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# **CRISIS INTERVENTION TEAM (CIT) TRAINING FOR CORRECTIONAL OFFICERS**

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AN EVALUATION OF NAMI MAINE'S 2005-2007  
EXPANSION PROGRAM



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## I. SUMMARY

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Many county jails in Maine routinely face challenges due to constraints on resources and staffing, placing inmates with serious mental illness at high risk of having their conditions overlooked or ignored. To address the needs of inmates with mental health and substance abuse problems and the limited resources available to help them during incarceration, NAMI Maine developed an expansion Crisis Intervention Team (CIT) training program to educate law enforcement and correctional officer teams to successfully identify mental health-based problems and appropriately intervene in psychiatric emergencies. The two-year expansion program builds upon a pilot project that was completed in 2005. This report evaluates the effectiveness of the expansion program, particularly its effectiveness among correctional officers, who have not traditionally been included in CIT training.

The CIT model is a nationally recognized pre-booking diversion program for preventing unnecessary incarceration or institutionalization of people with mental illness. Likewise, the preventative focus is useful in diverting unnecessary use of local medical facilities. CIT has been shown to improve health outcomes and help prevent the exacerbation of psychiatric illness that often accompanies incarceration.<sup>1,2,3</sup> During the expansion program, correctional and law enforcement officers from Kennebec, Cumberland, Knox/Waldo, Somerset, Franklin, Washington, and Lincoln/Sagadahoc Counties were trained in CIT skills during week-long training sessions held in each county or region. NAMI provided ongoing support to corrections and law enforcement sites prior, during, and after the training to all participants and facilities committed to CIT training.

To accomplish the goals of the evaluation and to test whether expected outcomes were met, data was collected before, during, and after the program to evaluate the impact of adapting the CIT model within a correctional institution. Data collection was conducted through surveys and focus groups with correctional officers, key stakeholder interviews, and review of jail incident reporting forms. Analysis of the data provides insight into the effects of CIT implementation in a jail setting and illustrates gaps in program outcomes.

The main findings of the evaluation include:

- Before attending CIT training, Maine correctional officers generally did not feel they had received adequate training in crisis intervention. This problem is made worse because jails do not consistently have adequate staffing or staff skilled in working with inmates' mental health and substance abuse problems, and community resources to assist staff and inmates are not readily available to the jails.
- Support from NAMI before, during, and after the training helped CIT supervisors at the jails overcome some of the difficulties they faced in implementing CIT.

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<sup>1</sup> Police Response to Mental Health Emergencies – Barriers to Change. Dupong, Cochran. *Journal of the American Academy of Psychiatry and the Law*. 28: 338-44, 2000.

<sup>2</sup> Crisis Intervention Team training for police officers responding to mental disturbance calls. Teller, JLS, MR Munetz, KM Gil, C Ritter. *Psychiatric Services*. February 2006. 57:232-237.

<sup>3</sup> <http://www.memphispolice.org/Crisis%20Intervention.htm>. Accessed September 19, 2007.

Meetings were held regularly, and questions and concerns were addressed in a timely manner.

- Officers generally found the CIT training sessions to be useful in broadening their understanding of mental illness and substance abuse issues. They appreciated the opportunity to hear from family members of people with mental illness or substance abuse disorders at the CIT training and suggested expanded opportunities for role playing in future trainings.
- 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.
- Officers who volunteered to attend the training tended to gain more knowledge and better understanding of CIT issues after attending the training compared to those who were mandated to attend. However, key informant interviews indicated that there is value in providing training to officers of all temperaments, background, and interest levels.
- The opportunity for correctional officers to gain awareness about mental health issues with members of law enforcement was a valuable and beneficial component of the training that provided important networking opportunities for both groups.
- Between May 2006 and August 2007, 162 CIT incidents were reported by participating county jail sites. There did not appear to be a correlation between the size of the jail and number of incidents reported. Although the number of trained officers at each site increased over time, the number of events observed did not appear to have increased over time. Instead, the incident rate peaked during some months.
- Approximately one quarter of CIT incidents involved at least one type of inmate aggression. To control the situations, officers were more likely to use force during instances of inmate aggression and verbal de-escalation techniques when inmates did not exhibit aggression.
- Inmates requiring CIT interventions are more likely to have preexisting mental illness and/or substance abuse problems. More than two thirds of the incidents included inmates with at least one mental health condition and almost two thirds of CIT incidents involved an inmate with at least one type of substance abuse problem.
- The most CIT incidents resulted in a mental health referral to a provider or community service.

- Some injuries occurred during CIT reported incidents. Of the 13 injuries sustained by inmates, 5 required medical attention. Of the 3 reported injuries to officers, 2 required medical attention. It is important to note that only one inmate injury resulted from CIT officer use of force; the rest occurred prior to officer intervention.<sup>4</sup>

Findings suggest that NAMI's introduction of the CIT model to correctional facilities across seven Maine counties was effective. The CIT program received positive feedback from correctional officers and was recognized as filling a gap in correctional officer training. However, beyond the training, documenting and reporting CIT incident reporting in the jail setting proved to be a challenge for some organizations. Although policies and standard operating procedures were in place to require that all CIT incidents be reported, few were actually completed. Findings suggest that ongoing clarification is needed across locations on what constitutes a CIT incident. Due to the lack of reporting consistency, it was difficult to collect reliable and comparable incident data from participating jails for evaluation purposes.

The current demands within Maine's corrections system make the CIT training program a timely and important program. However, the high turnover rate associated with correctional officer positions will make it challenging for administrators to sustain the CIT program without dedicated funds and the support of agency leaders. Additionally, it will be essential to continue to train new officers in CIT and to offer refresher courses to those who have been trained in the past.

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<sup>4</sup> When injuries to inmates occurred, CIT officers were asked to mark on a CIT form whether that injury occurred prior to the contact with the corrections officer or whether the injury was caused by use of force by the corrections officer. There is no information on where injuries occurred if they occurred prior to contact with the corrections officer (e.g., within jail, in community, etc.).

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## II. INTRODUCTION

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Inmates with mental illness or co-occurring substance abuse problems are among the most stigmatized, neglected, and vulnerable groups in the country. The rates of mental illness among inmates are three to four times higher than the rates in the general population. Federal Bureau of Justice statistics suggest that nationally, 16% of inmates are seriously ill. However, estimates for Maine are much higher at 25%<sup>5</sup>, accounting for nearly 10,000 of Maine's inmates each year. In short, Maine has significantly more inmates with mental health and/or substance use conditions than the rest of the nation and few resources to help them. The lack of adequate resources to treat inmates with serious mental illness places these inmates at high risk for death by suicide, drug overdose or withdrawal and underscores the pressing need to prevent the unnecessary arrest and incarceration of people with mental illness and substance abuse problems. Furthermore, individuals who are incarcerated have the right to serve their sentence in an environment that can facilitate and support their recovery and reentry into society.

To address these issues, NAMI Maine launched a pilot training program for law enforcement and correctional officers, using the Crisis Intervention Team (CIT) model. The CIT model is a nationally recognized pre-booking diversion program for preventing unnecessary incarceration or institutionalization of people with mental illness. Likewise, the preventative focus is useful in diverting unnecessary use of local medical facilities. CIT has been shown to improve health outcomes and help prevent the exacerbation of psychiatric illness that often accompanies incarceration. The hallmark of CIT is its effective use of volunteers (officers and providers volunteer to participate) and its focus on changing local behavior and the responses of law enforcement and corrections officers to successfully identify and intervene in psychiatric emergencies. While CIT traditionally has been used with law enforcement officers, NAMI Maine's pilot program also extended CIT training to correctional officers.

A CIT program traditionally starts by identifying and securing support from key community stakeholders including local families, consumers, and providers willing to participate in hands-on training, role playing, and site visits that comprise the core 40 hour CIT training. CIT training improves officers' ability to recognize mental health disorders, respond appropriately to the needs of a person with mental health problems, and appropriately make referrals to community-based services. CIT addresses these issues in a comprehensive and systemic way by:

- Training officers to understand and recognize psychiatric signs and symptoms;
- Training officers to use de-escalation skills to calm and reassure people with psychiatric disorders - these skills frequently conflict with tactics learned in

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<sup>5</sup> Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers, 7/1999; Bureau of Justice Statistics Special Report, Mental Health Treatment in State Prisons, July 2001; Final Report, Maine State Legislature. Committee to Study the Needs of People with Mental Illness who are Incarcerated. 12-2002, Report of the Commission to Improve the Sentencing, Supervision, Management, and Incarceration of prisoners. Jan. 2004.

criminal justice training programs, where officers are trained with a public safety approach to take immediate control of the situation rather than taking a person-centered approach that benefits a person in crisis.

- Linking officers with mental health service providers in their local community who can respond quickly to calls for assistance;
- Building on each officer's experience and comfort level in working with individuals with psychiatric disorders.
- Networking officers with local mental health and community service providers, families, consumer organizations, and emergency room staff to forge future referral and consultative relationships; and
- Providing on-going training and consultation to CIT teams and the community organizations with which they have been linked.

CIT was featured at the 1999 White House Conference on Mental Health as a best practice and has since been replicated nationwide. CIT promotes a systemic change for crisis care by focusing on the provision of support and treatment from a community approach, rather than relying on individual public programs. In Memphis, where the program was first implemented with police officers in 1988, 75% of mental disturbance cases resulted in a treatment disposition, rather than the historic approach of arrest or restraint disposition.<sup>6</sup> Additional studies on the effectiveness of CIT in the community have identified two positive outcomes of CIT: (1) officers felt well prepared to respond to psychiatric crises and (2) the program has transformed police officers into being more friendly towards the mental health system.<sup>7,8</sup>

In 2005, NAMI Maine's pilot CIT program trained law enforcement and correctional officer teams to successfully identify and intervene in psychiatric emergencies. The pilot project significantly improved the identification and treatment of individuals with serious behavioral health problems in seven Maine towns and one jail.<sup>9</sup> Success with the pilot CIT program led to requests to expand trainings to additional cities and jails. NAMI Maine responded by developing an expansion program funded by ten organizations, with the largest contribution coming from the Maine Health Access Foundation (MeHAF). The expansion program was designed to improve the manner in which individuals demonstrating psychiatric crises are treated and managed, strengthen access to mental health services for inmates, and establish and/or strengthen the link between the corrections system and community behavioral health providers. Due to the success of the pilot program, the State of Maine has dedicated funds to supplement NAMI's efforts to continue this work throughout the state and to offer CIT to more corrections officers.

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<sup>6</sup> Police Response to Mental Health Emergencies – Barriers to Change. Dupong, Cochran. Journal of the American Academy of Psychiatry and the Law. 28: 338-44, 2000.

<sup>7</sup> Crisis Intervention Team training for police officers responding to mental disturbance calls. Teller, JLS, MR Munetz, KM Gil, C Ritter. Psychiatric Services. February 2006. 57:232-237.

<sup>8</sup> <http://www.memphispolice.org/Crisis%20Intervention.htm>. Accessed September 19, 2007.

<sup>9</sup> CHPPR also served as the evaluator for this pilot project.

An evaluation of the effectiveness of the expansion program was conducted by the Center for Health Policy, Planning, and Research (CHPPR) at the University of New England. This report presents the highlights of that evaluation.

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### III. PROJECT BACKGROUND

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#### OVERVIEW

Correctional officers and law enforcement officers from Kennebec, Cumberland, and Knox/Waldo Counties began the expansion program during the first year of the evaluation with Somerset, Franklin, Washington, and Lincoln Counties beginning CIT training during the second year. In some counties, more than one training session was necessary to meet the demands of officers in the area. For example, training was held in Cumberland County in the first year and repeated in the second year to train additional correctional and law enforcement officers who had not been trained initially. Regardless of the time CIT training was received, all participating county jails are listed in Table 1. The table presents information on the average inmate population, the dates of the training, and the number of correctional officers trained.

**Table 1: County Jails Participating in NAMI Maine's CIT Trainings during the Expansion Project**

County Jail	Dates of Training	Average Inmate Population <sup>10</sup>	Current Bed Capacity <sup>11</sup>	Size of Jail (Small, Medium, Large)	Total Number of Correctional Officers Trained
Cumberland	Feb 27 – Mar 3, 2006 Sept 11, 2006 May 21-25 <sup>th</sup> , 2007	430	490	Large	14
Kennebec	March 27, 2006 Oct 16, 2006	164	131	Large	14
Knox	April 24, 2006	56	55	Medium	4
Waldo	April 24, 2006 January 2007	30	33	Small	9
Somerset	March 26-30, 2007	55	45	Medium	4
Franklin	April 30-May 4, 2007	26	23	Small	7
Washington	June 25-29, 2007	48	42	Medium	17
Lincoln/Sagadahoc	May 14-18, 2007	26	20	Small	5

#### SUPPORT PRIOR TO TRAINING

Prior to each of the trainings, NAMI had contact with each of the sites for six to eight months, presenting them with information on the CIT program, including the history of how the CIT model was developed in Memphis. Findings that supported the

<sup>10</sup> Data from communication with Mark Rubin, University of Southern Maine, Muskie School, Aug 2006.

<sup>11</sup> Austin, J. Maine Department of Corrections, Maine County Jail Population Study. February 2002. <http://www.maine.gov/spo/sp/commission/docs/JailPopStudy.pdf>

implementation of the program in Memphis were compared and contrasted with prior efforts to address mental health issues of inmates in Maine. The conclusions were used to explain why the model makes sense and what the benefits of receiving the training were. After receiving information on CIT, sites decided if they wanted to participate in the training. For those that chose to participate, a training date was arranged.

During the lead-up to each training session, NAMI carried out a variety of tasks to ensure that training sessions and materials would be tailored to meet the needs of the local area. Using knowledge from prior work in the community, NAMI identified and contacted mental health providers, mental health crisis providers, sheriffs, police chiefs, and other community members concerned with CIT issues in each local area. The goal was for officers in each county to receive training from providers and stakeholders in their local communities with whom they would interact on a regular basis. NAMI screened every community site thought to be appropriate for officer site visits prior to the training.

Potential CIT officer participants were also selected during this time. Potential candidates who possessed the skills and interests appropriate for CIT training were identified by the sheriff or police chief, and were given a package containing information on the core tutorials and activities that would take place during training. In most cases, an oral board was then formed to interview potential participants. The oral board usually consisted of a NAMI representative, a mental health representative, and a command staff representative. Interviewers only selected officers whose values aligned with the core values of CIT. Site administrators made efforts to train at least one officer on each shift but some shifts have no trained officers due to staff rotation and turnover.

Another activity that generally took place prior to the training was the writing of policies or standard operating procedures to be implemented after officers returned from the training. NAMI shared model policies with new sites and provided support to new sites for the writing of their own policy. Having standard operating procedures in place prior to the training ensured full organizational commitment and support for the CIT program prior to the training.

### **STRUCTURE OF TRAINING SESSIONS**

During the week of each training, representatives from NAMI facilitated the training sessions, bringing in many guest speakers to present information. Figure 1 shows an example of a CIT training schedule. Following the Memphis model, NAMI's 40-hour CIT training was held Monday through Friday and included topics such as background information on mental illness, community resources, consumer perspectives, legal issues, medications, and substance abuse. Role playing was an important component of the training and was used to teach de-escalation skills. One day of the training was devoted to site visits with community resources. In an effort to broaden the officer's perspective on mental illness, family members of people with mental illness told their stories during one session to help officers understand the impact mental illness has on families. Although the content of the sessions is highly structured, the Memphis model allows for some flexibility in selecting issues to be covered (e.g., dementia, aging, autism, deaf

services, etc.). To address the most pressing local issues, NAMI contacted stakeholders prior to the training to determine which issue to focus on during the training

**Figure 1: Example CIT Training Schedule**

	Monday	Tuesday	Wednesday	Thursday	Friday
8am	Intro and Mental Illness Basics	Deaf Services	Community Visits	Resources	Substance Abuse and Co-Occurring Disorders
9am		Consumer Perspectives		Policy and Procedures	
10am	Suicide Prevention	Legal Issues		Personality Disorders	Autism
11am				Family Perspectives	
12pm	Lunch	Lunch		Lunch	Lunch
1pm	Children and Adolescent Mental Health	De-Escalation Skills and Role Play		De-Escalation Skills and Role Play	De-Escalation Skills and Role Play
2pm				Diversity Issues in Mental Illness	Graduation
3pm	Trauma			Psychiatric Meds and Toxicology	
4pm					

**AFTER THE TRAINING**

After the training was completed, NAMI continued to provide ongoing support to sites as officers began to implement their CIT skills. A supervisors’ meeting was held every other month to update supervisors on new information, check on the status of CIT implementation at each site, and check on the reporting of CIT incidents occurring at each site. NAMI developed a newsletter and sent it quarterly to all CIT certified officers. At the end of the training, officers were given contact information for NAMI trainers and encouraged to make contact to ask questions or discuss challenging situations they faced once back at work in the jail. Anecdotal reports indicate that some officers have contacted NAMI trainers for assistance when they came across a difficult case.

Acknowledgement of CIT course completion and certification is done informally at the officer’s workplace with many officers wearing pins to designate they are graduates of the program.

NAMI strongly suggests that officers attend 4-6 hours of training annually to maintain their CIT certification. To facilitate the certification process, NAMI has committed to offering two regional continuing education classes per month with a 50 officer capacity. The topics covered in these sessions will be informed by discussions NAMI has with command staff about issues to which officers need additional exposure. As part of this continuing CIT education effort, NAMI also will disseminate information on other relevant trainings going on throughout the state so that officers who are interested can attend and earn continuing education units. NAMI is working closely with the criminal justice academy to provide curriculum and educational materials that reinforce CIT concepts through adjunct trainings offered at the academy.

**IV. EVALUATION METHODS**

**OVERVIEW**

Although CIT has traditionally focused on training the law enforcement community, the model has not been implemented with correctional officers. To better understand the effectiveness of the program and the unique issues that may arise when applying the CIT model to the corrections community, this evaluation focuses on the implementation of CIT among correctional officers in terms of process (e.g., the degree to which goals for program implementation were met) and outcome (e.g., the effectiveness of the program, as indicated through a set of measures). Data were collected before, during, and after program implementation to evaluate the impact of adapting the CIT model within a correctional institution.

**DESIGN/INDICATORS**

This evaluation focused on three dimensions of the training: implementation of CIT, officer perceptions of the program, and CIT program outcomes (see Table 2).

**Table 2: Evaluation Indicators and Measures**

<b>Domain</b>	<b>Indicators</b>	<b>Data Source</b>	<b>Measures</b>
Implementation	<ul style="list-style-type: none"> <li>• The extent to which each agency implemented CIT within their facility</li> <li>• Variation in CIT implementation across agencies</li> <li>• Continuity of care between county jails and behavioral health providers</li> <li>• Number of CIT related incidents</li> <li>• Descriptions of CIT documented incidents including time of day, month, location, number of officers involved, mental health history among inmates involved in CIT documented incident, Inmate activity/ cause of CIT response</li> </ul>	Key informant interview with CIT supervisors and/or commanding officer at end of year 2  Notes from NAMI's contacts with sites re: implementation  Jail incident forms	Implementation levels with sites re: implementation
Officer Perceptions	<ul style="list-style-type: none"> <li>• Officer satisfaction with CIT program</li> <li>• Officer self-efficacy regarding use of training</li> </ul>	Pre/Post Surveys  Pre-implementation Focus Groups	Likert Scale measures
CIT Program Outcomes	<ul style="list-style-type: none"> <li>• Officer behaviors as measured by use of seclusion/restraint during CIT documented incidents</li> <li>• Document inmate and officer injuries among CIT documented incidents</li> </ul>	Jail incident reports	Rates of seclusion/restraint among CIT documented incidents.  Rates of injury – among CIT documented

The implementation of CIT within jail facilities was an important part of the process evaluation and provides an understanding of the appropriateness of using CIT in the jail setting. Information on how CIT was implemented was collected through interviews with key informants at the jails and at NAMI and through incident forms that officers filled out when a CIT event occurred.

Another important component of the evaluation was officer satisfaction with the CIT program and their comfort level in using what they learned during the training. Officer surveys and focus groups were designed to measure changes in officer perceptions due to the program.

Ideally, implementation of the CIT program should reduce the number of injuries to inmates and officers, improve the quality of in-jail response to suicide threats, aggression, and other psychiatric behaviors (including reduced use of seclusion and restraint), and improve inmate access to treatment during incarceration. Program outcomes were measured through jail incident reports and interviews with CIT supervisors.

## **DATA COLLECTION AND ANALYSIS**

### **CIT Officer Focus Groups**

Focus groups were conducted during most of the CIT training sessions with participating officers. During the first year of the expansion, focus groups with correctional officers from Cumberland, Kennebec, Knox, and Waldo Counties (the first year sites) were conducted *prior to* the CIT training sessions. These focus groups helped the evaluation team gain insight on the various dispositions of correctional officers before receiving CIT training. Officers were asked a series of questions that included prior crisis intervention training, additional training needs, and perceptions and attitudes toward their jobs.

During the second year of the expansion, focus groups were conducted during the *last day* of the CIT training to elicit officer satisfaction with the CIT training program, generate ideas for additional resources to utilize during the training process and gather suggestions for program improvement.

During the second-year focus groups, CIT officers were asked to fill out a brief survey at the end of the CIT training. Survey answers provided insight as to whether officers were more confident in their knowledge and skills when addressing people with mental health and substance abuse disorders within the context of their jobs (see Appendix A). The survey was intended to provide data on the effectiveness of the training and to spark conversation in the focus group. It also provides a comparison between groups of participants (e.g., corrections officers and law enforcement officers, voluntary participants and those who were required to attend), and helped differentiate the effectiveness of CIT for the two groups. Comparisons were made using the Wilcoxon Signed Rank and Pearson Chi Square tests, where relevant.

### **CIT Officer Surveys**

CIT officer surveys were administered to correctional and law enforcement officers before and after they attended the 40-hour CIT training (See Appendix B). The officer survey contained questions about officer perceptions of mental illness, comfort level with their mental health crises intervention skills, familiarity with community mental health

resources, and job satisfaction. Survey items were presented and officers were asked to identify their level of agreement using a Likert-type scale. For example, officers were asked to mark whether they “Strongly Agreed,” “Somewhat Agreed,” “Neither Agreed nor Disagreed”, “Somewhat Disagreed”, or “Strongly Disagreed” with a statement.

In the first year of the expansion, copies of the officer surveys were mailed to the supervisors of officers enrolled in an upcoming CIT training. Supervisors distributed the surveys to these officers, who completed and returned the survey to CHPPR in pre-stamped/addressed envelopes. In the second year of the expansion, initial surveys were conducted in the morning of the first day of the CIT training to ensure a 100% response rate. During both years of the expansion, the officers were re-surveyed after they attended the training and had begun to apply their CIT skills on the job. The post-training survey was administered within several months of attending the training. Again, surveys and pre-stamped and addressed envelopes were mailed to supervisors to give to officers to fill out and send back to CHPPR. Each year, attempts were made to follow up with officers who did not return the surveys.

Data from the surveys were analyzed for changes in officer attitudes and perceptions pre and post training. Where relevant, Wilcoxon Signed Rank tests or Pearson Chi Square tests were used to highlight significant differences between responses of officers before and after training.

### **Jail Incident Forms**

Jail incident forms were first developed for the pilot CIT project in Maine. The incident forms are intended for CIT officers when a CIT incident occurs (See Appendix C). These forms collect information on the time and date of the occurrence, cause of the incident, how the incident was managed by the officer, injuries to the inmate or officer, and the mental health history or status of the inmate. CIT officers were directed to fill out an incident reporting form each time they were involved in a CIT incident. During the first year, jail representatives were asked to mail completed forms directly to CHPPR. However, this method yielded a low response rate. During year 2 of the expansion project, forms were faxed to NAMI Maine and subsequently turned over to CHPPR, resulting in an improved response rate.

During the time between the pilot project and the expansion effort, the form was revised with input from CHPPR and NAMI. Subsequently, a subcommittee was formed including representatives from NAMI, CHPPR, and CIT supervisors to further improve the incident form, ensuring that it was clear and easy to use.

Using data collected on the forms, frequencies characterizing events were computed by incident.<sup>12</sup> The Pearson Chi Squared test was used to test differences in responses between groups or sites.

### **Interviews with Key Informants**

Interviews were conducted to help clarify observed differences between implementation sites, to further elucidate program implementation issues, and to understand general

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<sup>12</sup> Frequencies were not computed by inmate; the same inmate may have been involved in more than one incident

perceptions of the programs. Phone interviews were conducted with CIT supervisors from three jails (Waldo, Washington, and Lincoln/Sagadahoc). An effort was made to choose supervisors from jails participating in both years and from jails that had different experiences in the program. Questions on the utility of the training program, barriers and successes during implementation, interactions with NAMI staff, recruitment of officers, appropriateness of the training for corrections officers, and other perceptions of the program were asked. Data from jail incident forms were also clarified; a phone interview was conducted with one of the CIT trainers from NAMI.

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## V. RESULTS

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### FOCUS GROUPS

#### Pre-CIT Training Focus Groups

The focus groups conducted prior to CIT training identified some important trends and needs among Maine correctional officers, which are presented here.

- ***Before attending CIT training, correctional officers generally had not received adequate training in crisis intervention.*** Previous officer trainings focusing on crisis interventions tended to be minimal in content and of short duration. Officers rated the sessions as inadequate considering the gravity of the problems they routinely encounter in their job.
- ***Additional training for correctional officers combined with a greater level of assistance from mental health and substance abuse treatment professionals is needed.*** Many of the correctional officers in the focus groups felt that they did not have the level of expertise needed to address mental health issues on the job. Since the jails were not appropriately staffed to deal with mental health and/or substance abuse problems, officers expressed a need for increased levels of support from professionals in the treatment communities.
- ***Gaps in community resources available to correctional officers need to be addressed.*** Officers reported that it often takes too long to get the level of help needed and that there were gaps in availability (e.g., weekends, evenings, and holidays). In most jails, the resolution of problems that occur during these gap periods becomes the responsibility of the correctional officer in charge. Officers felt that existing help provided by rehabilitation programs and substance abuse counselors is inadequate, lacks a consistent approach to solving problems, and is rarely successful. There is also a significant disconnect between hospital emergency departments (EDs) and the county jails. EDs do not tend to give priority to inmates.
- ***Correctional officers need assistance given the high stress environment in which they work.*** Focus group participants indicated that the stress and pressure on correctional staff is high. Having to manage inmates who are actively coping (successfully and unsuccessfully) with mental health and substance abuse problems while dealing with the stress of the correctional environment is taking its toll on correctional officers.

#### Post-CIT Training Focus Groups

The focus groups that were conducted at the end of CIT training revealed officers' opinions regarding the usefulness of the training, skills imparted, and ways to improve the training. Both police officers and correctional officers attended these focus groups

pertaining to the training. Data from the focus group survey are also presented in this section.

Eighty-three people attended the post-CIT training focus groups at the five training sites. Of those that attended the focus groups, 22 indicated on the focus group survey that they were corrections officers, 43 were law enforcement officers, 2 were dispatchers, and 3 held other positions. The other 13 did not report their employment position. The mean number of years in service among participants was 10 years.

- ***Officers generally found the training to be very useful in broadening their understanding of mental illness and substance abuse issues.*** Many were touched by stories told by family members of people with mental illness or substance abuse disorders at the CIT training and felt that this helped them empathize with individuals and families. Some felt that role playing activities and site visits were helpful components and that the training was an opportunity to learn about local resources.
- ***The trainings can be improved by keeping language simple and expanding opportunities for role play.*** Many officers felt that there was too much clinical language and that some of the pharmacological information presented was too technical. Many thought that additional opportunities for role play would be helpful so that they could practice using the skills they had learned during training. Some also thought that follow-up training would be useful.
- ***Officers learned a variety of skills during the training.*** They learned more about mental illness, the corresponding behaviors of people with mental illness, how to better evaluate the underlying problems people are facing, how different medications affect people, how to de-escalate or defuse situations, how to route a person in crisis to the appropriate resource, and how to work effectively with outside providers. The training also provided a valuable opportunity for collaboration and communication between law enforcement and correctional officers.

Officers are frustrated with the time commitment involved in addressing the needs of inmates with mental health or substance abuse conditions. Officers felt that dealing with these issues often prevented them from accomplishing other job-related duties. Meanwhile, mental health services were not always available when requested or within a reasonable timeframe. For example, inmates and the officers escorting them to the hospital for medical help were not giving priority over other patients and had to endure long waits.

Officers who participated in these post-CIT training focus groups had the following characteristics (See also Table 3):

- Most have a high level of satisfaction with their job (82.1% are mostly or very satisfied).
- Few frequently use of force to de-escalate crisis situations

- The understanding of mental health and substance abuse issues and confidence in CIT skills was not significantly different between corrections officers and law enforcement officers.
- There were differences in perceptions between officers who had volunteered and those who had been required to take the training.

**Table 3: Perceptions of Year 2 Focus Group Participants after Attending the Training \***

Survey item	All Participants (N=83)
Report use of physical intervention skills to de-escalate crisis situations <b>frequently</b> .	7.6%
Report knowledge of mental health, drug and alcohol disorders is <b>strong</b>	43.4%
Report understanding of how people develop mental illness and become drug and alcohol abusers.	59.0%
Report ability to communicate with jail and community resources and refer inmates or others to them	61.5%
Report understanding of mental illness, drug and alcohol problems as biological and psychological processes.	63.4%
Report use of verbal skills to de-escalate and/or prevent crisis situations <b>all the time</b> .	66.7%
Report ability to recognize people who might have mental illness, drug and alcohol disorders.	68.4%
Report ability to easily access jail and community resources available for mental health and drug and alcohol treatment.	70.7%
Report attended training voluntarily	72.5%
Report that, during initial training as an officer, they learned skills to de-escalate situations and/or prevent them from occurring.	76.2%
Report awareness of jail and community resources available for mental health and drug and alcohol treatment.	77.2%
Report use knowledge of that cycle during interactions with people having mental illness or drug and alcohol problems.	79.5%
Are <b>mostly</b> or <b>very</b> satisfied with job	82.1%
Report an understanding of how problem behaviors exhibited may be symptoms of mental illness or drug and alcohol problems.	84.6%
Think that the types of intervention skills used <b>frequently</b> affect the intensity and duration of crisis events.	86.4%
Report an understanding of the risk of harm to self and others when interacting with an individual who has these problems	90.4%
Report an understanding of the cycle that brings people with mental illness, drug and alcohol problems into correctional facilities or to attention of police	95.1%

\* All training participants filled out a survey during the focus group on the last day of training.

As mentioned earlier, one important hallmark of the CIT program is that officers are willing and interested in receiving the training. While many participants volunteered to participate, officers from some organizations were mandated to attend. At three sites (Washington, Lincoln, and Cumberland), we checked for differences in attitudes and knowledge among officers who volunteered for the training (37 officers) compared with those who were required to attend (14 officers).

Our findings suggest (using Mann Whitney and Pearson’s Chi square) that officers who had volunteered to attend the CIT training reported a higher level of knowledge and

understanding about CIT issues by the end of the training. Statistically significant differences ( $p < .05$ ) were noted in several areas. Voluntary participants were more likely to understand how problem behaviors exhibited in the jail or in a public place may be symptoms of mental illness or drug and alcohol problems ( $p = 0.017$ ) and understand the cycle of imprisonment affiliated with these problems ( $p = 0.020$ ). Voluntary participants were more likely to report a higher frequency of use of verbal skills to de-escalate and/or prevent crisis ( $p = 0.047$ ). The mean number of years of service of voluntary participants (8.2 years) was also significantly less than the mean number of years of service of mandatory participants (13.3 years) ( $p = 0.038$ ), which may have some influence on difference in attitudes and knowledge.

The data collected does not afford the ability to determine whether differences in knowledge of mental illness and use of de-escalation skills occur because volunteers had a greater interest in these topics prior to attending the program or because volunteers took away more information and insight from the training. It is also unclear what effect age of participants have on attitudes and knowledge.

**CIT OFFICER SURVEYS (PRE- AND POST-)**

During the two years of the expansion, 95 officers filled out officer surveys before attending the training. These surveys evaluated their perceptions of mental illness and confidence in their ability to handle mental illness crisis situations on the job. Of the 95 officers, only 40 officers returned post-training surveys (a response rate of 42%), despite repeated follow-up with the officers. Among these officers, 27 were corrections officers. This analysis includes only the 27 corrections officers who returned both surveys. Table 4 presents characteristics of respondents.

**Table 4: Characteristics of Respondents**

	Number of Respondents
<b>Year of Training</b>	
Year 1	12
Year 2	15
<b>Gender:</b>	
Male	16
Female	11
<b>Education Level:</b>	
High School Diploma	11
Some College	11
4 Years of College	3
Graduate school	1
Unknown	1
<b>Age:</b>	
18-24	2
25-34	7
35-44	9
45-54	4
55-64	5
<b>Years as an Officer</b>	
<4	9
4-10	7
>10	10
Unknown	1
<b>Total Number of Respondents</b>	<b>27</b>

Comprehensive data on the analysis of changes detected through the CIT officer survey are available in Table 5. Officers were asked to respond to a series of statements pertaining to their perceptions using Likert-type scale measures, (e.g., level of agreement with the statement), and this table compares responses measured during the pre- test to responses measured during the post- test. A change in perception was also calculated and Wilcoxon Signed Rank Tests were conducted to evaluate whether perceptions had changed significantly ( $p < .05$ ) after completion of the training.

### **Number of Encounters**

Officers were asked to report the number of encounters they had with mentally ill people in the past 30 days. Prior to attending the training, officers reported a mean of 9.5 encounters in the past 30 days. After attending the training, they reported a mean of 6.2 encounters. The decline in the mean of the reported encounters, however, was not statistically significant using paired sample t-test ( $p = 0.179$ ).

### **Understanding of Mental Illness**

After the training, officers were significantly more likely to respond “yes” when asked if they understand how people develop mental illness. While only 30% of respondents felt they understood this process before the training, 69% understood it after the training. Pearson Chi Square testing showed that this change was significant ( $p = 0.014$ ).

### **Self-Reported Confidence with Addressing Mental Illness on the Job**

After attending the training, officers were significantly more comfortable with their encounters with people displaying signs of mental illness ( $p = 0.045$ ). They tended to feel significantly more confident in their ability to recognize signs of mental illness ( $p = 0.003$ ) and felt more confident about their ability to de-escalate crisis situations when necessary ( $p < 0.001$ ).

### **Preparation for Handling Mental Illness Crises**

After attending the training, officers felt significantly better prepared to handle people with mental illness in crisis ( $p < 0.001$ ). They also appeared to feel more prepared to address a person threatening to commit suicide ( $p = 0.053$ ) and appeared to feel that other officers in the department were more prepared to handle people with mental illness in crisis ( $p = 0.052$ ). However, changes in responses for these two perceptions were not quite significant at the 95% confidence level.

### **Departmental and Community Resources**

After attending the training, officers tended to feel significantly more positive about their own familiarity with community resources ( $p = 0.010$ ). They also felt significantly more positive that the written policies in their respective departments adequately provided guidance for handling mental health crises ( $p = 0.014$ ). After learning about community resources, they were also somewhat more likely to feel that there were people in their agency to support them in their work with mental illness in crisis situations ( $p = 0.078$ ), though this finding was not significant at the 95% confidence level. Despite the increased knowledge and understanding of community resources gained through the training, officers’ comfort levels in working with other agencies to find solutions to

problems encountered did not improve, mainly because comfort levels with this role were high before the training (96% had felt at least somewhat comfortable in the pre-training survey).

After the training, there were no significant changes in officer perceptions about the effectiveness of their department's response to mental health crises ( $p=0.179$ ) or their department's ability to implement a new mental health crisis response program ( $p=0.782$ ). Thus, while officers felt the training and implementation had made their department more likely to have adequate written policies for dealing with mental health encounters, it did not change the overall functioning and structure of their department.

There were also no significant changes in the perception of the helpfulness of the emergency room and hospital system in providing assistance ( $p=0.913$ ). This is not surprising, given that emergency room and hospital system stakeholders were not part of the training and the interactions between these medical providers and the corrections and law enforcement communities are likely to remain unchanged.

### **Job Satisfaction**

Officers were also asked to rate their satisfaction with various aspects of their job. Officers reported a high level of job satisfaction prior to attending the training in a variety of areas (e.g., meaningfulness of the work, relationships with coworkers and supervisors, adequate training, overall job satisfaction). After the training, officers were significantly more likely to express satisfaction with administrative support ( $p=0.029$ ) and satisfaction that they have the skills and knowledge to resolve inmate crises ( $p=0.011$ ). Satisfaction with other aspects of their job did not change significantly but remained high.

### **Additional Training or Support Needed**

The follow-up survey that was administered after the training asked officers open-ended questions on additional types of training or support that could have improved the use of CIT and how CIT could be better implemented within their organization. Unlike the survey administered during the focus group on the last day of CIT training, by the time officers filled out the post-CIT officer survey, they had already had time to go back to their jobs and try to use what they had learned for up to several months and were able to identify additional needs to improve their use of CIT.

Needs that were identified included:

- Longer training or refresher course. Officers felt that one week of training was not enough. Training of additional staff or requiring all officers to be trained was also suggested.
- More information on how to implement CIT on the job and policies in place to support implementation, including understanding of the CIT program by non-trained officers or training of additional staff.
- Additional practice on the job and a greater understanding of the role of a CIT officer. More support and acceptance of skills from supervisors was also identified as a need.

- Crisis counselors and after hour contact information to reach the

**Table 5: Officer Responses to Questions on Departmental and Community Resources**

	Pre-test	Post-test	% Change	p Value
<b>Self Confidence with Addressing Mental Illness</b>	<b>% Somewhat or Strongly Agreed</b>			
I am comfortable with my encounters with people displaying signs of mental illness.	67	81	+14	<b>0.045*</b>
I am confident in my ability to recognize signs and symptoms of mental illness in people.	56	82	+26	<b>0.003*</b>
I am adequately trained to de-escalate a crisis situation.	39	85	+46	<b>0.004*</b>
I am confident in my ability to recognize aggression at an early stage.	82	82	0	<b>0.06</b>
I am confident in my ability to defuse aggression before it becomes violence (verbal de-escalation)	67	89	+22	<b>0.102</b>
<b>Preparation for Handling Mental Health Crises</b>	<b>% Very Well or Moderately Well Prepared</b>			
How well prepared do you feel when handling people with mental illness in crisis?	44	86	+42	<b>&lt;0.001*</b>
Overall, how well prepared do you think the other officers in your department are to handle people with mental illness in crisis?	22	37	+15	<b>0.052</b>
To what extent do you feel you are prepared to address a person threatening to commit suicide?	63	82	+19	<b>0.053</b>
<b>Departmental and Community Resources</b>	<b>%Very or Moderately Effective</b>			
Overall, how effective is your department's response to handling people with mental health in crisis?	59	74	+15	<b>0.179</b>
	<b>% Excellent or Good</b>			
How would you rate your department's ability to implement a new program for improving mental health crisis response?	70	73	+3	<b>0.782</b>
	<b>% Very or Moderately Helpful</b>			
How helpful are your community's mental health resources in providing assistance to you when you are handling mental illness in crisis	82	85	+3	<b>0.218</b>
How helpful is the emergency room/hospital system in providing assistance to you when you are handling people with mental illness in crisis?	68	67	+1	<b>0.913</b>
	<b>% Agree Strongly or Somewhat</b>			
I am comfortable in working with other agencies to find solutions to problems encountered by persons with mental illness.	96	85	-11	<b>0.190</b>
I am familiar with agencies in my community/jurisdiction that I can refer a mentally ill person to.	67	96	+29	<b>0.010*</b>
My department has established relationships with local organizations to assist with a mentally ill person.	89	96	+7	<b>0.130</b>
Access to mental health services is adequate in my jurisdiction.	67	78	+11	<b>0.206</b>
Public/private community services are conveniently available to my agency to deal with substance abuse.	74	74	0	<b>0.439</b>
My department's written policy/protocol adequately provides guidance for handling mental health encounters.	63	78	+5	<b>0.014*</b>
I have someone I can count on in my agency who can support me in my work with mental illness in crisis.	73	85	+12	<b>0.078</b>
<b>Job Satisfaction</b>	<b>% Very or Somewhat Satisfied</b>			
The meaningfulness of the work itself	96	96	0	<b>1.000</b>
Recognition of work performed	67	74	+7	<b>0.233</b>
Administrative support	59	85	+26	<b>0.029*</b>
Interpersonal relationships with coworkers	96	96	0	<b>0.796</b>
Adequate training for job responsibilities	78	85	+7	<b>0.134</b>
Working relationships with your supervisor	85	89	+4	<b>0.971</b>
Skills and knowledge to resolve inmate crises	89	96	+7	<b>0.011*</b>

Overall job satisfaction	100	93	-7	<b>1.000</b>
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o Changes in Likert scale perceptions are significant at 95% confidence level (Wilcoxon Signed Rank testing for non-parametric data).

\* Statistical significance p<.05

**JAIL INCIDENT REPORTS**

**Frequency of CIT Incidents Reported by Site**

One indicator of the level of use of CIT within the county jails is the number of incidents in which CIT-trained officers use the skills they have learned. Between May 2006 and August 2007, 162 CIT incidents were reported by participating county jail sites. The sites varied greatly in the number of CIT incidents reported. In general, a greater number of reports were received from the first year sites than the sites that entered during the second year. This can be explained in part by the fact that some sites had just completed initial training near the end of the second year and at the end of the data collection period, limiting the number of reports and reporting opportunities.

Jails were categorized and analyzed by bed size, with large jails managing over 100 beds, medium jails managing 40 to 100 beds, and small jails managing less than 40 beds. Findings suggest that there was neither a correlation between the size of the jail and number of incidents reported nor a correlation between the number of officers trained and the number of incidents reported. The greatest numbers of reports (62) were received from Knox, a medium-sized jail that entered the program in the first year. Likewise, the largest jail (Cumberland) submitted the fewest reports of the first year sites.

**Table 6: Total Number of CIT Incidents Reported by Site**

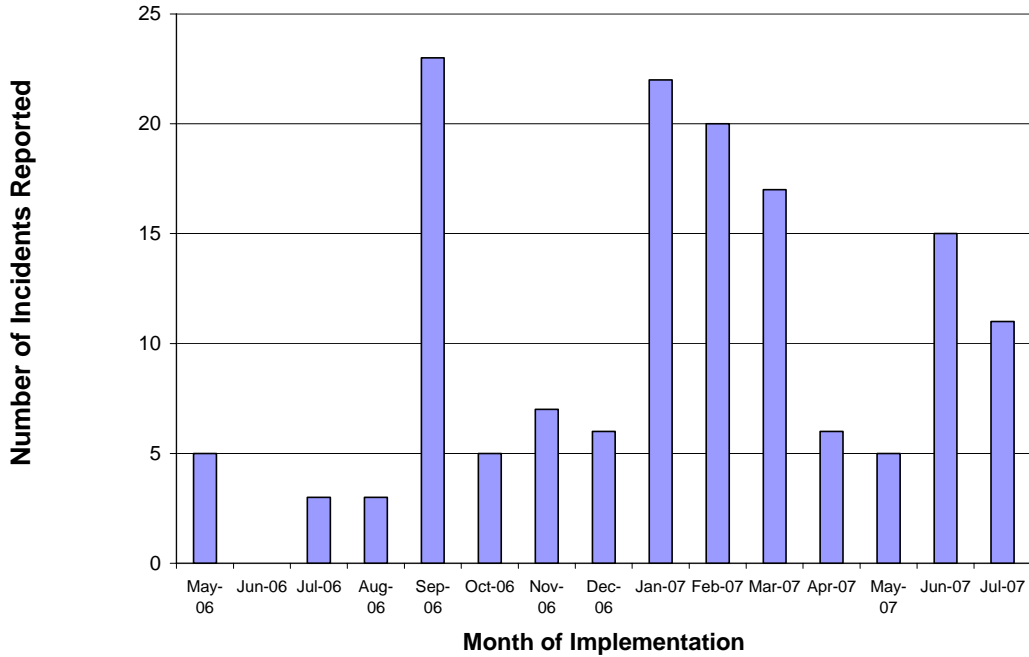
County Jail	Year Entered the Program	Size of Jail	Number of Correctional Officers Trained	Total CIT Incidents Reported
Cumberland	1	Large	14	16
Kennebec	1	Large	14	28
Knox	1	Medium	4	62
Waldo	1	Small	9	37
Somerset	2	Medium	4	--
Franklin	2	Small	7	15
Washington	2	Medium	17	--
Lincoln/Sagadahoc	2	Small	5	4
<b>Total</b>	--	--	<b>74</b>	<b>162</b>

Figure 2 presents the number of CIT incidents reported during each month of data collection during this expansion. Assuming that the rate of events requiring CIT interventions remains relatively constant over time, we would expect that, as additional officers are trained in CIT and become comfortable with its use, the number of incidents in which CIT is used would generally increase over time. Figure 2, however, shows that the number of CIT incidents reported was higher during some months (September 2006, January through March 2007, and June and July 2007) and lower in the other months. The number of events observed does not appear to have increased over time. This indicates that that number of reports filed was not directly proportional to CIT officers available and that other factors may be responsible for filing rates.

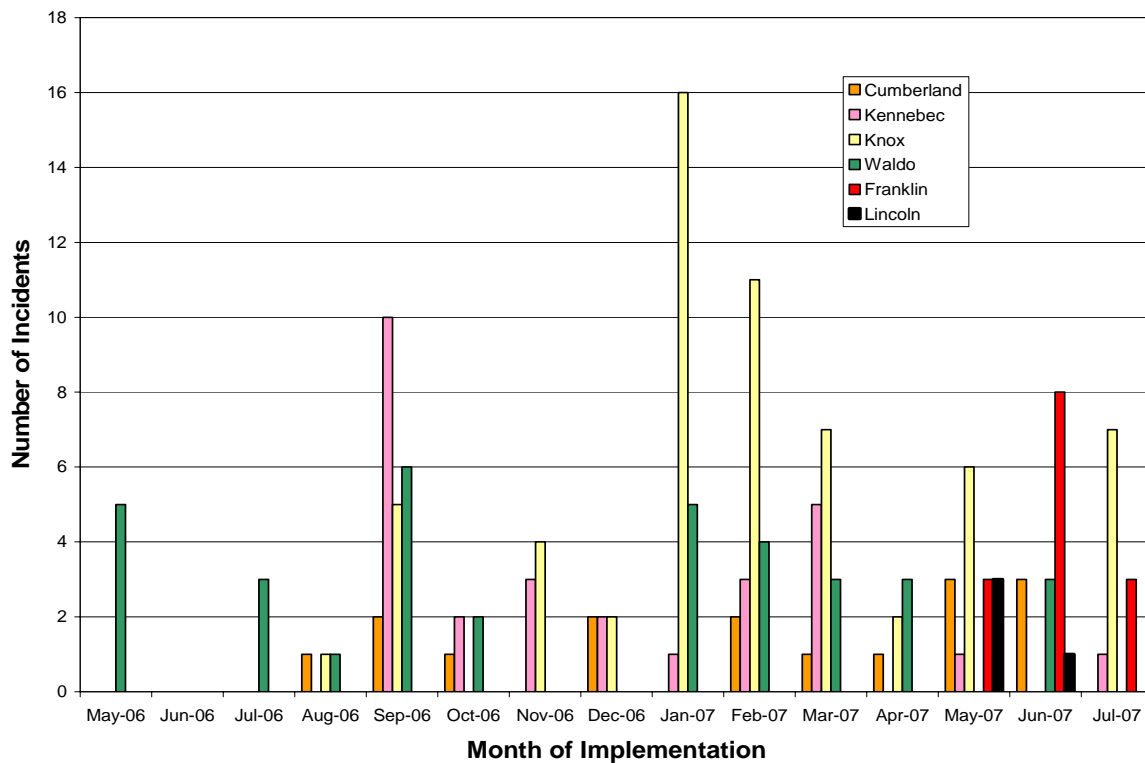
Some jails had a high frequency of CIT use and reporting in certain months (see Figure 3). For example, the months with the greatest number of jail incident reports were

received were September 2006, January 2007, February 2007, and March 2007. These peaks can be explained by high numbers of CIT incident reports among Knox County and/or Kennebec County during those months.

**Figure 2: Number of CIT Incidents Reported by Month**



**Figure 3: Number of CIT Incidents Reported by Month and Site**



In the months when particularly high numbers of CIT incidents were reported, there was usually at least one CIT officer who reported a large number of incidents and, thus, had a large influence over the overall numbers that month. For example, in January 2007, one officer was responsible for reporting ten incidents – nearly half of the 22 incidents that were reported. In general, some officers were far more likely than others to report CIT incidents, and among the officers who were most likely to fill out the forms, reporting was clustered in certain months. It is unclear whether this was due to naturally occurring spikes in the CIT incident rate or merely reflected inconsistent reporting strategies at some sites.

**Characterization of CIT Incidents**

This section characterizes CIT incidents occurring during the study period as recorded in jail incident forms. The data presented are descriptive and reflect proportions and counts. Where relevant, Pearson Chi Square tests were used to highlight significant differences between jails with respect to measures of CIT program outcomes, particularly with respect to inmate aggression, officer use of force and incident outcomes.

*Number of Officers Involved*

Approximately 90% of the CIT incidents that were reported and characterized involved at least one CIT-trained officer. Incidents that involved more than one CIT officer or no CIT officers were relatively rare. In approximately 60% of the reported and characterized incidents, however, there was at least one non-CIT officer who provided support during the incident.

*Physical and Verbal Aggression*

Inmate behavior dictates, in large part, the actions taken by corrections officers as well as incident outcomes. Although inmate behavior is not necessarily expected to change as a direct result of CIT training, an understanding of the different types of behavior that officers typically face helps to highlight the need for and appropriate use of de-escalation skills gained through CIT. Table 7 compares inmate verbal and physical aggression reported in CIT incidents. Approximately one quarter of CIT incidents involved one or more types of inmate aggression.

**Table 7: Characterization of Inmate Aggression in CIT Incidents (n=162 incidents)**

Type of Inmate Aggression	Number of Incidents in which Aggression Type Reported	Percent of Total Incidents
Verbal Self-Aggression	22	13.6%
Verbal Aggression to Others	24	14.8%
Physical Self-Aggression	16	9.9%
Physical Aggression to Others	7	4.3%
<b>Any Aggression (combined)*</b>	<b>41</b>	<b>25.3%</b>

Note: Inmate aggression variables are not mutually exclusive. More than one may be reported in a single incident

\* Count of incidents involving one or more types of inmate aggression.

The proportion of CIT incidents reporting some type of inmate aggression varies significantly between the sites ( $p < 0.001$ ), ranging from 9.7% to 80.0%. This indicates that there may be differences between the jails in the types of incidents for which a CIT is used and reported. For example, Knox officers are more likely to report that a CIT incident occurred even when the incident does not include aggression. This may account, in part, for a higher number of CIT incidents reported in Knox.

*Suicide*

Suicide ideation was noted in 27 of the reported CIT incidents (16.7%) and suicide threat/attempt was noted in 16 of the incidents (9.9%). The greatest number of recorded suicide ideation incidents occurred in November 2006, March 2007, and June 2007 (3 or more in each month). The greatest number of recorded suicide threats occurred in May and June 2007 (3 or more in each month).

*Use of Force*

One of the skills taught in the CIT training session is use of verbal de-escalation to diffuse problems. In 54.9% of CIT incidents, officers reported use of verbal de-escalation. In contrast, the use of force (e.g., restraint equipment, physical restraint, chemical agents) was reported in only 25.3% of CIT incidents.

**Table 8: Characterization of Use of Force and Verbal De-Escalation in CIT Incidents (n=162 incidents)**

Officer Action	Number of Incidents in which Activity Reported	Percent of Total Incidents
Verbal De-escalation	89	54.9%
Any Use of Force*	41	25.3%
<i>Use of Restraint Equipment</i>	37	22.8%
<i>Use of Physical Restraint</i>	12	7.4%
<i>Use of Chemical Agent</i>	5	3.1%

\* Count of incidents involving one or more types of force used by officers.

Force was more likely to be used in instances of inmate aggression. Force used in 51.2% of incidents when inmate aggression was reported compared with 16.5% of incidents when inmate aggression was not reported ( $p < 0.001$ ). Verbal de-escalation, on the other hand, was more likely to be used in incidents when inmates do not exhibit aggression. Verbal de-escalation was used in 36.0% of incidents when aggression was reported compared to 64.0% of incidents when inmates did not exhibit aggression ( $p < 0.0001$ ).

Gender of the inmate did not appear to influence whether force was used. Use of force did not differ significantly during CIT incidents involving male and female inmates. Compared to incidents involving one or two officers, however, incidents involving three or more officers were more likely to result in use of force ( $p < 0.001$ ). This is possibly because incidents that require a greater officer response may be more severe.

There were significant differences in the frequency that force and verbal de-escalation were used to address CIT incidents between the sites ( $p < 0.001$ ). For example, at one site officers used force in 60.0% of reported CIT incidents, while at several sites officers only

used force in less than 20% of reported CIT incidents. In addition, while some sites used verbal de-escalation in more than 80% of incidents, other sites used this tactic in less than one third of incidents. Site-specific differences may be due to differences in the nature of the incidents. For example, at one of the sites, there was an especially high level of inmate aggression and, consequently, a greater use of force was also reported. Upon further exploration, this finding was attributable mainly to reports filed by just one officer.

*Incident Outcomes*

An important component of CIT training is to give officers the tools to refer inmates to appropriate mental health services. The most frequent outcome of a CIT incident was a referral to a mental health provider such as Crisis and Counseling, Mid Coast Mental Health, or Allied Resources for Correctional Health. In 43.8% of CIT incidents, the inmate was subsequently referred to some type of mental health service. Referrals were significantly higher in Kennebec, where up to 85.7% of inmates were given a mental health referral after an incident, compared to the other sites (p<0.001).

In 12.4% of incidents, a medical health referral was completed after the incident, and 11.1% of incidents resulted in a suicide watch. Other outcomes, such as moving/reclassifying the inmate, verbal warnings, lockdowns, and write-ups occurred in less than 10% of incidents (see Table 9).

Minimizing injuries to inmates and officers is an important part of CIT. During the period that CIT was implemented, a total of 13 incidents of injuries to inmates (5 requiring medical attention) occurred and 3 injuries to correctional officers (2 requiring medical attention) occurred during CIT incidents. Only one of the injuries to inmates resulted directly from CIT officer use of force; the rest occurred prior to the officer intervention.

For most of the CIT incident outcomes listed in Table 9, officers used force frequently before resolving the incident. For example, in 100% of incidents when corrections officers were injured, force was used; and in 72% of incidents ending in a suicide watch, force was used. Only incidents with mental health referrals or moves/reclassifications as the outcome had relatively low use of force (less than 25%).

**Table 9: CIT Incident Outcomes**

<b>Incident Outcome</b>	<b>Number of incidents in which Outcome Occurred (% of total incidents)</b>	<b>Among incidents with this outcome, % involving force</b>
Mental health referral completed	71 (44.1%)	26.8%
Medical referral completed	20 (12.4%)	70.0%
Suicide watch	18 (11.1%)	72.2%
Moved/Reclassified	13 (8.0%)	23.1%
Injury to Inmate	13 (8.0%)	92.3%
Verbal warning	10 (6.2%)	50.0%
Lockdown	9 (5.6%)	66.7%

Write up	9 (5.6%)	55.6%
Injury to corrections officer	3 (1.9%)	100%
Injury to other inmates	2 (1.2%)	50.0%

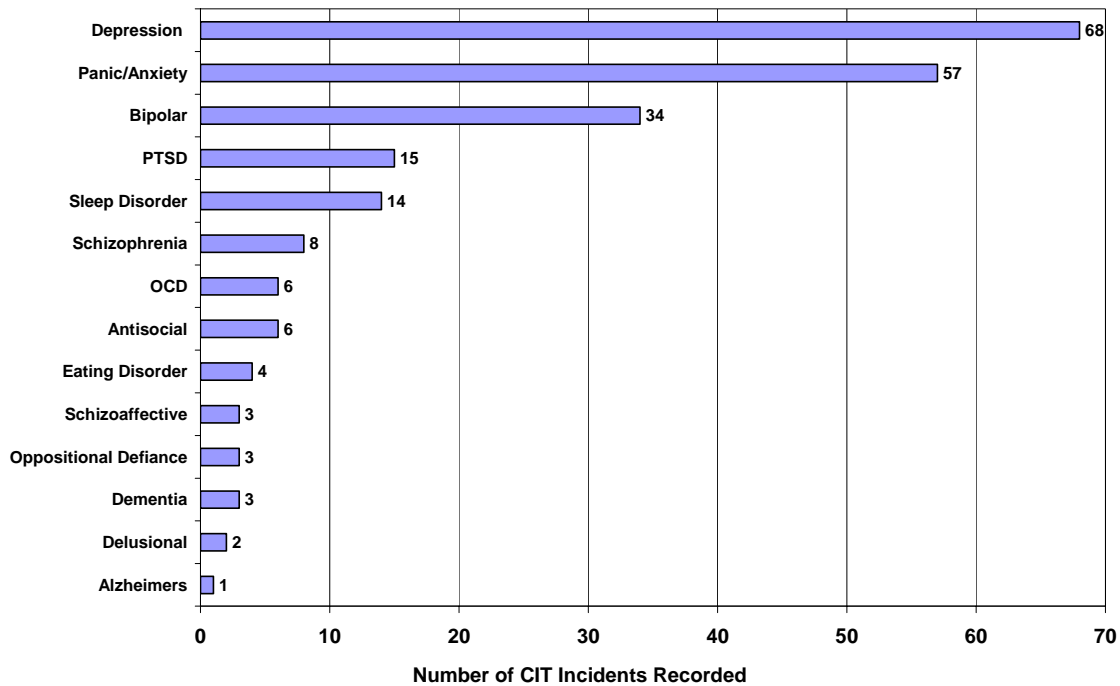
*Location of Incident*

Approximately 38% of CIT incidents took place during the intake process. Prior to admission (intake) officers routinely assess persons brought to the jail for booking to determine whether the individual is in need of medical care or clearly shows signs of severe mental illness and/or substance abuse. The results of that assessment are used to determine whether medical clearance prior to jail intake is recommended. There were differences in the percentage of incidents occurring at intake between the sites (p=0.005). While some sites had more than 40% of CIT incidents occurring at intake, others had less than 20% of incidents taking place at intake. There were no significant differences found in the handling of incidents taking place at intake and the outcomes of such incidents.

*Inmate Mental Health and Substance Abuse History*

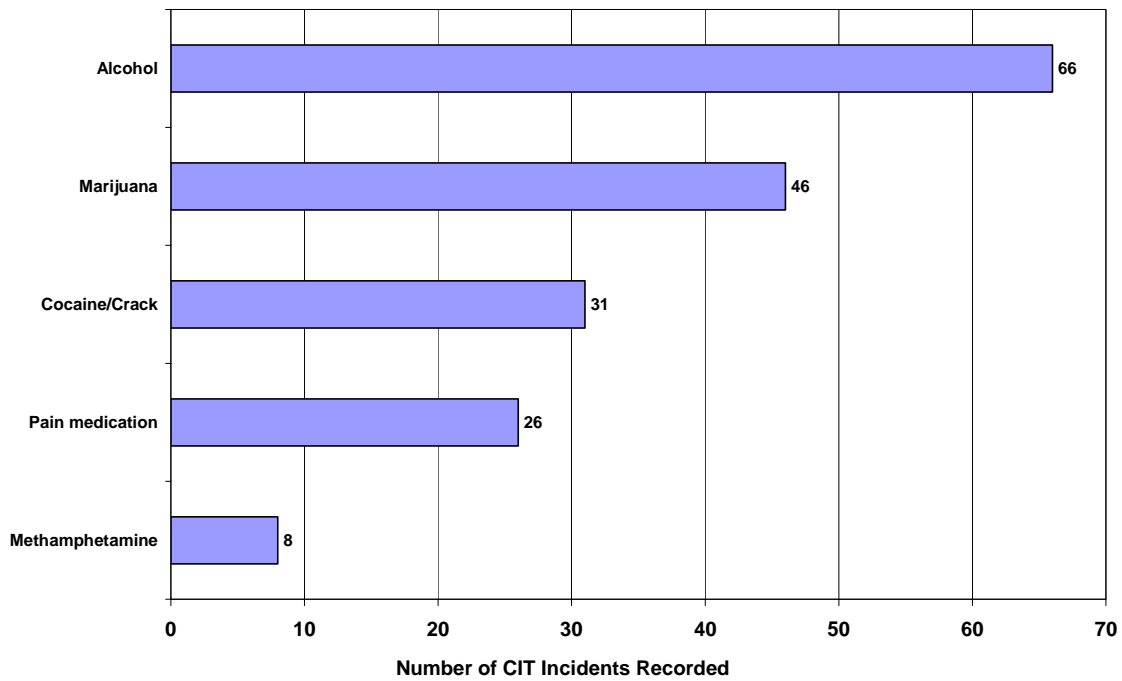
The data provided on CIT forms indicate that consumers of CIT have a high likelihood of mental health and/or substance abuse problems. In approximately 69.5% of incidents, at least one mental health condition was reported (111 incidents). Depression was the most frequent condition (68 incidents or 42%), followed by panic/anxiety (57 incidents or 35%) and bipolar disorder (34 incidents or 21%). Figure 4 shows the reported mental health problems of inmates who are confronted by officers using CIT strategies. An inmate may have more than one mental health problem recorded in their history.

**Figure 4: Inmate Mental Health History and Number of CIT Incidents Recorded**



In addition to mental health issues, CIT incidents frequently involve inmates with a history of substance abuse problems. In approximately 62.3% of CIT incidents (101 incidents) the inmate was known to have a history of at least one type of substance abuse. Findings suggest that inmates involved in CIT incidents who had substance abuse problems most frequently had a history with alcohol abuse (66 incidents or 41%) followed by marijuana abuse (46 incidents or 28%). Figure 5 shows the frequency of reported substance abuse problems of inmates with whom CIT is used. CIT incident reporting forms may indicate that an inmate has more than one substance abuse problem in their history. Despite high levels of prior abuse, there were only four incidents in which the inmate was reported to be intoxicated at the time of the incident.

**Figure 5: Incidents Involving Inmate Substance Abuse and CIT**



Inmates who had a recorded history of one or more mental health conditions were more likely to be referred to a mental health professional after the incident ( $p=0.020$ ) compared with those who did not have a mental health history recorded. Inmates with mental health conditions also appeared to be more likely involved in incidents where force and verbal de-escalation was used, and where medical referrals were completed. However, these differences were not significant at the 95% confidence level (See Table 10).

No differences in the outcomes of CIT incidents were found between those with and without substance abuse histories (see Table 10). However, use of force was somewhat more likely to occur when officers were dealing with inmates with a history of cocaine/crack abuse ( $p=0.050$ ) or pain medication abuse ( $p=0.033$ ) compared to those who had not abused these substances. In contrast, use of force was somewhat less likely for those with a history of marijuana abuse ( $p=0.029$ ).

**Table 10: A Comparison of Incident Outcomes with Inmate Mental Health and Substance Abuse Status**

Incident Outcome	% Incidents involving Mental Health Issue(s)	% Incidents involving no Mental Health Issues	p value	% Incidents involving Substance Abuse	% Incidents not involving Substance Abuse	p value
Use of Force	28.8%	17.6%	p=0.091	29.7%	18.0%	p=0.069
Verbal De-Escalation	58.6%	41.4%	p=0.116	54.5%	55.7%	p=0.502
Suicide Watch	11.7%	9.8%	p=0.475	10.9%	11.5%	0=0.550
Medical referral completed	15.5%	5.9%	p=0.068	13.9%	10.0%	P=0.324
Mental Health referral completed	50.0%	31.4%	p=0.020	45.5%	41.7%	p=0.377

**DATA AND ANALYSIS LIMITATIONS**

There are several important data limitations that affected the evaluation. First, because correctional officers tend to have many competing demands, it was difficult to get a high response rate on the officer survey. Despite repeated efforts to follow up with CIT officers and their supervisors, less than half of trained officers returned the follow-up officer survey. While we only included responses from officers who replied to both surveys, there may be some bias in the results due to the low response rate. For example, if officers were more likely to respond to the follow-up survey if they had a positive impression of the program, this would affect the results.

A similar issue affects the data from the jail incident forms. While response rate was high from some officers and some jails, others were less likely to fill out and submit incident forms when CIT was used. As the decision to report an incident using the jail incident forms is somewhat subjective, data was not collected systematically, so reporting bias may have been introduced. For example, if officers do not fill out a CIT form each time that they use their skills, use of CIT will be underestimated. In addition, if officers are more likely to fill out a form only when an officer is injured compared to incidents when an officer is not injured, this would affect our characterization of the rate of injury during CIT incidents.

One important limitation affected our ability to observe change in this project. As data about CIT-type events were not collected on jail incident forms prior to the training of officers at each jail, it was not possible to evaluate if there were changes in CIT use and reporting attributable to the training. However, the frequency and the type of incident for

which CIT was used in jails were calculated. Some information on the trends in usage of CIT is presented in this report.

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## VI. DISCUSSION

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### IMPLEMENTATION

County jails in Maine are currently facing difficult resource constraints. Every county jail is filled beyond its designed capacity and many have high staff turnover rates, as correctional officers often leave the jails to pursue other employment opportunities. Low staff retention rates make implementation of CIT in the jail system particularly difficult because when CIT-trained officers leave their position, continuity of the program is jeopardized. Additionally, NAMI has found that when command staff leave the organization, it is particularly difficult to reinstate the CIT program. The new leadership may not be familiar or dedicated to the CIT project and may not have the time or interest to work with NAMI to learn more.

Supervisors interviewed for this evaluation generally agreed that support from NAMI before, during, and after the training helped them overcome some of the difficulties they faced during implementation. Meetings were held regularly, and questions and concerns were addressed in a timely manner. Supervisors and officers also generally felt that the CIT training modules were useful and appropriate for correctional officers and helped them implement CIT when they returned to their organization.

Although most sites adopted similar standard operating procedures for implementing CIT, there were large differences in the number of jail incident reports filed between the jails. This could be, in part, due to differences in the numbers of officers trained at each site and variations in reporting time opportunities within the evaluation period. Supervisors generally agreed that despite administrative policies, there were no formal guidelines or timeframes identifying when CIT should be implemented or when reports should be completed and filed. Implementation and reporting was left up to the discretion of the officer and supervisor. As a result, this resulted in differences between jails in how a CIT event is defined and when a form should be completed.

Some sites provided more supervision than others did. For example, one of the supervisors reported that he would read incident logs to identify CIT incidents and would then suggest to officers to fill out a CIT form for that incident. However, this type of follow-up was not done by supervisors at all of the jails. These differences in protocol may, in part, account for the large differences in the number of jail incident reports received from the various jails and differences in the types of incidents for which CIT was reported (e.g., differences in percentage of events with inmate aggression, differences in percentage of events using force). Interviews suggested that CIT was used in the jails on an informal basis far more than it was actually reported, indicating that the CIT forms likely underestimate the degree to which CIT skills were used in most facilities. For example, after attending the training, officers reported in their post-CIT officer survey a mean of 7.3 encounters with people who had mental illness. However, only a small fraction of those encounters were ever reported on CIT forms and returned to NAMI or CHPPR. It is clear that officers who attended the training brought the skills they learned back to their jobs and used them in appropriate situations, at least on an informal basis, but did not always feel that incidents warranted a report.

The number of incident reports that were filed had a temporal pattern. Peaks observed in September 2006, January through March 2007, and June and July 2007 may be attributable to a temporal pattern of mental health in the jails, but there may be other underlying issues. Using Waldo County as an example, the highest number of incidents in that jail occurred in May and September 2006, and January and February 2007. One potential reason for a peak in January in Waldo is the effect of the holidays. Inmates with mental illness who are away from their families during the holidays may be more likely to undergo a crisis event. However, most of these dates also correspond closely in time to training sessions held in Waldo in April 2006 and January 2007, indicating the possibility of higher levels of interest, awareness, and commitment immediately following each training session. Over time, officer interest in reporting CIT incidents may have waned.

One way of maintaining interest in CIT and continuing to improve its use in the jails is to send officers to annual refresher courses developed by NAMI. Two of the supervisors thought that ongoing training or refresher courses would be necessary but that resource issues would make it difficult to send officers back to training each year. One supervisor suggested that an online course be developed for officers to complete at their facilities may be a viable solution, providing the needed flexibility and placing limited demands on jail resources.

CIT training appears to have improved officers' awareness and access to mental health services. Jail incident reports demonstrated that officers were frequently accessing mental health services after events and completing mental health referrals. Officer surveys indicate that the training increased officers' comfort levels with referring inmates to mental health services and increased their knowledge of such services. Supervisor interviews confirmed that officer comfort level increased and that officers frequently referred inmates as a precautionary measure whenever there was a question about the inmate's mental health needs.

Another important question is whether CIT is effective when participation is mandated by the organization. Traditionally, CIT officers are selected based on their temperaments, background, and demonstrated interest in helping individuals who suffer from mental illnesses. Previous studies have also indicated that use of volunteers who possess a general interest in mental health issues has been successful in the past. However, as previously discussed some organizations in Maine and in other states have decided to mandate the training. As CIT has been shown to be so effective, departments across the country are beginning to identify CIT as a universal training need and are beginning to mandate participation. Yet, since the effectiveness of CIT was largely established from positive outcomes attributable to a voluntary participant base, whether or not universal training will have as great an impact on the appropriate handling of a crisis situation will remain to be seen. As per data collected for this evaluation, findings corroborate with the tendency of volunteers – who were generally selected by their supervisors for having characteristics conducive to succeeding as a CIT officer – to have a greater level of knowledge and understanding of CIT issues after attending the training compared to those who were mandated to attend. However, it is also difficult to ascertain if differences in knowledge of mental illness and use of de-escalation skills occur because volunteers

had a greater interest in these issues prior to attending the program or because volunteers got more out of the training.

Supervisors felt that there was definite value to training officers of all temperaments, background, and interest levels – as long as it does not disrupt the training – and that even people who came to the training with less positive attitudes learned a lot and came out of the training as better officers. Essentially, supervisors think the training is very valuable and that it can only help officers to receive it. One of the NAMI CIT trainers agreed, citing a case when several officers came into the program with very negative attitudes and opinions about mental health issues and emerged with profound changes in their reactions and attitudes toward mental health and substance abuse issues; a consequence of the training. The trainer added that, in her experience, CIT spread through the culture of organizations and even those who didn't initially want to be trained later wanted to be involved when they saw how effective CIT skills could be on the job. At the same time, she felt that it is not necessarily appropriate to force people to take the class. In addition, it may be incorrect to assume that all volunteers are motivated by interest in mental health issues. Desire for monetary compensation or potential for a promotion are other motivating factors for volunteering that are not necessarily in line with the Memphis model. The issue of volunteerism in CIT is an issue that warrants continued attention not only to determine the value of having additional officers trained, but also to understand whether the model can be effective when universally mandated. However, it is agreed that when resource issues limit the training of all officers, volunteers should receive the training first because they tend to come out of the training with a higher degree of understanding and confidence. Regardless, it is also important to recognize that anecdotal evidence reveals some benefit to training other officers who would not otherwise have been selected as volunteers.

A final comment pertaining to implementation unique to this project was the training of correctional officers alongside law enforcement officers. Interviews with supervisors and NAMI revealed this to be a particularly valuable part of the training. Most of the training modules were appropriate for both groups, and NAMI divided the group into two sections for role playing and policy/procedure issues that were more specific to the individual groups. Supervisors cited that networking opportunities between the two groups were helpful and felt that attending the same training enabled the two groups to gain a better understanding of the issues each faced.

### **OFFICER PERCEPTIONS**

The focus groups and officer surveys demonstrated that there was a high level of officer satisfaction with the CIT program and that officers felt much more comfortable with their de-escalation skills after the training. One of the highlights of the CIT expansion program was the significant increases in officer confidence with CIT skills and the positive perception of the program among officers. Officers felt more comfortable with their own knowledge and understanding of mental illness and substance abuse issues, more confident and prepared to use CIT skills on the job, and more positive about their department's role in addressing mental health crises, their own familiarity with community resources, and availability of substance abuse community services.

Supervisors also noted improvements in officers' confidence and efficacy regarding CIT. Officers tended to perceive the training as useful and, if anything, would like to have more training in these issues in the future. Although some aspects of the training have been covered in other venues, officers still generally found the forty-hour training module to be very helpful.

In general, supervisors interviewed for this evaluation had positive attitudes about the program and felt that officers trained in CIT gained a greater awareness of mental illness and more confidence in dealing with people with mental illness.

### **CIT PROGRAM OUTCOMES**

Prior to attending the training, many officers had not generally received adequate training in crisis intervention and many felt that there were gaps in the ability to secure professional help from mental health services for inmates in need. These issues, combined with the high stress environment in the county jail and the high numbers of inmates with mental health and/or substance abuse issues, mean that the CIT training fills an important need among Maine correctional officers to ensure that crisis incidents are handled appropriately and that when incidents occur, inmate and officer injuries are kept to a minimum and the incident is resolved through verbal de-escalation rather than force, when possible.

As discussed earlier in the report, there is no record of the degree to which CIT skills were used prior to the training. Data on officer control, de-escalation, and injuries during CIT-type crises were not collected until the officers had been trained. Thus, we cannot compare usage of CIT before and after the training. We do know, however, from the supervisor interviews that, even shortly after returning from training, officers were able to begin streamlining people with mental illness into appropriate care. One of the supervisors noted that officers were more "kind" after attending the training and made a greater effort to resolve issues without using force.

The data indicate that it is possible for CIT outcomes to be documented by correctional officers in a jail setting, although documentation appeared to be more thorough in some jails compared with others. The data collected indicate that, in general, CIT incidents were more frequently resolved using verbal de-escalation as opposed to force, and, where force was used; it was usually used to address cases of inmate aggression. During the period that CIT was implemented, documented injuries were low. There was only one incident where an inmate was injured by an officer during an intervention and three incidents when an officer was injured by an inmate.

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## VII. RECOMMENDATIONS

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NAMI's expansion of CIT to county jails in seven Maine counties shows that the CIT model can be effectively used with correctional officers and that CIT course helps to fill a gap in correctional officer training. Officers who attended the CIT training gained confidence in their abilities to address mental illness and to de-escalate crisis situations and gained knowledge of community resources available to them. In addition, the inclusion of correctional officers and law enforcement officers at a training event appears not only to help both groups gain needed skills but also resulted in important exchanges between the groups and a greater level of understanding about the role each plays in dealing with people who have mental illness and substance abuse conditions.

The following are recommendations for NAMI Maine's CIT program as it continues in the future:

- Continue to train new officers to replace officers lost to turn-over within each organization.
- Offer refresher courses in CIT to those who have been previously trained so that skills will be maintained and expanded.
- Work with state agencies to make CIT a permanent component of corrections training in Maine with sustained funding and commitment.
- Integrate both law enforcement and corrections officers into CIT trainings so that both groups can benefit from common interaction.
- Where resources are limited, priority for training should be given to volunteers. However, NAMI should continue to monitor the impact of CIT in organizations that have made training mandatory for all officers, as non-volunteers also may gain value from the training.
- A better definition of what types of incidents are "CIT incidents" needs to be developed. Officers could use additional detail in the training on when to fill out a CIT incident form and submit it to NAMI.
- Consider exploring more efficient ways for collecting data on CIT incidents in a jail setting. For example, if other forms or database systems are already being used to collect data on specific types of incidents, perhaps those could be leveraged to avoid duplication or extra paperwork.
- After incidents when force is used by officers, develop procedures for follow-up by command staff.

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## VIII. APPENDIX A: FOCUS GROUP SURVEY

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### **Crisis Intervention Team (CIT) Training Evaluation Pre-CIT Training Correctional Officers**

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1. Rate your knowledge of mental health, drug and alcohol disorders?
  1. Very strong
  2. Strong
  3. Fair
  4. Little
  5. None
  
2. Do you understand mental illness, drug and alcohol problems as biological and psychological processes?
  1. Yes
  2. Somewhat
  3. No
  
3. Do you understand how people develop mental illness and become drug and alcohol abusers?
  1. Yes
  2. Somewhat
  3. No
  
4. Do you understand the risk of harm to self and others when interacting with inmates having mental illness, drug and alcohol problems?
  1. Yes
  2. Somewhat
  3. No
  
5. Do you recognize inmates who might have mental illness, drug and alcohol disorders?
  1. Yes
  2. Sometimes
  3. No
  
6. Do you understand how problem behaviors exhibited in the jail might be symptoms of mental illness or drug and alcohol problems?
  1. Yes
  2. Sometimes
  3. No
  
7. Do you understand the cycle that brings people with mental illness, drug and alcohol problems into correctional facilities?
  1. Yes
  2. Sometimes
  3. No

8. Do you use that knowledge (Q.7) during interactions with inmates having Mental illness or drug and alcohol problems?
1. Yes
  2. Sometimes
  3. No
9. What additional skills and knowledge regarding mental illness and drug and alcohol problems would you be interested in learning? **Please list.**
- 
- 
10. What additional skills and knowledge do you think are necessary when dealing with inmates having mental illness and drug and alcohol problems? **Please list.**
- 
- 
11. Are you aware of the jail and community resources/services available for mental health and drug and alcohol treatment? If so, what are the resources/services available?
1. Yes
  2. Somewhat
  3. No
12. Please list any resources or services you are knowledgeable of.
- 
- 
13. Do you feel that you can easily access these resources/services?
1. Yes
  2. Sometimes
  3. No
14. Have you been able to communicate with these facilities and refer inmates with mental health and/or drug and alcohol problems to them?
1. Yes
  2. Sometimes
  3. No
15. During your initial training as a Corrections Officer, did you learn skills that helped you de-escalate crisis situations in the jail and/or prevent them from occurring?
1. Yes training was provided. How much time was devoted? \_\_\_\_\_
  2. No, did not receive any training.
  3. There was instructor discussion but no participation by C/Os

16. Are there specific skills that you are required to use when confronted with a crisis situation? **Please list them.**

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17. How often do you use **verbal skills** to de-escalate and/or prevent crisis situations?

1. All the time
2. Frequently
3. Sometimes
4. Never

18. How often do you use **physical intervention skills** to de-escalate and/or prevent crisis situations?

1. All the time
2. Frequently
3. Sometimes
4. Never

19. Do you think the types of intervention skills used affect the intensity and duration of crisis events?

1. All the time
2. Frequently
3. Sometimes
4. Never

20. How satisfying is the job of a correctional officer in today's world?

1. Very satisfying
2. Mostly Satisfying
3. Not very satisfying
4. Very Dissatisfying
5. No opinion

21. Total years working in corrections? \_\_\_\_\_

22. Was participation voluntary or mandatory? \_\_\_\_\_

The results of this survey are confidential and data will be presented in generalized format only. No individuals are identified. Center for Health Policy, Planning & Research - University of New England

**IX. APPENDIX B: CIT OFFICER SURVEY (PRE/POST)**

**Maine CIT Expansion Project  
DRAFT CIT Officer Follow-up Questionnaire**

**Respondent ID:** \_\_\_\_\_ **Current Rank:** \_\_\_\_\_ **Site:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/06

*In collaboration with the National Alliance for the Mentally Ill (NAMI) Maine, Center for Health Policy, Planning and Research (CHPPR) of the University of New England is conducting an evaluation of the CIT Program in your facility. We are interested in learning about your experiences and knowledge with mental health disorders. Your participation is voluntary and your responses will be kept confidential. CHPPR will not release participants' names. Accurate and complete information is necessary to determine the impact of the program. For all questions, please choose only one response. Please mail the completed survey to CHPPR in the attached envelope. Please contact CHPPR at (207)221-4560 if you have any questions. We would like to thank you for your cooperation.*

<i>To what extent do you agree or disagree with the following statements:</i>		Strongly Agree	Somewhat Agree	Neither Agree Nor Disagree	Somewhat Disagree	Strongly Disagree
1.	When someone has a mental illness, their brain is impaired in a way that effects their behavior and emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	When someone is paranoid and believes the FBI is out to get them, it is best to play along with them to get them to do what you want.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Most people who have mental illness had poor parenting as children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	In between episodes, people with a mental illness can think and feel pretty much like other people who are not ill.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	One of the main causes of mental illness is a lack of self-discipline and will-power.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	The best way to deal with people in mental health crisis is to set firm limits and make it clear that the officers are in charge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	I am comfortable in my encounters with people displaying signs of mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	I am confident in my ability to recognize signs and symptoms of mental illness in people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	I am adequately trained to de-escalate a crisis situation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	I am confident in my ability to recognize aggression at an early stage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	I am confident in my ability to defuse aggression before it becomes violence (verbal de-escalation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Yes	No	Don't Know
12.	In your view, is mental illness a biological process?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you understand how people develop a mental illness?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Do you know of anyone among your friends or family who has a mental health problem or a mental illness, including depression?			<input type="checkbox"/>	<input type="checkbox"/>	NA
15.	About how many encounters with mentally ill people in crisis have you had in the past 30 days?			# of Encounters		
<i>For the following statements please rate your level of preparation:</i>		Very well prepared	Moderately well prepared	Somewhat prepared	Not at all prepared	
16.	How well prepared do you feel when handling people with mental illness in crisis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Overall, how well prepared do you think the other officers in your department are to handle people with mental illness in crisis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18.	To what extent do you feel you are prepared to address a person threatening to commit suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19.	Overall, how effective is your department's response to handling people with mental illness in a crisis?	Very effective <input type="checkbox"/>	Moderately effective <input type="checkbox"/>	Somewhat effective <input type="checkbox"/>	Not at all effective <input type="checkbox"/>	





**X. APPENDIX C: JAIL INCIDENT FORM**

**CIT REPORT  
USE OF CIT IN MAINE COUNTY JAILS**

<p><b>1. Incident Information</b></p> <p>Reporting Agency: _____</p> <p>Incident Date: ____/____/07 Time: _____</p> <p>Event ID Number: _____ Inmate ID: _____</p> <p>Gender: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Number of CIT Officers Involved: _____</p> <p>Number of Non-CIT Officers: _____</p> <p>Location of Incident:  <input type="checkbox"/> Intake <input type="checkbox"/> Other (specify): _____</p> <p><b>2. Inmate Activity/Cause Of Incident (Check all that apply)</b></p> <p><input type="checkbox"/> Verbal aggression/threats to self <input type="checkbox"/> Intoxicated/appears intoxicated  <input type="checkbox"/> Verbal aggression/threats to others <input type="checkbox"/> Resistance to restraint  <input type="checkbox"/> Physical aggression to self <input type="checkbox"/> Suicide ideation  <input type="checkbox"/> Physical aggression to others <input type="checkbox"/> Suicide threat/attempt  <input type="checkbox"/> Other (specify): _____</p> <p><b>3. Suicide Attempts/Threat</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Method used:  <input type="checkbox"/> Hanging <input type="checkbox"/> Edged Weapon <input type="checkbox"/> Overdose <input type="checkbox"/> Jumping  <input type="checkbox"/> Other (specify): _____</p> <p><b>4. Officer Control / Use Of Force (Check all that apply)</b></p> <p><input type="checkbox"/> Verbal de-escalation</p> <p>Restraint device used: <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Other (specify): _____</p> <p><b>5. Injuries (Check all that apply)</b></p> <p><input type="checkbox"/> Injury to corrections officer(s) → <input type="checkbox"/> Medical treatment needed  <input type="checkbox"/> Injury to other inmate(s) → <input type="checkbox"/> Medical treatment needed  <input type="checkbox"/> Injury to inmate → <input type="checkbox"/> Medical treatment needed  <small>(indicate timing below)</small>  <input type="checkbox"/> Injury to inmate caused prior to corrections officer contact  <input type="checkbox"/> Injury to inmate caused by use of force by corrections officer</p> <p><b>6. Incident Outcome (Check all that apply)</b></p> <p><input type="checkbox"/> Verbal Warning <input type="checkbox"/> Write-up  <input type="checkbox"/> Lockdown <input type="checkbox"/> Moved/Reclassified  <input type="checkbox"/> Suicide Watch <input type="checkbox"/> NA: De-escalated prior to CIT arrival  <input type="checkbox"/> Arrested  <input type="checkbox"/> Medical Referral to : _____  <input type="checkbox"/> Mental Health Referral to : _____  <input type="checkbox"/> Other (specify): _____</p> <p><b>7. Known Inmate Mental Health History (Check all that apply)</b></p> <p><input type="checkbox"/> Antisocial <input type="checkbox"/> Dementia <input type="checkbox"/> Panic/Anxiety <input type="checkbox"/> Schizophrenia  <input type="checkbox"/> Bi-polar <input type="checkbox"/> Depression <input type="checkbox"/> PTSD  <input type="checkbox"/> Other (specify): _____  <input type="checkbox"/> Provider/ Outside Counseling (specify): _____</p>	<p><b>8. Known Prescribed Medications (list)</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>9. Known Inmate Substance Abuse History (Check all that apply)</b></p> <p><input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana  <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Heroin <input type="checkbox"/> Methadone  <input type="checkbox"/> Pain Medication (specify): _____  <input type="checkbox"/> Other (specify): _____</p> <p><b>10. Symptoms Checklist (Check all that apply)</b></p> <p><input type="checkbox"/> Agitated/Irritable <input type="checkbox"/> Insomnia  <input type="checkbox"/> Anxiety/Panic <input type="checkbox"/> Isolating  <input type="checkbox"/> Assaultive <input type="checkbox"/> Lack of eye contact/Blank Stare  <input type="checkbox"/> Confusion <input type="checkbox"/> Lack of personal hygiene  <input type="checkbox"/> Delusions <input type="checkbox"/> Not eating → How many meals ____  <input type="checkbox"/> Depression/Sadness <input type="checkbox"/> Pacing  <input type="checkbox"/> Disorientated <input type="checkbox"/> Pain  <input type="checkbox"/> Embarrassed <input type="checkbox"/> Paranoia  <input type="checkbox"/> Hearing Voices/Command voices <input type="checkbox"/> Phobia/ Fear  <input type="checkbox"/> Hopelessness/Crying <input type="checkbox"/> Recent loss  <input type="checkbox"/> Hyperactive <input type="checkbox"/> Self Harm  <input type="checkbox"/> Impulsive <input type="checkbox"/> Yelling/Screaming</p> <p><b>11. Comments (Describe what you Observed)</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>CIT Officer Name (Print) _____  Officer Signature _____  Emp# _____  Distribution: <input type="checkbox"/> Original to CIT Coordinator <input type="checkbox"/> Copies to Medical  <input type="checkbox"/> Emergency Room <input type="checkbox"/> Inmate File</p>
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