

Evaluation Report of NAMI CIT Implementation at the Androscoggin County Jail

December 31, 2005

Prepared by:



Public Health Research Institute
120 Exchange Street
Portland, ME 04101
(207) 761-7093
www.phrg.com

TABLE OF CONTENTS

Introduction

Overview

Background

 Crisis Intervention Training

 Description of Androscoggin Jail

CIT Program Implementation at Androscoggin Jail

Methodology

Design/Indicators

Data Collection

Data Quality Limitations

Findings

Outcomes Evaluation Findings

 CIT Incident Reports

Process Evaluation Findings

 Pre-CIT Officer Interview Summary (PCJ)

 Post-CIT Focus Group Summary (ACJ)

Discussion

Conclusions and Recommendations

Appendices

A. ACJ CIT Report Form

B. ACJ Medical/Mental Health Referral Form

C. Focus Group Facilitation Guide

Data

Table 1: Inventory of evaluation data

Table 2: Inmate Gender

Table 3: Pre-Post Comparison of Inmate Aggression

Table 4: Pre-Post Comparison of Incidents at Intake and Use of Force

Table 5: Pre-Post Comparison of Number of Corrections Officers Involved

Table 6: Pre-Post Comparison of Actions Taken by Officers

Table 7: Pre-Post Comparison of Inmate Resistance

Table 8: Pre-Post Comparison of Incident Outcomes

Table 9: Frequency/Distribution of CIT Incident Reports

Table 10: CIT Incidents: Mental Health Diagnoses

Table 11: CIT Incidents: Inmate Substance Abuse

Table 12: Threat Assessment Behavior

Table 13: CIT Incident Reports: Officer Disposition of Outcome

I. Introduction

Overview

In June of 2004, the NAMI (formerly the National Alliance for the Mentally Ill) Maine, with assistance from the Maine Health Access Foundation (MeHAF) and others conducted a pilot project to implement and evaluate a Crisis Intervention Training program at Androscoggin County Jail (ACJ), Maine. Based on the success of the Crisis Intervention Team (CIT) model originally developed in 1987 by the Memphis, Tennessee Police Department as a pre-booking jail diversion program, this project represents a first attempt at applying a modified-CIT program in a jail setting.

The overall goal of CIT is to improve inmate access to treatment, improve the quality of the in-jail response to psychiatric emergencies, and provide a cost effective response to mental health and substance abuse issues in jail settings. NAMI Maine contracted with the Public Health Research Institute (PHRI) to evaluate the pilot CIT program at Androscoggin County Jail. The evaluation assessed short-term and immediate expected project outcomes including the feasibility of implementing the CIT model in a corrections setting and the barriers that correctional officers face in using CIT strategies in a jail environment. This report, in part, describes the extent to which this theory could be tested on a pilot basis.

CIT training is theorized to improve mental health care access and quality while reducing the burden of mental illness on the jail system by improving correctional officers' ability to recognize, respond to and appropriately refer jail inmates with behavioral health disorders. The CIT model addresses these issues in a comprehensive and systematic way by:

- Selecting officers who volunteer for CIT training based on their interest in mental health issues;
- 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; and
- Linking officers to providers of mental health services in their local community.

CIT has been described as a process of “addressing system change for crisis care within a community as a whole”¹. To account for the differences in approach and response options available to police officers and correctional officers, modifications to CIT and its training were made. While police officer engagement with disruptive individuals is generally limited to temporary custody, corrections officers are charged with holding and monitoring disruptive individuals over extended periods of time and often involving mental illness and/or substance abuse issues. This requires that correctional officers possess a set of skills to effectively manage and de-escalate disruptive incidents. In addition, CIT skills often are quite different from those covered in standard correctional officer training, where immediate control and restraint skills are emphasized. Therefore, the training emphasizes alternatives to standard jail responses to mental health/substance abuse related crisis incidents.

¹ 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.

The Short-term expected outcomes of the implementation are as follows:

- Officer satisfaction with new CIT skills
- Increased officers' ability to identify mental health/substance abuse disorders among inmates
- Increased officer repertoire of non-violent skills for diffusing crisis situations
- Increased officer knowledge of internal and community resources for treating inmates with mental health and/or substance abuse disorders
- Improved coordination and collaboration between county jail personnel and mental health providers
- Improved referral of mentally ill inmates to appropriate health providers
- Increased officer use of evidence-based crisis management

The Intermediate-term expected outcomes of the implementation are as follows:

- Reduced number of injuries to inmates and officers
- Improved quality of in-jail response to psychiatric emergencies including the reduced use of seclusion and restraint as a response to inmate suicidality, aggression and other psychiatric behaviors
- Improved inmate access to treatment during their incarceration

PHRI's objectives were specifically to 1) identify indicators with which to measure program effectiveness, 2) develop an appropriate evaluation strategy including tools for data collection, 3) systematically collect the available data and 4) evaluate the outcomes and process of the CIT program implementation at ACJ.

Data were extracted from a number of sources including ACJ standard incident and medical reports, the project-related ACJ CIT Report, focus groups with CIT and non-CIT trained corrections officers, and a survey instrument. Analysis of these data provides insight about the effects of CIT implementation in a jail setting, and illustrates gaps within the program. Recommendations to further the use and effectiveness of the CIT program in a jail setting are presented.

Background

Mental Health Issues in Correctional Environments

There is ample evidence, nationally and in Maine, that people with mental illness and those with co-occurring substance use are increasingly over-represented in correctional institutions². Twenty-five percent of Maine's prison inmates are taking medication for a mental health disorder and between 24 percent and 50 percent of Maine's jail inmates have a behavioral health disorder. Correctional institutions often are ill-equipped to meet the needs of this population. A 2002 Call to Action by the Citizen's Committee on Mental Illness, Substance Abuse, and Corrections and NAMI Maine reported that between 1998 and 2002 four Maine State Prison inmates committed suicide, ten Maine county jail inmates committed suicide, and three other county inmates died due to medical problems, drug overdose, and an alcohol withdrawal related seizure. In addition to overcrowding and capacity issues, the report concluded that 50 percent of

² Literature review conducted by the National Alliance for the Mentally Ill of Maine, September 2004

Maine jails have reported difficulty in accessing psychiatric hospital beds, even in cases of emergency³.

The need for a jail-focused intervention has been sparked by high numbers of incarcerated persons that are diagnosed with mental illnesses and/or substance abuse problems and the possible in-jail crises that may result (e.g. suicide attempts, aggressive and violent behavior, etc.), coupled with a weak relationship between Maine jails and community mental health treatment providers. To address this need, NAMI revised the CIT program for implementation in a jail setting as a crisis recognition, response and management program designed to minimize the frequency and magnitude of mental health related crises among inmates.

Crisis Intervention Teams (CIT) in Community Settings

Crisis Intervention Team (CIT) is a specialized police response to handling mentally ill individuals in crisis. Originally developed in 1987 by the Memphis, Tennessee Police Department, this pre-booking jail diversion program combines proven training methods developed by the University of Tennessee's law enforcement training program with demonstrated team management principles. The primary goal of CIT is to improve officer recognition of and response to people with mental illness, that is, to handle crisis episodes without injury to the parties and to place the mentally ill offender in treatment for their illness rather than in jail⁴. Crisis Intervention Teams are specialized teams of police who have been trained and then linked to local providers of mental health services. In addition to symptom recognition of major mental illnesses, the CIT officer training includes role-playing techniques, verbalization skills, and officer interaction with mentally ill individuals. Once trained, CIT officers become the first responders when police are called to a psychiatric emergency. CIT has been demonstrated to reduce arrest rates, officer injuries, community injuries, the use of restraint, emergency room admissions and to improve community and officer satisfaction. The Substance Abuse and Mental Health Services Administration (SAMSHA) now considers CIT an evidence-based practice for jail diversion for people with behavioral health needs. Because CIT training is theorized to improve officers' ability to recognize, respond to and appropriately refer respond persons with behavioral health disorders, an application of this evidence-based model within a correctional setting is warranted.

Description of Androscoggin County Jail

The Androscoggin County Jail is certified for 130 beds. Five thousand adults are detained each year for an average length of stay of 61 days, although some inmates may stay for as long as one year. Inmates are on average 25 years old and hold a high school diploma. Seventy-five percent of inmates are male and 25 percent are female. Results from a 2003 survey revealed that 70 percent of male inmates and 65 percent of females were taking medications for a mental health disorder, and 50 percent of males and 69 percent of females were attending in-jail substance abuse programs, such as AA meetings.

³ Report on the Current Status of Services for Persons with Mental Illness in Maine's Jails and Prisons: 2002. The Citizen's Committee on Mental Illness, Substance Abuse, and Criminal Justice and the National Alliance for the Mentally Ill of Maine, September 2002.

⁴ The Mentally Ill and the Criminal Justice System: A Review of Programs. Spaitte et al. National Alliance for the Mentally Ill, Columbus Ohio, June 2005.

Medical resources are accessed through the ACJ Medical/Mental Health Department and the Substance Abuse Department. The medical/mental health department employs a nurse to administer daily medications and make routine checks of inmates, and receives part-time assistance from Allied Resources for Correctional Health, Inc. (ARCH), a Maine health care provider serving corrections facilities throughout the state. The substance abuse department employs a part-time provider to accept referrals and complete inmate evaluations. During hours where no medical staff is in the facility, both the ACJ nurse and ARCH provider are on-call.

CIT Program Implementation at ACJ

NAMI Maine collaborated with numerous organizations during the course of implementing CIT in Maine, and began by identifying and obtaining buy-in from key community stakeholders, including local families, consumers, and providers. Collaborating organizations for the in-jail project included the Androscoggin County Jail, St. Mary's Hospital and Tri-county Mental Health Services, and Common Ties/100 Pine Street Social Center.

NAMI Maine worked with the ACJ to develop a modified CIT training program and to identify the first group of correctional officers to be trained. The 40-hour training was held in December 2003 for a group of eight ACJ officers. NAMI Maine facilitated the training. Additional presenters included staff from the Tri County Mental Health Services, Androscoggin County Jail Sheriff's Office, the Lewiston Police Department, Spring Harbor, a defense attorney, a local sexual assault program member, a physician from the Maine Department of Mental Health, a Portland City Department of Health and Human Services professional, in addition to a family member and consumer.

Participating officers were selected by their superiors, with the intention of having at least one CIT trained officer on-duty during each shift at ACJ. During the training session, officers were provided with skills and information to aid them in recognizing and responding appropriately to the symptoms of mental illness and psychiatric crises.⁵ Through hands-on training, role-playing, and site visits officers were able to practice these skills in various de-escalation and intervention activities. Officers had the opportunity to interact with people with mental illness and their families in treatment settings. In addition, service providers spent a day with officers at ACJ.

The intent of the training was to provide ACJ with a pool of CIT-trained officers to call upon to assist in crisis situations thought to be related to mental illness and/or substance abuse. A CIT report form (Appendix A) was designed specifically to record CIT-related incident information in a standardized format⁶ when CIT-trained officers were called to assist. This report form provided a way to document CIT-related incidents for ACJ documentation, as well as for

⁵ The training covered risk prevention and suicide, psychiatric medications, behavior management, mental illness basics, substance abuse and co-occurring disorders, personality disorders and psychopathy, trauma, consumer perspectives and personal experiences, family perspectives, de-escalation skills and role-plays, diversity issues, policy and procedures, consumer rights, and legal issues.

⁶ The ACJ CIT Report includes the Date, Time, DC#, Zone Location, Inmate Name, Inmate Date of Birth, Officers Involved, Supervisor; the Mental Illness (Yes/No) and Diagnosis (if known); the Threat Assessment (Yes/No): Suicide Ideation, Suicide Attempt, Self Abusive, Aggressive; the Substance Use for Alcohol, Heroin, Methadone, Marijuana, Cocaine, Unknown, and other; the Use of Force (Yes/No) and If yes, the level of force; if a Report was attached (Yes/No); the CIT officer narrative; Tri-County Referral (Yes/No); Disposition (in narrative format); and the CIT Officer and Supervisor signatures.

evaluation purposes. In addition to the form, a CIT incident Excel spreadsheet⁷ was developed by ACJ staff to keep track of basic information regarding each CIT-related incident.

As part of ACJ's usual documentation practice, Medical / Mental Health Referral forms are typically completed every time an inmate is referred to the medical / mental health department. In addition, a Tri County Mental Health Services (TCMHS) Western Crisis Services Outcome Recommendation form is typically completed and kept on file when an inmate is seen by TCMHS. It should be noted, however, that inmates may be seen or referred to the jail's medical staff or TCMHS without such documentation. When available, these additional forms were attached to the original ACJ CIT Report and forwarded to the evaluation team.

II. METHODOLOGY

Design/Indicators

A pre-post, quasi-experimental design was employed to assess program changes and measure the effectiveness of the modified CIT program at ACJ. The analysis of evaluation data was designed to identify intervention-related changes with respect to both the process and short-term and intermediate outcomes. To the extent possible, data were collected so that CIT program changes and effectiveness could be quantified. In addition, qualitative data was collected to further describe and document program implementation.

Quantitative Indicators

- Number of ACJ incidents during pre- and post- time intervals
- Number of incidents at intake and use of force
- Number of corrections officers involved
- Number of incidents involving inmate aggression
- Distribution of actions taken by officers
- Inmate resistance
- Response to inmate resistance
- Incident outcomes
- Frequency of CIT reported incidents
- Distribution of mental health/substance abuse issues among CIT-related incidents
- Disposition of outcome of CIT-related incidents

Qualitative Indicators

- Officer understanding of mental health and drug/alcohol problems and the ability to identify inmates with those disorders
- Officer attitudes surrounding mental health and drug/alcohol problems and individuals having those problems
- Officer knowledge of jail and community resources for treating inmates with mental health or drug/alcohol problems
- Officer repertoire of non-violent skills for diffusing crisis situations to reduce risk of injury to correctional officers and inmates

⁷ The CIT incident spreadsheet includes Name of Inmate, Date, Time, Type of Incident, Supervisor, Medical Treatment/CIT Officer, and DC#.

- Officer perception of barriers faced when confronted with a crisis situation
- Officer satisfaction with working conditions at the jail

Data Collection

Table 1 describes the data sources compiled for the evaluation.

ACJ incident reports: ACJ incident reports contain the date and time, the inmate(s) and officer(s) involved, and a narrative description of a jail incident. An incident in the jail is defined as requiring correctional officer intervention to respond to improper behavior of an inmate to the extent that it is classified, recorded, and demands follow-up by correctional authority. These reports are standardized printouts from the jail's computer system and are routinely utilized by all jail staff. PHRI created a coding scheme to extract data from these reports to create a data set of incident indicators. The created data set included variables describing inmate behavior (including verbal and physical aggression, resistance to instruction and restraint, and suicidal ideation), officer use of seclusion and restraint, injury to officers and inmates, and mental health/substance abuse-related incidents. Data were extracted from both pre and post-CIT program implementation incident reports. Pre-CIT data was compiled from ACJ incident reports completed between September through December 16, 2003 and post-CIT data was compiled from ACJ incident reports completed between December 17, 2003 through May 2004. PHRI excluded irrelevant "incidents" from the data set, including reports of damaged property unrelated to inmate behavior and officer illness.

CIT Incident Report: Between December 17, 2003 and October 31, 2004, ACJ staff recorded 39 CIT-related incidents, although only 33 ACJ CIT Reports were kept on file. Incident data recorded for 39 incidents include the time and date of the occurrence. Thirty-three CIT reports contained more detailed incident information, including threat assessment, use of force, mental illness diagnosis, substance use and referral . Frequencies and percentages were computed by incident and not by inmate, as the same inmate may have been involved in more than one incident. Records show that three inmates had two recorded ACJ CIT Reports; all other inmates were reported only once.

Additional ACJ Forms: Additional data sources used for the evaluation included the ACJ Incident Report Spreadsheet, the ACJ Medical / Mental Health Referral form, the ACJ Use of Force Report, and the Tri-County Mental Health Services (TCMHS) Western Crisis Services Outcome Recommendation form. The data extracted from these reports and forms pertained only to incidents where a CIT officer was involved and therefore were utilized to see how well the officers made use of their CIT skill set.

Qualitative Data Sources: To support the process evaluation, qualitative data were collected through 1) a post-training focus group with ACJ CIT-trained corrections officers, 2) semi-structured telephone interviews with CIT trainers, and 3) a focus group with non-CIT trained corrections officers at another Maine correctional facility. The post-CIT focus group with ACJ corrections officers was designed to elicit CIT-trained corrections officers' satisfaction with the CIT program, recommendations regarding additional resources needed to continue successful implementation of the CIT program, and suggestions for improvement. The CIT Trainers survey was developed to assess the trainers' perceptions of the impact of and satisfaction with CIT,

including the trainers' perceptions of officer awareness, training impact and ACJ's linkages with community resources. Questions were also asked about how the training and linkages could be improved further. In addition, a focus group was conducted with non-CIT trained officers at another Maine jail, to better understand officer attitudes and responses to inmates with mental health issues.

Table 1: Inventory of data collected for the evaluation of CIT at ACJ

Type	Data	Source	Date(s)	Obs. (N)
Quantitative (Pre- and Post-CIT)	Incident Characteristics	ACJ Incident Reports	Pre: 9/03 – 11/03 Post: 12/03 – 05/04	165 (pre) 206 (post)
Quantitative (Post CIT)	CIT Incident Characteristics	ACJ CIT Reports ⁸	12/03 – 10/04	33
	CIT Incident Characteristics	ACJ CIT Excel Spreadsheet	12/03 – 10/04	39
	Referral Information	ACJ Medical / Mental Health Referral forms	12/03 – 10/04	6
	Officer Use of Force	ACJ Use of Force Reports	12/03 – 10/04	2
	Recommendations/ Crisis Interventions	TCMHS Recommendation forms	12/03 – 10/04	9
Qualitative (Post-CIT)	CIT-Trained Corrections Officer Satisfaction and Awareness	Focus group	10/22/2004	5
Qualitative (Post-CIT)	CIT Trainers Perspectives	CIT Trainer's Phone Survey	11/2004	5

Data Limitations

An important aspect of the evaluation of the CIT program was to assess the feasibility of data collection strategies within a correctional institutional setting. There were several influences affecting the analysis of data and reporting outcomes. The evaluation of the CIT program at the Androscoggin County Jail began after training was completed. There was no opportunity to properly put data collection strategies in place, to educate staff on the data collection process or to instill the importance of obtaining quality and consistent information. Issues that constrained data collection included incomplete and inconsistent data recording by ACJ staff. Collecting data specific to CIT training was not integrated into the jails record keeping system. Inmate behavior requiring correctional officer intervention was recorded on a standard report used for all inmate disruption incidents. With implementation of CIT additional information was recorded when the intervention was handled by a CIT trained officer. The data collection process suffered from inconsistency in recording, periods of time when no data was recorded, and a loss of the data set, later restored by PHRI. The result was a data-set that provided information useful for the examination of CIT Incident Reports, but it did not replicate continuous data.

⁸ Frequencies and percentages were computed for each ACJ CIT Report and not for individual inmates, as the same person may have been involved more than one incidents. Records show that three inmates had two recorded ACJ CIT Reports; all other inmates were reported only once.

Inconsistent documentation of mental health and medical referrals, to both the ACJ Medical / Mental Health Department and to Tri-County Mental Health Services impeded the ability to evaluate changes in ACJ's relationship with outside resources, including the number of referrals made and follow-up, attributable to CIT training. In addition, the ACJ Medical / Mental Health and Substance Abuse departments could not sufficiently provide information on the use of psychotropic medications in the jail.

The data on inmate treatment for mental illness and substance abuse were not reliable. Treatment information was not recorded consistently on incident reports. Inmate treatment for mental illness and substance abuse was not necessarily associated with individual incidents. Inmates may have received treatment as a result of an incident, but this information was not recorded on the incident report. Only two pre-CIT incidents and 6 post-CIT incidents recorded treatment for mental illness and there was no reporting of treatment for substance abuse.

PHRI did not have access to ACJ Injury Reports, which are required in the case of officer or inmate injury. Because inmate and/or officer injuries are not consistently documented in the narrative of the ACJ Incident Reports, PHRI could not ascertain the universe of injuries at ACJ. Few inmate injuries were reported via ACJ incident reports (10 pre-CIT, 12 post-CIT), and three post-CIT officer injuries were noted (no pre-CIT officer injuries were recorded). Injuries to other inmates by an inmate were also noted infrequently. Only one pre-CIT and three post-CIT injuries were documented.

Use of force was not documented consistently during the evaluation. The ACJ CIT report form did not initially document officer use of force, but was later revised to measure this indicator.

Other limitations in data collection and analysis occurred because the evaluation team was retained after the CIT training took place and project implementation began. For example, data regarding ACJ officer perceptions and opinions before CIT were not collected, because CIT training occurred before the evaluation team was in place. Therefore, a quantitative pre-post analysis of officer level data could not be conducted.

In addition, staff changes at ACJ impacted both CIT project implementation and evaluation. In June 2004 the supervisor of CIT resigned and was replaced by another officer who was not familiar with CIT. Of the eight officers trained in December 2003, by October 2004, only five CIT trained officers were still on staff. The reduction in CIT-trained staff resulted in ACJ's inability to have at least one CIT trained officer on-duty during each shift. The lack of staffed CIT trained officers and supervisor support contributed to the decreasing number of documented CIT interventions over the study period. Thus the number of ACJ CIT Incident Reports filed is not indicative of the number of incidents involving CIT officers nor those involving inmates with mental illness/substance abuse issues. A further consequence of reliance on data extracted from narrative reports was that because incidents were not uniformly documented by ACJ staff, the evaluation data set suffers from missing and inconsistent data.

III. FINDINGS

Outcomes Evaluation

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

During the study period, a total of 391 incidents were reported at ACJ, 165 occurring in the three months prior to CIT training (September through November 2003); and 226 occurring in the six month period after CIT training (December 2003 to May 2004). Non-inmate related incidents and repeat incident entries are excluded from this count. For simplicity, these two subsets of incidents will be called pre and post incidents, respectively throughout the remainder of the section. As stated earlier, the data is based on reported incidents, therefore does not reflect the total bookings occurring during the study period. For example, in the six month period between January and June, 2004, a total of 2,681 persons were booked at ACJ. An analysis limited to incident reports does not measure the true mental health burden of inmates.

Table 2 provides information on incidents by gender. A larger proportion of pre and post-CIT incidents involved male rather than female inmates. However, the ratio of incidents involving males to females is comparable to the proportion of male and female inmates at ACJ.

Table 2: Inmate Gender

Inmate Gender	Pre Incidents (n = 165)		Post Incidents (n = 226)	
	Frequency*	Percent	Frequency*	Percent
Male	122	73.9	202	89.4
Female	38	23.0	23	10.2

* Frequency counts do not add up to incident totals due to missing data on gender.

Inmate Behavior: 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. Inmate expression of verbal and/or physical aggression, either towards themselves or towards others is a common occurrence. Table 3 below compares inmate verbal and physical aggression reported in pre and post incidents. Fifty-three percent of pre-CIT incidents involved one or more types of inmate aggression, while nearly 65 percent of post-incidents involved aggression. The proportion of post-CIT incidents reporting inmate verbal aggression to others is 35 percent higher than pre incidents ($p=0.00$). Additionally, the proportion of post-CIT incidents reporting inmate physical aggression towards others is 59 percent higher than pre incidents ($p=0.00$).

CIT-trained officers were involved in 53 percent of post-incidents involving inmate physical aggression towards others and in 47 percent of the post-incidents where any type of aggression was reported, suggesting the use of CIT-trained officers in more severe types of incidents.

Determining the cause for increased aggression during the post-CIT period is beyond the scope of the present study. Differences in aggression levels between pre- and post-CIT incidents were statistically controlled for in several analyses including officer action, inmate resistance, and incident outcomes.

Table 3: Pre-Post Comparison of Inmate Aggression

	Pre Incidents (n = 165)		Post Incidents (n = 226)	
	Frequency	Percent	Frequency	Percent
Inmate Aggression*				
Verbal Self-Aggression	8	4.8	7	3.1
Verbal Aggression to Others	70	42.4	129	57.1
Physical Self-Aggression	13	7.9	12	5.3
Physical Aggression to Others	41	24.8	89	39.4
Any Aggression** (combined)	88	53.3	146	64.6

*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.

Comparison of Incidents at Intake and Use of Force: Nine percent of pre-CIT incidents and thirteen percent of post incidents took place at intake. Prior to admission (intake) ACJ 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. A review of pre- and post-incident reports revealed that medical clearance was requested less frequently for incidents occurring in the pre-intake phase prior to CIT implementation than post-CIT incidents (20% vs. 41%). Consistent with expectations of CIT training, pre-intake referrals for medical clearance were significantly more likely to occur in post-CIT incidents ($p=0.05$).

Within the population of incidents occurring at intake (pre-CIT $n=15$, post $n=29$), reports of officer use of force (i.e. physical restraint and restraint equipment) were more frequent during post-CIT incidents than pre-CIT incidents. Table 4 indicates higher proportions of post incidents reporting officer use of physical restraint. The same is true for post incidents reporting officer use of restraint equipment. However, the differences between pre and post incidents (at intake) reporting officer use of physical restraint ($p=0.11$) or use of restraint equipment ($p=0.06$) are not statistically significant.

Table 4: Pre-Post Comparison of Incidents at Intake and Use of Force

	Pre-CIT Incidents Occurring at Intake (n = 15)		Post-CIT Incidents Occurring at Intake (n = 29)	
	Frequency	Percent	Frequency	Percent
Use of Force*				
Physical Restraint	11	73.3	26	89.7
Restraint Equipment	7	46.7	21	72.4

*Use of force variables are not mutually exclusive. More than one may be recorded in a single incident.

Intoxication and the Use of Restraint: Three percent of pre incidents and 7 percent of post incidents involved an intoxicated inmate. Among pre incidents involving an intoxicated inmate, 80 percent resulted in officer use of physical restraint. This proportion increases to 93 percent in the post period. The proportion of incidents involving an intoxicated inmate that resulted in officer use of restraint equipment also increased from pre (40%) to post (67%).

Comparison of the Number of Corrections Officers Involved: The majority of pre and post incidents involved only one responding officer, although pre-incidents were more likely to involve one responding officer than post incidents. Post-incidents were more likely to involve between 2 and 4 officers than pre-incidents (30% and 22% respectively). As displayed in Table 5, however, incidents involving five or more officers occurred as frequently among post incidents (16%) as pre incidents (16%).

Among incidents documenting inmate physical aggression, generally fewer officers responded to post-incidents than pre-incidents. For example, a greater proportion of post-incidents (reporting inmate physical aggression towards others) required only one responding officer than pre-incidents (33% and 29% respectively), while a lower proportion of post-incidents required the response of 5 or more officers than pre-incidents (28% and 34% respectively, data not shown).

The number of officers involved does not correlate with increased use of physical restraint, however, use of restraint equipment is more likely among incidents involving four or more officers.

Table 5: Pre-Post Comparison of the Number of Corrections Officers Involved

# Officers Involved	Pre Incidents (n = 165)		Post Incidents (n = 226)	
	Frequency	Percent	Frequency	Percent
1	102	61.8	121	53.5
2	16	9.7	34	15.0
3-4	20	12.1	34	15.0
5 or more	27	16.4	37	16.4

Comparison of Officer Actions: All ACJ corrections officers have a set of actions they are trained to utilize during the course of an incident in an attempt to resolve it. For simplicity, these actions are summarized into four categories; verbal warning, physical restraint (hard and soft contact), pepper spray, and several types of restraints (i.e. handcuffs, leg irons, belly chains, PRO-STRAINT Prisoner Safety Seat, protective headgear, and spitting hood). Hard contact is utilized primarily when an inmate resists soft contact. Table 6 compares actions taken by officers across pre and post incidents. Most notable is a significant increase in officer use of verbal warning from pre to post incidents (59% to 82%; p=0.00). This difference remained when inmate physical aggression against others was controlled for in the analysis. Seventy-one percent of pre-CIT incidents involving inmate physical aggression resulted in a verbal warning, while 84 percent of post-CIT incidents involving inmate physical aggression against others resulted in a verbal warning.

With respect to officer use of physical restraint, pepper spray and restraint equipment; there are no significant differences between pre and post incidents. As displayed in Table 6, officer use of oleoresin capsicum or pepper spray was reported in 5 percent of all incidents and was slightly more frequent among pre-incidents than among post-incidents (7% and 3% respectively). Officers made use of restraint equipment, in 18 percent of pre and post incidents, with handcuffs being the most frequently used form of restraint equipment.

Statistical differences in officer actions during pre- and post-incidents were observed when inmate physical aggression towards others was accounted for (data not shown). For example, 24 percent of pre-CIT incidents involving inmate physical aggression resulted in officer use of pepper spray, while eight percent of post-CIT incidents involving inmate physical aggression against others resulted in officer use of pepper spray. Officers used physical restraint in nearly 49 percent of pre-CIT incidents involving inmate physical aggression, and in 37 percent of post-CIT incidents involving inmate physical aggression. In addition, officers used restraint equipment in 44 percent of pre-CIT incidents involving inmate physical aggression, and in 37 percent of post-CIT incidents involving inmate physical aggression towards others.

Table 6: Pre-Post Comparison of Actions Taken by Officers

Actions taken by Officers	Pre Incidents (n = 165)		Post Incidents (n = 226)	
	Frequency	Percent	Frequency	Percent
Verbal Warning	97	58.8	186	82.3
Physical Restraint	28	17.0	39	17.3
Soft Contact	9	5.5	10	4.42
Hard Contact	19	11.5	29	12.8
Pepper Spray	11	6.7	7	3.1
Restraint Equipment	31	18.8	41	18.1

*Officer action variables are not mutually exclusive. More than once may be recorded in a single incident.

Post incidents involving the population of eight CIT trained officers reported higher proportions of each officer action listed in Table 6 (verbal warning, 84%; physical restraint, 39%; pepper spray, 7%; and restraint equipment, 44%).

Comparison of Inmate Resistance: Inmate resistance to officer use of verbal warning, physical restraint, or restraint equipment was compared across pre and post incidents to illustrate a potential relationship between officers' use of de-escalation skills and response to crises. Table 7 compares inmate resistance to actions taken by officers across pre and post incidents.

Forty-four percent of pre incidents reported inmate resistance to verbal warnings, while this proportion increased to 59 percent in the post period. Relatively few pre and post incidents involved inmate resistance to physical restraint (11% and 15% respectively) and restraint equipment (6% and 9% respectively). It is notable that the proportion of incidents involving inmate resistance to all types of officer actions increased from pre to post-CIT training. In addition, inmate resistance was highest among post incidents involving a trained CIT officer, with 64 percent reporting inmate resistance to verbal warning, 32 percent reporting inmate

resistance to physical restraint, and 22 percent reporting inmate resistance to restraint equipment (data not shown).

Of the incidents characterized by physical aggression towards others, 61 percent of these pre-incidents resulted in inmate resistance to verbal warnings, while this proportion increased to 65 percent in the post period; 34 percent of aggression related pre- and post-incidents resulted in inmate resistance to physical restraint; and 15 percent of aggression-related pre-incidents and 21 percent in post-incidents resulted in inmate resistance to physical restraint (data not shown).

Table 7: Pre-Post Comparison of Inmate Resistance

	Pre Incidents (n = 165)		Post Incidents (n = 226)	
	Frequency	Percent	Frequency	Percent
Inmate Resistance*				
Verbal Warning	72	43.6	133	58.8
Physical Restraint	18	10.9	33	14.6
Restraint Equipment	9	5.5	21	9.3

*Inmate resistance variables are not mutually exclusive. More than one may be reported in a single incident.

Comparison of Incident Outcomes: The resolution of each crisis incident is based on the severity of the incident and the inmate’s behavior. The most common and least severe form of disciplinary action is a write-up. In this case, a description of the incident and how the inmate violated jail policy is kept in the inmate’s jail file. An inmate may also be placed on a 24-hour lockdown, where they cannot leave their cell without permission for a full 24-hour period. If the inmate is disrupting other inmates to the point where the situation cannot be controlled, an officer may decide to move the inmate to a different cell and/or reclassify them to a higher security block. Following the most severe incidents, including those that involve inmates who show physical aggression towards themselves, an officer may choose to escort the inmate to holding where they can be observed for a prolonged period of time until the crisis resolves.

Table 8 compares these outcomes across pre and post incidents. Seventy-four percent of all incident reports specified an outcome to the crisis. Post incidents were more likely to have an outcome recorded than pre incidents (77% vs. 69%). There are no significant differences between pre and post populations with respect to each type of outcome (write-ups, lockdowns, reclassifications, and escorts). Among the incidents involving CIT trained officers, 48 percent resulted in a write-up, 15 percent resulted in 24-hour lockdowns, and 54 percent resulted in escorting the inmate to holding - the most time and effort consuming outcome available to officers. Nearly 42 percent of pre-incidents involving inmate aggression towards others and 44 percent of post-incidents resulted in escorting the inmate to holding.

Of the twelve pre-incidents in which suicide ideation was documented, 50 percent of inmates were escorted to holding; and among the 11 post-incidents documenting suicide ideation, nearly 73 percent of inmates were escorted to holding. In addition, of the pre-incidents in which suicide ideation was documented, 33 percent resulted in a reported inmate injury. Of the post-incidents in which suicide ideation was documented, 18 percent resulted in a reported inmate injury.

Table 8: Pre- Post Comparison of Incident Outcomes

Incident Outcome*	Pre Incidents (n = 65)		Post Incidents (n = 226)	
	Frequency	Percent	Frequency	Percent
Any outcome recorded	114	69.1	175	77.4
Written Up	51	30.9	56	24.8
24-hour Lockdown	34	20.6	61	27.0
Inmate Moved/Reclassified	31	18.8	53	23.5
To a new cell	4	2.4	9	4.0
To heightened security	27	16.4	44	18.2
Escorted to Holding	35	21.2	60	26.5

*Incident outcome variables are mutually exclusive, however not all incidents reported one of the above outcomes.

CIT Incident Reports: As part of the CIT program implementation at ACJ, trained CIT officers were asked to complete a CIT Incident Report in cases involving an inmate with mental illness and/or substance abuse issues. The subset of incidents for which a CIT Incident Report was completed provides additional data used to describe this population of incidents. A total of 33 CIT Incident Report forms were completed during the study period.

Table 9 displays the frequency of CIT Incident Reports during the post training period of this study. The observed drop in reporting in April 2004 may reflect the attrition of several CIT trained officers or changes in CIT program implementation due to the departure of the primary supervisor familiar with CIT.

Table 9: Frequency of CIT Incident Reports

Month	CIT Incident Reports (n=39)	
	Number	Percent
December 2003	5	13
January 2004	8	21
February	4	10
March	10	26
April	3	8
May	1	3
June	1	3
July	2	5
August	1	3
September	1	3
October	3	8

CIT: Reported Mental Health Issues: Seventy-six percent of CIT related incidents took place at intake, prior to inmate booking. CIT trained officers questioned inmates at intake about mental health issues. In the majority of these cases, the diagnosis recorded was based on an inmate self-report of their history and current status, although in some cases, the mental health assessment was based on CIT officer observation. Table 10 displays the mental health diagnoses reported in 33 CIT Incident Reports. This population of incidents illustrates inmate conditions requiring a

variety of interventions including medication, officer awareness of methods for handling these individuals, and crisis responses for those who are uncooperative or uncontrollable at intake. The majority of inmates had multiple diagnoses. Overall, bipolar disorder is the most commonly reported mental illness (60%), followed by schizophrenia and depressive disorders.

Table 10: CIT Incidents: Reported Mental Health Issues

MH Disorder Specified	CIT Incident Reports (n = 33)	
	Frequency	Percent
Bipolar disorder/ Manic Depressive	20	60
Schizophrenia ¹	6	18
Depression	5	15
PTSD	4	12
ADHD	3	9
Other	5	15
Total ²	43	

¹ Includes Paranoid Schizophrenia ² Total includes more than one disorder with a single inmate

CIT: Reported Substance Use: Within the population of CIT Incident Reports, 45 percent of inmates either reported or were observed by a corrections officer to be substance users. Table 11 displays the type, number and frequency of substance use reported among these inmates. Inmates may have been using more than one of these substances in combination.

Table 11: CIT Incidents: Inmate Substance Abuse

Substance	CIT Incident Reports (n = 33)	
	Frequency	Percent
Alcohol	14	42.4
Cocaine	2	6.1
Marijuana	2	6.1
Oxycontin	2	6.1

CIT: Threat Assessment: CIT trained officers were asked to assess and report “threat assessment” behaviors they observed on the CIT Incident Report form. Table 12 displays the type of behavior officers observed, the frequency and proportion of behaviors reported. Expressed suicidal ideation was reported in 94 percent of CIT incidents. Aggressive behavior and self-abuse were also frequently reported in CIT Incident Reports, and a majority of inmates reportedly expressed a combination of more than one type of threat assessment behavior.

Table 12: Threat Assessment Behavior

Threat Assessment Behavior	CIT Incident Reports (n = 33)	
	Frequency	Percent
Aggressive	11	33.3
Self-Abusive	8	24.2
Suicidal Ideation	31	94.0

CIT Referrals: The CIT Incident Report form also recorded whether an inmate was referred to Tri-County Mental Health Services (TCMHS) for services that could not be provided by the jail. Sixty-one percent of CIT Incident Reports indicated a referral was made. However, only 27 percent of these incidents were accompanied by the appropriate documentation. Furthermore, most inmates were referred to the ACJ medical/mental health staff (52%), but only 18 percent of these incidents had an ACJ Medical / Mental Health Referral form attached to the incident report.

The officer disposition or narrative of the incident outcomes reported in the CIT Incident Reports included a variety of additional response options not reflected in the ACJ Incident form (Table 13). The majority of CIT Incident Reports recorded more than one response option.

Table 13: CIT Incident Reports: Officer Disposition of Outcome

Response Option	CIT Incident Reports (n = 33)	
	Number	Percent
High suicide watch	5	15
Suicide watch	15	45
Close observation	5	15
Jail medical/mental health referral	17	52
Refused to talk with crisis worker or TCMH	4	12
Seen by TCMH	10	30
Sent to St. Mary's	2	6
TCMH notified	2	6
Listed as aggressive	2	6
Unknown/Other	2	6

Process Evaluation Findings

Pre-CIT Officer Interview Summary, Penobscot County Jail

For the purposes of comparison, correctional officers who did not receive crisis intervention training (CIT) were assessed through individual interviews. Officers were asked about their understanding of mental illness and substance abuse, their knowledge of community resources for diagnosing and treating these disorders, their de-escalation and prevention skills, their attitudes and beliefs regarding mental illness and substance abuse, the barriers they encounter

day-to-day as a correctional officer that inhibit effectively addressing these issues, and their level of job satisfaction.

Interviews were conducted between November 2004 and March 2005 with seven correctional officers at the Penobscot County Jail. This group consisted of six males and one female with ages ranging from mid 20s to late '40's. All of the officers had at least three years of experience as a correctional officer although they had diverse work backgrounds. The officers rated their level of job satisfaction as being between three and four on a five-point scale with greatest job satisfaction being a five.

The officers indicated that they had received minimal training in the basic duties of a correctional officer and little to no training in addressing mental health and substance abuse problems. Despite their lack of training, the officers consistently felt they could generally manage inmates with a mental-health /substance-abuse problem often acting on their own intuition. The majority of the officers felt that they practiced de-escalation skills with the inmates. Talking calmly and attempting to listen to the inmate were noted as primary responses.

Officers indicated that the use of restraint, either physical or chemical, generally occurred in the intake area. Officers indicated that there was no consistent policy regarding the use of restraint. They expressed concern regarding the safety of inmates when restraint devices such as the five point Restraint bed were used. The officers also expressed concern regarding the lack of proactive interventions versus the use of reactive interventions such as restraint.

These officers had little knowledge regarding community resources available to the inmates to assist them in dealing with the mental health or substance abuse problems. The resource used most frequently by the officers was the PCJ's in-house mental health counselor. The officers noted the lack of resources and programs in the jail to address these problems, and also noted related limitations of the facility including the lack of private space to talk with a disturbed inmate. With respect to the availability of community resources, the officers indicated that on the night shift and weekends there was little available to assist them with the mentally ill inmate other than phone consultation. Commitments seldom occurred on evenings or weekends.

Correctional officers felt they received adequate support from administration and superiors and that the sheriff frequently visited the jail. Despite their concerns they felt inmates were treated in a humane and respectful fashion by most correctional officers. Staff and inmate interaction problems were most likely to occur when the census in the jail was high. Most of the officers indicated that the mentally ill population was not a group that they especially liked working with, but given the large number of mentally ill inmates in the jails, they generally accepted it as part of their job. They did not feel that their attitudes were negative regarding this population or that mentally ill inmates were discriminated against or mistreated.

Post-CIT Focus Group Summary, Androscoggin County Jail

A focus group with CIT correctional officers was held at the Androscoggin County Jail on August 16, 2004. The focus group was conducted to establish benchmarks of their experience, issues, needs and recommendations for change in future Crisis Intervention Training (CIT) program implementation. A snapshot of crisis intervention training utilization revealed

important information that can assist in guiding improvements and change endeavors leading to program enhancement.

The focus group consisted of five males and one female correctional officer. Five of the six officers had a minimum of three years of job experience. The one officer not in this category had completed just over one-year of experience. Job satisfaction with CIT officers was high.

The officers greatly appreciated the new skills and knowledge obtained from CIT, and all of the officers present noted their possession of increased crisis de-escalation skills and being able to restore calm and devise appropriate action for the inmate. They felt well-prepared to handle situations where mental illness and/or substance abuse issues were manifested and required intervention. Several officers expressed the need for additional CIT training to strengthen their knowledge and skill levels. New situations had been encountered since training where they were not able to draw on experience or knowledge.

ACJ officers stated they had limited knowledge about the availability of community resources for inmates in the areas of mental health or substance abuse problems prior to CIT training. ACJ officers felt that CIT training has helped them to better understand the community resources available to them and the inmates. The in-house mental health counselor was used with great frequency and they all were complimentary of her help with inmate issues. They also stated greater resources were needed within the jail to help with disruptive inmates. According to the officers, services to help correctional officers with disruptive inmates with mental health issues were almost non-existent prior to CIT training.

Officers also discussed the use of authorized force against disruptive inmates. They felt that although non-CIT officers and CIT officers used force according to policy, CIT offered alternatives to force in instances of psychiatric crisis. They felt the CIT skills enabled officers to de-escalate the situation without use of physical or chemical agents.

Androscoggin County Jail officers stated that inmates were treated in a humane and respectful fashion by most correctional officers. They felt that inmates were treated well within established policy and that CIT offered a new level of skill that all correctional officers should receive. A problem between an inmate and correctional officer was most likely to occur when the census in the jail was high. ACJ CIT officers stated they liked working with the mentally ill patients, including creating resolution to issues and working within and external to the jail for appropriate levels of help.

Officers identified problems and issues remaining unresolved. They stated the immediate need for the jail administration to create for jail policy detailing how CIT officers were to be used. Policy was also needed to state the availability of a CIT officer for each shift and if enacted would require the training of additional CIT officers. They also recommended that all command officers receive orientation to CIT to help them understand the needs of the program and to assist with finding solutions. Insufficient awareness of CIT inhibits command officers from providing the level of assistance needed by CIT officers.

Initially eight officers and an administrative sergeant were trained in crisis intervention skills and knowledge. Prior to losing three of these officers to active duty call up, shift coverage was adequate. A Sergeant was assigned as supervisor of the unit with responsibilities of report collection, problem-solving, liaison with administration and NAMI, outreach to the larger provider community, and with inmates. The value of having a committed and knowledgeable CIT unit supervisor cannot be underscored as evidenced by the negative changes that occurred with his departure. Prior to his leaving service with the Androscoggin County Jail the CIT officers felt respected, maintained strong inter-agency communications, addressed problems and issues as they arose, and generally maintained a positive and engaged attitude to their responsibilities as CIT staff. According to the group of officers, the departure of this supervisor and his replacement not being CIT trained, they perceived loss of support, which in turn resulted in diminished morale.

As the study period progressed, some shifts had no available CIT personnel, which resulted in the less frequent availability of these skills. The habit of calling for a CIT officer to handle disruptive inmates by non-trained CIT officers was interrupted and system expectations diminished as a result. This in turn appeared to affect officer relationships, with non-CIT trained officers making comments that were deemed derogatory to CIT trained officers. The feelings of CIT officers went from one of excitement and pride to defensive and a sense that their support system had disintegrated. No longer feeling that what they were doing was important, the CIT officers reported a general sense of discouragement.

IV. DISCUSSION

This project represents a first attempt at applying a Crisis Intervention Training (CIT) model in a jail setting. Research about the effectiveness of CIT as a pre-booking jail diversion program in community settings has demonstrated its ability to avoid inappropriate arrests by making direct referrals to community-based behavioral health programs. For example, after CIT was implemented in Memphis, 75 percent of mental disturbance cases resulted in a treatment disposition, instead of an arrest or restraint disposition⁹. The program's impact on dispositions reflects the role of police as front line responders to mental health emergencies occurring in communities, and the importance of appropriate response alternatives. The relevance of adapting this model for use in correctional facilities is based upon the prevalence of mental health related issues and incidents in correctional facilities, and the CIT model's demonstrated success in increasing officers' ability to respond to psychiatric crises and enhancing system linkages to community behavioral health resources. Modifications to the CIT model, outcomes, and their measurement are necessary to reflect the differences in the purpose, goals, philosophy and mission of correctional facilities and community-based police settings.

NAMI Maine adapted components of the Memphis police evidence-based CIT training for use in training and implementing a team of crisis intervention corrections officers at ACJ. A select group of corrections officers participated in this 40 hour training in December 2003. One purpose of the evaluation was to document the implementation of the model in a corrections setting. Based on qualitative data collected from CIT-trained officers, the officers stated they had

⁹ Journal of the American Academy of Psychiatry and the Law. 28:338044. 2000; US Department of Justice document number 179984. "Police Response to Emotionally Disturbed Persons: Analyzing New Models of Police Interactions with the Mental Health System. 12-29-1999.

limited knowledge about the availability of community resources for inmates in the areas of mental health or substance abuse problems prior to CIT training. ACJ officers felt that CIT training had better prepared them to handle situations where mental illness and/or substance abuse issues arose requiring intervention and solution of a problem. They also better understood the community resources available to them and the inmates. Prior to implementation of CIT, the working relationship with mental health and substance abuse personnel and agencies was described as confrontational and nearly non-existent. CIT officers reported a substantial improvement in the relationship and cooperation with community providers that occurred following CIT implementation.

Following training, supervisors assigned CIT personnel to shifts with the intent of continuous coverage. Initially, this group provided adequate shift coverage until the reassignment of three officers. Not training additional officers resulted in shift deficiency with some shifts having no CIT officer available.

Given the level of crisis training and the acquisition of new skills and knowledge, it was anticipated that CIT officers would be called to handle difficult inmate behavior problems. Further exploration is needed to determine exactly how CIT trained officers were used in crisis response at ACJ, what short and long-term changes were made to ACJ's crisis response protocols due this project, and the extent to which the CIT program was known, regarded and used by ACJ's corrections officers and administration. Continuing professional development was not provided, and CIT officers expressed the necessity of maintaining skills and adding new methods and techniques to existing knowledge. For example, for incidents falling outside the areas covered in the initial training, officers relied on prior experience and knowledge, and a trial and error approach to resolution

Based on qualitative information gathered from CIT trained officers and CIT trainers, the descriptive results of the project suggest a level of success with the following short-term project outcomes:

- Officer satisfaction with new CIT skills
- Increased officers' ability to identify mental health/substance abuse disorders among inmates
- Increased officer repertoire of non-violent skills for diffusing crisis situations
- Increased officer knowledge of internal and community resources for treating inmates with mental health and/or substance abuse disorders
- Improved coordination and collaboration between county jail personnel and mental health providers

The collection of quantitative data was needed to provide evidence of additional short and intermediate project outcomes. In addition to a CIT incident form created for the project, quantitative data was extracted from existing forms that were part of the jail's reporting structure for several indicators. As stated earlier, documentation practices at ACJ were inconsistent, and data access was sometimes restricted, which impeded the ability to draw sound conclusions.

It is hypothesized that a greater system-wide emphasis on inmate mental health needs, improved officer ability to recognize relevant symptoms, and an enhanced referral system would result in

more appropriate responses to psychiatric crises and referrals. It was difficult to assess the improvement in referral practices of mentally ill inmates to appropriate health providers attributable to CIT program implementation. Sixty-six percent of CIT incidents occurred at intake, reflecting the need for officers with enhanced skill sets to be available during the intake process to more effectively respond to mental health issues arising at this point. Inconsistent documentation of mental health and medical referrals impeded the ability to evaluate changes in the appropriate use of referrals attributable to CIT training, including the number of referrals made and follow-up.

It was also hypothesized that the CIT program would result in improved inmate access to treatment during their incarceration. The data on inmate treatment for mental illness and substance abuse were not reliable. Treatment information was not recorded consistently on incident reports. Inmate treatment for mental illness and substance abuse was not necessarily associated with individual incidents. Inmates may have received treatment as a result of an incident, but this information was not recorded on the incident report. Only two pre-CIT incidents and 6 post-CIT incidents recorded treatment for mental illness and there was no reporting of treatment for substance abuse.

Officer use of evidence-based crisis management was hypothesized to increase, and the quality of in-jail response to psychiatric emergencies was thought to improve as a result of the CIT program. A continuum of action and use of force alternatives is available to correctional officers and their use must be appropriate to the situation encountered. One indicator of this outcome is an assessment in changes in the level and types of actions taken by officers. In general, the use of verbal warnings among the population of all officers increased dramatically from pre to post incidents (59% to 82%). Among the population of CIT trained officers, verbal warnings were given in eighty-four percent of post-CIT incidents. This result is promising because it indicates an increased use of a less severe action alternative. Although all forms of officer actions were higher among post-CIT incidents, when inmate aggression was controlled for in the analysis, a different pattern emerged. Among incidents involving inmate aggression towards others, decreased use of pepper spray, physical restraint, and restraint equipment was observed for post-CIT incidents.

Severity of inmate behavior appears to dictate the response by correctional officers. Qualitative data gathered from CIT officers suggests that they were able to negotiate a more positive outcome that did not necessitate additional action on their part, although there is insufficient data to substantiate this. CIT-related incidents differ from non-CIT related incidents. Evidence supporting this includes an increased proportion of inmate resistance to officer actions among post-CIT incidents involving CIT officers, the high proportion of CIT incidents involving inmate aggression, self-abuse and suicide ideation, and the increased proportion among CIT-related incidents resulting in a holding escort. Therefore, a determination of adherence to evidence-based crisis management is made complex because of the nature of CIT incidents.

The primary goal for correctional officers called in a crisis situation is to quickly contain inmate outbursts in a safe manner with minimal to no injury to either officers or inmates. Determining if the CIT program led to a reduced number of injuries to inmates and officers was difficult to determine as this data was not consistently reported on ACJ incident reports and PHRI did not

have access to the ACJ's standard injury report form. Multiple influences occur simultaneous during a disruptive event that might impact outcomes including whether other prisoners are present, the current density of inmates, the number of officers' on-duty and present, the availability of officers to provide additional help, the nature and severity of the outburst, multiple inmate involvement, etc.

An important aspect of the evaluation of the CIT program was to assess the feasibility of data collection strategies within a correctional institutional setting. There were several influences affecting the analysis of data and reporting outcomes. The evaluation of the CIT program at the Androscoggin County Jail began after training was completed. There was no opportunity to properly put in place data collection strategies, to educate staff on the data collection process, instill the importance of obtaining quality and consistent information, and to collect relevant pre-training data.

Conclusions and Recommendations:

Crisis intervention training can be considered a revolutionary change for the tradition bound institution of county jails. Changing philosophies and attitudes is a major undertaking in any organization and mammoth in a jail. CIT has demonstrated some success in enhancing the ability of correctional institutions to handle individuals with mental illness and substance abuse problems. To sustain such changes, CIT protocols and procedures must be devised, adopted, and fully integrated by the institution.

NAMI must integrate CIT at all levels of the agency receiving training. It is not adequate to have a core number of correctional officers trained and using CIT, for when there are no available officers certified in these skills, other more traditional methods are employed. This brings a confusing and mixed message to inmates and other officers. The jail must aim to train all staff, including supervisors and administrators so that use of CIT skills becomes commonplace. Aspects of CIT can be introduced over time, bringing more officers to a higher level of skills that are applicable to the psychiatric situations.

Of importance to program sustainability was the determination that a pre-implementation meeting with the agency was critical. The necessity of NAMI to provide a pre-CIT orientation to administrators is deemed critical and would provide administrators with an understanding of CIT. This important step would remove institutional doubt and strengthen implementation commitments by administrators. This meeting would also provide an opportunity to stress the importance of data collection, and its utility for program adjustment. Ongoing communication between NAMI and the administration is necessary, given the observed occasional lack of support for the program once implemented.

A CIT policy should be developed to stipulate the roles and responsibilities of the CIT Correctional Officers and define when and why a CIT trained officer should be called upon to assist with an inmate in distress. It should include when an officer needs to file a CIT report and to whom it should be given, in addition to addressing the privacy issues when dealing with inmates with mental illness and/or substance abuse disorders. This policy will improve the outcomes associated with CIT—because officers will be called upon in situations of crisis before

any action is taken, thus making it less likely that force will be utilized—and improve the implementation process by eliminating organizational barriers before they are even faced

In order to further improve the linkages and relationship with community providers and resources, it is important that a protocol also exist that specifies when outside resources are needed (e.g. when referrals must be made) and what they are expected to accomplish once involved (e.g. what they can and can't do when assisting an inmate). Although this may be applicable only to each provider individually, NAMI and the jail staff should be included so that all parties involved are clear on the stipulations.

Maintaining a knowledgeable and empathetic supervisor with the CIT program is a critical agency commitment. The complexity of a jail and the types and extent of emergencies necessitates close supervision and timely problem-solving. The CIT supervisor is a critical component of CIT program implementation. Furthermore, the CIT supervisor should be CIT trained and enthusiastic about encouraging the use of CIT, and willing to take control in organizing the officer meetings, the data collection process, and overcoming any barriers that arise. As illustrated by the outcome at ACJ, if the supervisor does not possess these characteristics, the program will suffer.

Following the initial training of correctional officers a standard procedure for updating skills and problem-solving resolution is recommended. NAMI should establish regular in-service training sessions and a method for immediate consultation in resolving new issues and problems. Implementing continuous skills training for the core group of CIT is recommended to keep officers knowledgeable and well prepared to handle disruptive situations.

There is a need to have periodic face-to-face meetings with NAMI to discuss specific cases and seek assistance on interventions and long-term solutions. The ability to conduct a “peer case review” is beneficial and will result in better outcomes. The CIT officers must also meet regularly to exchange information, receive updates on particular inmates, and to support one another in using CIT. These meetings should be expanded to include jail supervisors, administrative staff, and jail mental health and substance abuse staff such that they stay integrated with the program and are aware of its use. It is suggested these meetings occur once per month. Meetings with community providers and resources should also be scheduled occasionally to maintain communication and collaboration, as well as strengthen the program. The meetings will foster support for CIT and sustain its use.

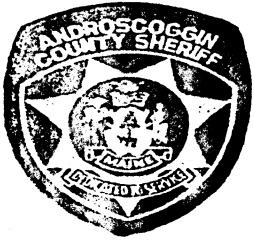
Periodic evaluation of the program must be completed to identify what changes need to be made and what components of the program are successful. With assistance and input from the evaluation team, the data should be managed by a knowledgeable CIT supervisor who can follow-up and communicate with CIT officers so that all pertinent incidents are documented. The data set should reflect the feasible, relevant, and important variables most essential to CIT evaluation. Officers will be more likely to utilize the forms if they are meaningful, well-constructed and require little effort.

This report indicates that procedures and policies related to implementing CIT in correctional settings may require further development. Implementation tactics may require change. Yet a

program of this magnitude can greatly impact a jail, and is worth further exploration. By implementing the suggestions and recommendations stemming from this exploratory analysis, the CIT program has the potential of demonstrating a great benefit to inmates, correctional officers, and the communities they serve.

Appendices

- A. ACJ CIT Report Form
- B. ACJ Medical/Mental Health Referral Form
- C. Focus Group Facilitation Guide



Androscoggin County Jail

Crisis Intervention Team Report

Date: ____/____/____

Time: ____:____ hrs.

DC# _____

Zone Location: _____

Inmate Name: _____ DOB: _____

Officers Involved: _____

Supervisor: _____

Mental Illness: Yes No

Diagnosis (if known): _____

Threat Assessment:

Suicide Ideation: Yes No
Suicide Attempt: Yes No
Self Abusive: Yes No
Aggressive: Yes No

Substance Use: Yes No

Alcohol: Marijuana:
Heroin: Cocaine:
Methadone:
Unknown: Other: _____

Was Force Used: Yes No

If Yes, What Level: _____

Report Attached: Yes No

Incident#: _____



ANDROSCOGGIN COUNTY JAIL

Medical / Mental Health Referral

Inmates Name: _____ Date: _____ Cell: _____

From: _____

To: _____

Reason for Referral: (Check One)

Suicide Risk Current Past History

Risk to Others Current Past History

Psychiatric Problems Current Past History

Substance Abuse Problems Current Past History

Behavior Problems Current Past History

Medical Problems Current Past History

Inmate Request Current Past History

Other: (Explain) _____

Source of Information: Inmate Officer Observation

Medical Screening Other _____

Referring Staff Name: _____ Signature: _____

Date Treated / Acted Upon: _____

Staff Providing Treatment: _____

**NAMI CIT Pilot Project
Focus Group Facilitation Guide
Crisis Intervention Training (CIT) Evaluation**

I. Skills, knowledge and abilities (ska's) acquired from CIT training

- What skills, knowledge and abilities did you acquire from CIT training? Be specific in your answers.

Understanding of Mental Illness

- a. Has the CIT training improved your understanding of mental health and substance abuse disorders? If so, how and in what way(s)?
 - Do you understand mental illness as a biological process?
 - Do you understand how people get mental illness?
 - Do you understand the risk of harm to self and others when interacting with inmates having mental illness?
- b. Has your understanding of mental health and substance abuse disorders improved your ability to recognize inmates who might have one of these disorders? Do you understand how problem behaviors exhibited in the jail might be symptoms of mental illness?
- c. Has the CIT training improved your understanding of the cycle that brings people with mental illness into correctional facilities? Do you use that knowledge during interactions with inmates having mental illness?

Knowledge of Resources

- d. Do you have a better understanding of jail and community resources available for mental health and substance abuse disorder treatment?
- e. Has the CIT training improved your ability to access these facilities? If so, how?
- f. Have you been able to communicate with these facilities and refer inmates with mental health and/or substance abuse disorders to them? If so, how?

De-escalation Skills

- g. Did the CIT training provide you with an effective range of verbal de-escalation skills for diffusing crisis situations in the jail?
- h. What skills have you used to de-escalate crisis situations? Have those skills reduced the risk of injury to all involved?
- i. Are these skills different from your initial training as a corrections officer? How do these skills differ? How do these skills compare?
- j. Do you see an advantage to using verbal de-escalation skills versus physical intervention? How do these skills compare?

II. Impact of skills, knowledge, and abilities acquired during CIT training

- Based on the ska's that you have obtained, has the use of seclusion and restraint procedures changed as a result of CIT training?
 - a. Has the number of times restraint is used lessened?
 - b. Has the number stayed the same, but the type of restraint used changed?
- Based on the ska's that you have obtained, have injuries to corrections officers lessened and work productivity increased?
- How has CIT training helped you to reduce the number of mental health related crisis events?
- How has CIT training helped you to reduce the intensity of mental health related crisis events?
- How has CIT training helped you to reduce the duration mental health related crisis of events?
- Has the CIT training helped to reduce conflict (i.e., fights, disputes, angry outbursts) between correctional officers and inmates? Among inmates? How?
- Regarding your current level of ska's with CIT concepts and practice, are you?
(a) Very satisfied, (b) Satisfied, (c) Unsatisfied, (d) Very Dissatisfied
- Based on your answer selection, what additional ska's do you feel are needed?

III. Attitudes and beliefs

- Has your attitude toward inmates with mental health problems changed since completing CIT? How?
- Have inmate attitudes and behaviors toward corrections officers changed since CIT was initiated? How?
- Comparing pre-CIT with post-CIT, have you changed your behavior/actions? In what ways?

IV. Application of CIT ska's

- How have you used CIT in behavioral and conflict situations?
Please provide an example.
- During CIT interventions, what has been the reaction of inmates when CIT is used with behavioral and conflict situations? Are the reactions of inmates different since the implementation of CIT?
- Describe your most favored success story where CIT was applied to behavioral and conflict situations.
- How would you rate your overall skill level in applying CIT to behavioral and conflict situations?

V. Barriers, outcomes, and satisfaction

- In your opinion, what barriers exist against the effective implementation of CIT?

- Do you think that the CIT program was implemented smoothly into the daily activity of corrections officers and inmates?
- How could NAMI change the training to make the implementation of CIT easier and more effective in a jail facility?
- What barriers do you as a corrections officer face when using your CIT training during interventions?
- What barriers do you as a corrections officer face during day-to-day activity?

- Overall, how has the CIT training prevented jail emergencies, as well as risks to inmates and corrections officers?
- Overall, how has the use of CIT training resulted in greater access to internal and community mental health and substance abuse treatment and resources?
- Overall, how has the quality of day-to-day activity with inmates changed since the implementation of CIT?

- How would you describe the value of CIT training to carrying out your job?
- Considering your job duties, how has it changed since completing CIT?
- What new ideas and thoughts have you had concerning your job since CIT?
- Has your satisfaction with work changed since completing the CIT training?
- How has the quality of life within the jail facility changed as a result of CIT implementation?
- What is your overall level of satisfaction with the CIT training and it's implementation in the jail?
(a) Very satisfied, (b) Satisfied, (c) Unsatisfied, (d) Very Dissatisfied, (e) No opinion

Do you have any questions and/or comments before we end?