U.S. 825, 1994) and *Dunn v. Voinovich* (93-166 S. D. Ohio) (DeMateo, 2008; Leong, 2010). These cases held that prison officials have an Eighth Amendment duty to provide humane conditions of confinement, which includes humane and responsive mental healthcare, and that correctional staffs can be held liable under the Eighth Amendment for acting with *deliberate indifference* to an inmate’s health or safety (DeMateo, 2008; Leong, 2010).

**Economic issues.** Consideration must also be given to economic issues surrounding the best use of scarce public resources (Fox & Albertson, 2010). The correctional system is demand-led, meaning that the judiciary primarily determines the
number and nature of inmates committed to jails and prisons (Fox & Albertson, 2010). When demand stretches short-term capacity on the supply side, institutional staffs must utilize finite resources to manage the inmate populations they serve. While it is true that providing CIT training to correctional officers throughout the country would have opportunity cost implications, in that the benefit of alternative uses of those funds would be foregone, it is reasonable to expect – and limited empirical analysis seems to support – that the benefits derived from CIT training would substantially outweigh the opportunity costs (Cattabriga, Deprez, Kinner, Louie, & Lumb, 2007; Fox & Albertson, 2010; Parker, 2009).

**Analysis.**

**Incorporating CIT training into correctional settings.** While CIT is typically conceptualized as a patrol-based initiative, there is nothing inherent in the CIT model that would preclude its incorporation into correctional settings (Compton et al., 2008; Reuland et al., 2010). In fact, a 2005 program evaluation of a successfully implemented jail-based CIT initiative in Portland, Maine, demonstrated a marked improvement in client-centered collaborations between correctional staff and jail mental healthcare providers after CIT was adopted within the jail (Compton et al., 2008). Moreover, the 2002 *Consensus Project Report* produced by the Council of State Governments Justice Center (as cited in Reuland et al., 2010) noted the importance of enacting consistent policies and practices across the entire criminal justice continuum. This included the application of post-booking interventions aimed at identifying and de-escalating people with mental illnesses within correctional institutions and referring them to mental health
services – a process that entails skill sets virtually identical to those possessed by CIT-trained patrol officers (Reuland et al., 2010).

A principal advantage of adapting the CIT model to correctional settings is that it has been vetted, refined, and successfully implemented by thousands of law enforcement agencies across the U.S. and around the world for over two decades (Compton et al., 2008; Reuland et al, 2010; Schwarzfeld, Reuland, & Plotkin, 2008). In other words, there would be no need to reinvent the proverbial wheel. The 40-hour training component of CIT covers topics that are equally relevant to patrol and correctional officers, including the recognition of mental illnesses, an introduction to psychopharmacology, the development of verbal crisis de-escalation skills, and imparting an appreciation of the impact of mental illness on consumers and their families (Reuland et al., 2010; Sayre & Brodie, 2010; Schwarzfeld et al., 2008). Another essential element of CIT training that would lend itself to effective integration into correctional settings is collaborative planning involving a broad spectrum of community stakeholders, focused on tailoring the initiative to the needs and resources of the particular institution (Reuland et al., 2010; Schwarzfeld et al., 2008).

Common objections to implementing CIT programs include the drain on staff resources inherent in any 40-hour training, as well as reluctance on the part of criminal justice executives to commit time and money to CIT training in the absence of existing mental health services to which officers can hand off persons contacted in CIT contexts (Compton et al., 2008; Schwarzfeld et al., 2008). Such objections notwithstanding, many jurisdictions have found that the benefits realized from implementing CIT programs substantially outweigh the temporary burdens associated with losing staff for a weeklong
training, and that the collaborations formed among stakeholder agencies in the collaborative planning and implementation processes can form the basis for developing follow-up services – for example, mental-health-center-based CIT case management services – that could not have materialized but for the existence of a CIT program (Compton et al., 2008; Reuland et al., 2010; Schwarzfeld et al., 2008). Since the knowledge, skills, and attitudes imparted during CIT training are equally applicable to patrol officers and correctional staff, and since patrol and correctional officers deal with essentially the same populations, it would be reasonable to hypothesize that correctional officers would achieve similar positive outcomes from CIT training as their patrol counterparts.

**Less time-intensive training models.** Of course, less time-intensive training models exist, and may be more feasible than a weeklong CIT training program in agencies with severe staffing shortages (Reuland et al., 2010). Additionally, in agencies that have organized CIT as a specialized subset of officers, abbreviated versions of mental health awareness training may be more suitable for those who are not members of the Crisis Intervention Team (Reuland et al., 2010). For example, the Los Angeles Police Department provides 24 hours of online training in mental health crisis de-escalation to its officers who are not part of CIT (Reuland et al., 2010). Other agencies have implemented brief, periodic in-service trainings on mental health-related topics as an alternative to putting all of their personnel through 40-hours of CIT training (Reuland et al., 2010). While these abbreviated training models may be valuable as an adjunct to the more comprehensive CIT training curriculum, and would almost certainly be more beneficially than receiving no mental health-related training at all, it would be equally
reasonable to hypothesize that the benefits derived from brief mental health training would be less significant than the outcomes realized from 40-hours of CIT training.

**Strategic Plan.**

**Marketing and global dimensions.** Mental illness is widely regarded as an equal opportunity ailment, spanning all social, economic, and geographic boundaries (Earley, 2006). Inmate populations, particularly among low-level repeat offenders, also tend to be highly transitory (Ford, 2005). These factors combine to suggest that inmates with mental illnesses are equally likely to be found in correctional facilities anywhere in the nation, and that these inmates, who are often charged with substance-related and nuisance crimes, are likely to cycle through multiple correctional institutions throughout their lifetimes (Earley, 2006; Ford, 2005; Torrey et al., 2011). Hence, the demand for specialized mental health training for correctional officers is broadly distributed across the global spectrum of correctional settings, from local lockups to state and federal prison systems. Since the first and most challenging step of marketing any new product, such as a specialized mental health training program, is the *creation of demand*, this global distribution of mentally ill inmates has created a widely acknowledged *unmet need* among correctional workers, making the marketing of correctional CIT training a relatively simple proposition (Lehmann & Winer, 2008; Northcentral University, 2008).

**Finance and accounting.** The remarkably similar experiences of established CIT programs in Georgia, Utah, and Colorado indicate that it costs approximately $200 per student to deliver CIT training, which includes the cost of materials as well as compensation for key instructors and role-play actors (National Alliance on Mental Illness, n.d.; Sayre & Brodie, 2010). Jurisdictions have accessed a broad array of funding
streams to pay these costs, including state and federal grants, legislatively earmarked jail booking fees, local training budgets, and marketing the training to outside entities on a fee-for-service basis (Denes & Ramirez-Romero, 2011; National Alliance on Mental Illness, n.d.; Sayer & Brodie, 2010). Obviously, since public funds are used to facilitate CIT training, hosting agencies must take care to adhere to the generally accepted accounting principles promulgated by the Financial Accounting Standards Board, which form the basis of all governmental accounting systems in the U.S. (Holt, 2007).

Creating sustainable CIT training programs in federal, state, and local correctional institutions across the U.S. will require not only substantial commitments of time and effort on the part of many partner organizations, but also the expenditure of sizable sums of money over an extended period. Yet, while many such large-scale programs are hamstrung by staggering implementation costs, CIT training can often be accomplished at nominal expense precisely because of the collaborative nature of the undertaking, as described by the National Alliance on Mental Illness (n.d.):

Because CIT is developed through community collaborations, it can be accomplished at low cost, through mostly volunteer efforts. In fact, asking partner organizations to commit their resources to CIT creates a sense of ownership over the program, which leads to long-term sustainability. (p. 1)

Cost-related assumptions. Estimating the overall costs of this program requires the assumption of certain facts, but the inputs are readily available, so the calculations are straightforward. Two central assumptions guide this cost estimate. The first is that personnel and overhead costs that would exist regardless of this project are immaterial; that is, only the marginal or incremental costs of implementation – sometimes referred to
as *hard costs* – will be considered (Thomas & Maurice, 2008). The second is that the number of correctional officers employed throughout the country, the inmate population, and the price of labor and materials will remain flat throughout the multi-year implementation period. While these latter assumptions are admittedly theoretical, they are necessary to permit all calculations to be expressed in 2011 U.S. dollars. Additional assumptions include the following:

- The National Institute of Corrections (NIC) will continue its leadership role in engaging collaborative CIT planning teams across the U.S. through its weeklong management training symposia conducted at its national training academy in Aurora, Colorado (Dooley, 2010).

- In the future, the NIC will explore the feasibility of less costly training models, including regionalized training and virtual training conducted in partnership with local colleges and universities, but these changes are unlikely to occur until after the initial three-year rollout of on-site trainings has been completed (personal communication with A. Pollard, July 27, 2011).

- As of July 2011, a total of 17 states will have become engaged in this process, meaning that 33 states remain to be so engaged (Cattabriga, Deprez, Kinner, Louie, & Lumb, 2007; Denes & Ramirez-Romero, 2011; Dooley, 2010).

- At each management symposium, the NIC can accommodate 30 students, representing two three-person teams from each of five states (Dooley, 2010).

- Two contract trainers will be needed to facilitate each NIC symposium. The costs for the services of these two trainers will average $3,500 per symposium (Dooley, 2010; personal communication with A. Pollard, July 9, 2011).
• Travel, lodging, and miscellaneous expenses for each person attending the NIC training will average $850.

• Thus, the total costs incurred by the NIC to conduct seven additional symposia, thereby engaging germinal teams in all remaining states, will be $208,950, which could readily be spread across three years at a cost of $69,650 per year.

• A total of 454,500 correctional officers are employed in the U.S. at the federal, state, and local levels (Bureau of Labor Statistics, 2011).

• In the first year of implementation, the targeted penetration rate in the 17 states already engaged in correctional CIT training would be 10 percent of correctional officers; thereafter, the targeted long-term national penetration rate would be 70 percent of correctional officers.

• Conservatively estimated, two percent of correctional officers have already completed CIT training (Cattabriga, Deprez, Kinner, Louie, & Lumb, 2007; Denes & Ramirez-Romero, 2011; Dooley, 2010).

• Thus, 311,787 correctional officers would require CIT training during the initial implementation period, which could be accomplished over the course of five years beginning in fiscal year 2013.

• To account for staff turnover, approximately five percent of correctional officers nationwide will need to complete CIT training after the initial six-year rollout, in order to maintain a 70 percent penetration rate (Bureau of Labor Statistics, 2011).

• On average, CIT training costs $200 per student, which includes the costs of materials as well as compensation for key instructors and role-play actors (National Alliance on Mental Illness, n.d.; Sayre & Brodie, 2010).
Discussion. Incorporating each of these assumptions, the resultant costs associated with this initiative are depicted in Table 1 below.

Table 1

*Projected CIT Training Costs by Year*

<table>
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<th>Year</th>
<th>NIC</th>
<th>Local</th>
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<tr>
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<tr>
<td>Total</td>
<td>208,950</td>
<td>69,931,180</td>
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</table>

*Note.* All figures are in 2011 U.S. dollars.

The ongoing cost of providing CIT training to account for staff turnover is estimated to be $4,545,000 per year. While the aggregate figures seem high, it is important to remember that this financial burden would be spread across a system housing roughly 2.3 million inmates and employing nearly a half-million correctional officers at any given time (Bureau of Labor Statistics, 2011; Minton, 2011; Pew Center on the States, 2010).

Put another way, the initial six-year rollout would cost, on average, $4.63 annually per inmate – less than two cents a day – and the ongoing cost of training due to staff turnover would be $1.93 per inmate annually. If one compares these figures to the cost of keeping a mentally ill inmate incarcerated for just one additional day – currently calculated at $63 in the Douglas County, Colorado, jail, for example – the economic sense of providing
CIT training to correctional officers becomes self-evident (personal communication with A. Cataffo, April 28, 2011).

**Management and leadership responsibilities.** Adopting the CIT model represents a significant change to the *status quo* in most correctional institutions. Skillfully managing this change and implementing organizational processes and policies supportive of CIT are critical functions of institutional leadership that will ultimately determine the program’s long-term success (NIC, 2011; Sayre & Brodie, 2010). In its 2011 sourcebook on CIT in correctional institutions, the NIC emphasized the crucial role of leadership in creating sustainable CIT programs thusly:

Leadership cannot be limited to endorsing the program and authorizing staff training. Establishing the CIT program must be a high organizational priority demonstrated through visible and practical behaviors both within the agency and with [external] partners. . . Corrections leaders must embrace new partners and generate a supporting culture through frequent communications and messages about the value of a CIT program. (p. 30)

Managers are responsible for “creating or adjusting organizational structures, policies and processes that support the program and its impact on the [organization’s] culture” (NIC, 2011, p. 31). Specific management functions that bear upon the success of a CIT program include: (1) adjusting officers’ schedules to facilitate their training; (2) securing and devoting funding to the effort; (3) assigning responsibility and empowering personnel to coordinate program activities; (4) recruiting appropriately skilled officers to attend the training; (5) revising deployment strategies to maximize the availability of CIT-trained officers across shifts and posts; and (6) working with facility mental health
staff to align policies pertaining to information sharing among institutional staff, medical providers, and mental health practitioners (NIC, 2011).

**Communicating the program’s mission and vision.** Many well-intentioned and passionately implemented social programs lose momentum and ultimately fail because they are undertaken without a clear sense of purpose or direction, a unifying philosophy that recognizes the objectives of the program’s various stakeholders, a salient concept of the desired future state, or a means to measure whether and to what extent the end state was ultimately attained (Christenson & Walker, 2008; King, Case, & Premo, 2010; National Institute of Corrections, 2011). Each of these shortcomings can be avoided, at least in part, through the development and articulation of well-drafted mission and vision statements (Christenson & Walker, 2008; King et al., 2010). Furthermore, the clarity of purpose achieved through the development of these key elements of strategic planning allows project managers to establish meaningful timelines, performance benchmarks, and project outcomes against which the efficacy of program activities can be measured (Chistenson & Walker, 2008; King et al., 2010).

**Mission statement.** At its core, a mission statement is a declaration addressed to an organization or program’s stakeholders that sets forth the entity’s reason for being (King et al., 2010). Depending upon the nature of the organization or program, a mission statement might express such factors as the entity’s business purpose, products or services, self-concept, philosophy, values, customers, and markets (King et al., 2010). McGinnis (as cited in King et al., 2010) posited that “the mission statement must also serve as a framework for evaluating both current and prospective activities” (p. 72).
The project that is the topic of this paper will be referred to as the Crisis Intervention Teams (CIT) Correctional Integration Project, or more succinctly, the CIT Correctional Integration Project. As previously discussed, this project is conceptualized as an extension of a pilot program undertaken by the NIC during fiscal year 2011 (Dooley, 2010). Since the NIC is expected to continue its national leadership role as this program comes to fruition, a useful starting point would be to look at the NIC’s mission statement: “The National Institute of Corrections is a center of learning, innovation and leadership that shapes and advances effective correctional practice and public policy” (National Institute of Corrections, 2011, p. 1). The CIT Correctional Integration Project’s mission statement should complement the NIC’s mission, while at the same time setting itself apart from all other projects in terms of its purpose and scope (King et al., 2010). The mission statement for the extant project, then, might be worded thusly: *The mission of the CIT Correctional Integration Project is to engage, educate, and empower collaborative stakeholder teams from correctional institutions across the United States to develop sustainable Crisis Intervention Team programs within their home institutions.*

**Vision statement.** According to Christenson and Walker (2008), projects that implement government or organizational policy “often fail because project stakeholders are not adequately aware or cognizant of what benefits the project will bring, its importance and impact upon stakeholders, and [how the project] can be delivered” (p. 612). Clear, convincing, and well-communicated vision statements can make “a strong and positive impact upon perceived project success” (Christenson & Walker, 2008, p. 611). Ideally, a vision statement should clarify the desired future state and link it to the project’s mission (Christenson & Walker, 2008). For the extant project, then, the vision
statement might be articulated as such: The CIT Correctional Integration Project envisions jails and prisons at all levels of government staffed by correctional officers who are equipped with the knowledge, skills, and attitudes – and who are empowered to work in partnership with a broad range of stakeholders – to enhance institutional safety, reduce unnecessary administrative and judicial sanctions, optimize clinical outcomes, reduce recidivism, and improve the well-being of inmates with mental illnesses.

Performance benchmarks and project timeline. As discussed earlier, if the NIC continues its current schedule of three CIT leadership symposia per year, germinal leadership teams from all U.S. states could be trained in just over two years. Of course, the ongoing economic slump has caused the federal government to pare back a wide array of what would commonly be considered social programs. For several months, the sustainability of federal funding surrounding many criminal justice/mental health interface projects, including the viability of NIC’s on-site CIT leadership symposia, were in question (personal communication with A. Pollard, July 9, 2011). Of particular concern was whether Congress would continue funding the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), which is the legislation that since 2004 has authorized the Justice Department’s Justice and Mental Health Collaboration Program (Council of State Governments Justice Center, n.d.). Signaling Congress’s recognition of the importance of criminal justice/mental health initiatives, the House Appropriations Committee on July 13, 2011 approved the fiscal year 2012 Commerce, Justice, and Science Appropriations bill, which included a $9.96 million appropriation to continue funding programs under MIOTCRA (Association of State Correctional Administrators, 2011). Although this was only the first of many steps in securing final
passage of Congressional appropriations for MIOTCRA, is was enough to solidify the NIC’s 2012 CIT training schedule, which will consist of CIT leadership symposia in December of 2011, and March and July of 2012 (personal communication with A. Pollard, July 9, 2011).

Because the success of the CIT Correctional Integration Project hinges on the continuation of federal funding for NIC to provide much-needed national leadership, the first major performance benchmarks would logically be: (1) ensuring the continuation of federal funding for fiscal years 2012 through 2014; and (2) engaging CIT leadership teams from all 33 remaining states by the end of fiscal year 2014. Another major component of the project’s success will be raising awareness among correctional administrators of the benefits of implementing CIT programs within their institutions, and of the availability of trained local leaders to act as mentors, coaches, and technical advisors to institutions interested in establishing their own CIT programs. One way of efficiently delivering this message to large numbers of correctional administrators is to prepare an outreach program to be presented at the national conferences of the American Correctional Association (ACA) and the American Jail Association (AJA). Work is currently underway to get this presentation on the agenda of the ACA’s national conferences in Phoenix, Arizona, during the week of January 20-25, 2012, and in Denver, Colorado, during the week of July 20-25, 2012, as well as at the AJA’s annual conference in Reno, Nevada, during the week of April 22-26, 2012 (personal communication with A. Pollard, July 9, 2011).

**Key leadership and management actions.** Christenson and Walker (2008) characterized projects that implement organizational policy as “change management
events” (p. 612). Indeed, at both the national and local levels, getting correctional administrators and their management staffs to understand the need for an undertaking of this scope, and to provide the ongoing leadership to see the project through, will require a studied approach to the organizational change process. As part of its CIT leadership training, the NIC advocates Kotter’s eight-step change management model as a simple yet effective way of creating the organizational forces needed to make sure that change becomes engrained within the structures and cultures of institutions (National Institute of Corrections, 2011). Although a complete discussion of Kotter’s change model is beyond the scope of this paper, the steps can be summarized as: (1) establishing a sense of urgency; (2) creating a guiding coalition; (3) developing a vision and strategy; (4) communicating the change vision; (5) empowering broad-based action; (6) generating short-term wins; (7) consolidating gains and producing more change; and (8) anchoring new approaches in the culture (National Institute of Corrections, 2011).

Within organizations that have decided to implement CIT programs, an often overlooked yet critical leadership function is to “identify and support a program champion who is in a position of authority within the organization and who demonstrates a commitment to the CIT program” (National Institute of Corrections, 2011, p. 37). The experience of many established patrol-based CIT programs suggests that the strongest programs are those that are led by passionate program champions who maintain their roles relative to the CIT program regardless of their specific assignments within their agencies (Denes & Ramirez-Romero, 2010; National Institute of Corrections, 2011). Organizations that assign the CIT coordination function to a specific job description, which is filled by various personnel over time, tend to have CIT programs that are less
robust and that lack the necessary emphasis within the organization’s culture. This can be attributed to the interruption of organizational momentum surrounding the CIT initiative (Denes & Ramirez-Romero, 2010; National Institute of Corrections, 2011). Identifying and empowering a program champion is especially critical during the early stages of program development, when acceptance of the new program by mid-level managers and line staff may not yet be fully realized.

Implementation Plan.

The purpose of the CIT Correctional Integration Project is to engage and train at least two leadership teams from each of the 33 U.S. states that have not yet implemented CIT programs within their jails and prisons. This will facilitate the genesis of sustainable corrections-based CIT programs within the teams’ home institutions, and will equip team members to serve as mentors to correctional administrators in neighboring communities who are interested in creating their own CIT programs (Dooley, 2010; National Institute of Corrections, 2011). Two primary mechanisms will be utilized to accomplish the project’s mission, which can be delineated as the training and awareness components.

Training component. Assuming that future participant teams are selected to represent states that have not previously received the NIC’s CIT leadership training, teams from all remaining states could be trained in as few as seven sessions, although at least two additional training sessions should be scheduled in fiscal year 2014 to account for delayed participation by some states. The training team retained for fiscal year 2012 consists of a program manager from NIC, a social worker from Florida, and a law enforcement administrator from Colorado (personal communication with A. Pollard, July 9, 2011). Training sessions during fiscal years 2013 and 2014 would presumably be
scheduled similarly to the 2012 trainings, and with a training team of similar
composition, although the exact details will be dependant upon several factors, including
the availability of trainers, facilities, and funding (personal communication with A.
Pollard, July 9, 2011).

**Awareness component.** The second primary component of this project involves
raising awareness among correctional administrators of the benefits of implementing CIT
programs within their institutions, and of the availability of trained local mentors to
advise facilities new to CIT.

Table 2.
*Implementation timeline.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>December 5-9, 2011</td>
<td>NIC training session 1</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>January 20-25, 2012</td>
<td>ACA Conference</td>
<td>Phoenix, AZ</td>
</tr>
<tr>
<td>March, 2012</td>
<td>NIC training session 2</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>April 22-26, 2012</td>
<td>AJA Conference</td>
<td>Reno, NV</td>
</tr>
<tr>
<td>July, 2012</td>
<td>NIC training session 3</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>July 20-25, 2012</td>
<td>ACA Congress</td>
<td>Denver, CO</td>
</tr>
<tr>
<td>December, 2012</td>
<td>NIC training session 4</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>March, 2013</td>
<td>NIC training session 5</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>July, 2013</td>
<td>NIC training session 6</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>December, 2013</td>
<td>NIC training session 7</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>March, 2014</td>
<td>NIC training session 8</td>
<td>Aurora, CO</td>
</tr>
<tr>
<td>July, 2014</td>
<td>NIC training session 9</td>
<td>Aurora, CO</td>
</tr>
</tbody>
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This message can be efficiently delivered through presentations at the conferences of the
professional associations representing American correctional administrators. The
schedules of these conferences are shown in relation to the proposed NIC training events in Table 2 above (personal communication with A. Pollard, July 9, 2011). Continuation of this component of the CIT Correctional Integration Project beyond fiscal year 2012 will be contingent upon the availability of funding. Moreover, the efficacy of this method of outreach will need to be assessed based upon feedback received from the three conferences held in 2012 (personal communication with A. Pollard, July 9, 2011).

Conclusion.

The comprehensive introduction of CIT training programs into correctional institutions throughout the U.S. would be a logical extension of the successes realized by CIT-trained patrol officers over the past two decades. However, developing broad support for the implementation of CIT programs in jails and prisons would entail significant investments of time and money, and would necessitate a system-wide paradigm shift regarding the role that correctional officers play within the criminal justice/mental health interface. Because the frequency and intensity of mental health emergencies encountered in correctional institutions are typically more pronounced than those seen in patrol environments (Torrey et al., 2011), it would be most advantageous to put correctional officers through the full 40-hour CIT training curriculum, rather than some abbreviated version of mental health training. Moreover, skillful strategic planning will be required by administrators and managers of institutions that choose to adopt this model, in order to ensure that their CIT programs are sustainable and firmly ingrained within their institutional cultures. Credible national leadership will be central to making this prospect a reality. The CIT Correctional Integration Project discussed in this paper, led by the National Institute of Corrections, would be a viable and cost-effective way of
achieving this ambitious vision. By making the necessary commitments to ensure this project’s success, the American correctional establishment may finally be able to affect a positive change in the social problems inherent in the criminalization of mental illness – problems that have blighted the criminal justice system for centuries.
References


