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DEMENTIA IN PRISON: AN ARGUMENT FOR TRAINING CORRECTIONAL OFFICERS

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Abstract

Dementia is a significant public health problem that is occurring behind bars. However, the number of inmates suffering from this disease is unknown (Feczko, 2014). Current research has exposed a serious gap in correctional health care for older adults, and correctional institutions are being encouraged to make changes to better address the needs of this population (Fellner, 2012; OIG, 2016; Williams, Stern, Mellow, Safer, & Greifinger, 2012b). The purpose of this paper is to bring awareness to the aging problem behind bars and respond to the identified need for additional training for custodial staff (correctional, parole, and probation officers). Training correctional officers to better understand the population they oversee on a routine basis improves their ability to preserve the safety and security of the correctional environment. Further recommendations are made to specifically adapt the Crisis Intervention Team (CIT) training model to improve the psychological health of correctional officers and allocate care for inmates (Compton, Bohora, Watson, & Olive, 2008).

Dementia in Prison: An Argument for Training Correctional Officers

America's prison population is rapidly graying, forcing correctional institutions to confront the various challenges associated with caring for the elderly. One topic of particular interest is the consequent potential for dementia within this demographic group. Hence, the purpose of this paper is to increase awareness of the limited research and statistics on dementia in the prison system, and respond to the identified need in research for additional training for correctional officers (Fellner, 2012; OIG, 2016; Williams, Stern, Mellow, Safer, & Greifinger, 2012b).

This paper will briefly explain the phenomena of aging behind bars, and review known information and current research on dementia. Then, it strives to expose the significant gap between what is known about dementia within the community and what is known about dementia within correctional institutions. Many studies have called attention to the multifaceted concerns of the aging phenomena in prison and proposed increased trainings for all custodial staff (correctional, parole, and probation officers) as one method for addressing this problem (Fellner, 2012; OIG, 2016; Williams et al. 2012b). To date, there is no information or research on the trainings being implemented for correctional officers in response to this need. Therefore, this paper will explain why adopting the Crisis Intervention Team (CIT) model is thought to be the best plan for training correctional officers to understand and work with the demographic needs of the prison environment. In addition, this paper will explain how adapting this method of training will help improve early detection of dementia within correctional institutions, reduce victimization within this population, decrease the probability for Eighth Amendment rights violations, insure the safety and security of the institution, and improve correctional staffs' ability to interact with those suffering from dementia.

Incarceration rates and demographics

The United States (U.S.) incarcerates the most people per capita of any nation (Walmsley, 2016), and over the past 30 years, correctional institutions have experienced significant growth with regard to population statistics. In 2014, there were an estimated 1.56 million prisoners in state and federal correctional facilities, a number that does not reflect the thousands more housed in local jails (Carson, 2015). Statistics also show that the U.S. criminal justice population is aging at a significantly more rapid rate than the overall U.S. population (Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012a), and adults 50 and older are the fastest growing demographic group within prison (Carson, 2015). Between 2000 and 2009, the overall U.S. prison population increased 16.3%, while the number of older prisoners increased 79.0% (Williams et al., 2012b). It is estimated that older prisoners will make up one third of the entire U.S. prison population in the coming decades if reforms are not made to current sentencing laws (Barry & Williams, 2015).

Demographic statistics indicate that older prisoners vary across gender, race, and offense type. It likely comes as no surprise that America's aging prison population is predominantly male, with females making up approximately 6% of all elderly prisoners (Chettiar, Bunting, & Schotterat, 2012). However, the number of aging female prisoners in the Federal Bureau of Prisons (BOP) is growing at a faster rate than that of their male counterparts, requiring more medical services and posing higher health care costs on the system (Kim & Peterson, 2014). Older prisoners are mostly White, although the number of Black and Hispanic aging prisoners is on the rise, and they continue to be overrepresented when compared to the general U.S. population (Chettiar et al., 2012; Kim & Peterson, 2014). In both state and federal institutions, most aging prisoners are serving sentences for violent and property offenses, which are lengthier

sentences, whereas the percentage of older prisoners convicted of drug offenses has grown relatively slowly (Fellner, 2012; Kim & Peterson, 2014). This has made it challenging for correctional institutions to transfer older prisoners to nursing homes or other facilities that are more appropriate for meeting their medical and mental health needs.

Research attributes “get-tough-on-crime” sentencing reforms from the late 1980s as a driving force of the rise of this demographic group. These reforms include the elimination of federal parole, mandatory minimum sentences, and third strike legislation, such as receiving a mandatory life sentence after a third violent or serious felony conviction (Williams et al., 2012a). However, in more recent years within BOP institutions, there has been an increase in the number of first time older offenders convicted of white-collar crimes and sex offenses (OIG, 2015).

As the incarcerated population ages, the correctional system as a whole is not prepared to withstand the demands of this demographic group (Fellner, 2012; Kim & Peterson, 2014; OIG, 2015). There are many implications of aging that cause significant strain on the system, such as chronic medical conditions, increased medical costs, and ill-equipped facilities (OIG, 2015). Policy makers and researchers have proposed methods for addressing these topics; however, the area that receives far less attention in the literature is the correctional system’s response to rising concerns about dementia.

Dementia

Dementia is the progressive decline in cognitive functioning due to damage or disease in the brain beyond what might be expected from normal aging. It is typically characterized by memory impairment, as well as marked difficulty with language, attention, problem solving, and motor abilities (Peterson, 2014). Dementia is a non-specific or umbrella term that encompasses many disease processes, such as Alzheimer’s disease, Parkinson’s disease, and Huntington’s

disease. Dementia is typically found in adults 65 and older, although early stages of dementia have been found much earlier in high-risk populations (Wilson & Barboza, 2010).

Dementia is usually chronic and impacts one's ability to function independently. Early symptoms of dementia are mild and can be easily overlooked, such as simple episodes of forgetfulness. Someone in the early stages of dementia may have trouble keeping track of time or get lost in familiar places. As this disease progresses, symptoms become more noticeable as the individual becomes more forgetful and confused. People with mild dementia may repeat questions or have trouble remembering what they have just read or heard. They also have a difficult time learning new things. Organizational difficulties and poor judgment also become more apparent. There also tends to be personality changes and moodiness (Coleman, Crews, Hall, Keji, & Williams 2013; Peterson, 2014; Rodgers, 2011).

Individuals in the moderate stage of dementia have a difficult time recalling names and recognizing well-known faces. They also struggle with following directions and maintaining personal hygiene. Tasks that were once easy for them, such as eating or using the bathroom, become more challenging. Individuals in the moderate stage may have difficulty sleeping through the night. Personality changes become more pronounced and people may experience hallucinations, delusions and paranoia. They also can become angry and violent. Dementia eventually affects one's long-term memory and people with severe dementia lose their ability to care for themselves (Coleman et al., 2013; Peterson, 2014; Rodgers, 2011).

The Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5) is often used by mental health professionals to diagnose an individual with dementia. Dementia is classified as a neurocognitive disorder and criteria are provided to determine if an individual is suffering from either a major or mild neurocognitive disorder (American Psychiatric Association,

2013). To meet DSM-5 criteria for mild neurocognitive disorder, the individual must evidence modest cognitive decline, but the decline does not interfere with everyday activities. To meet criteria for a major neurocognitive disorder, the individual must have significant cognitive decline, and that decline must interfere with the ability to independently perform everyday activities. Driving a car, paying bills, or managing medications are a few examples of where assistance may be needed.

Alzheimer's disease is the most common cause or form of dementia, and it is thought to represent 60 to 80 percent of all dementia cases (Gaugler, James, Johnson, Scholz, & Weuve, 2015). In 2015, an estimated 5.3 million Americans suffered from Alzheimer's and 5.1 million of those people were 65 years old or older (Gaugler et al., 2015). By 2025, the number of people 65 and older suffering from Alzheimer's is expected to climb to 7.1 million, barring any major medical breakthroughs, a 40 percent increase from the 5.1 million in 2015 (Gaugler et al., 2015).

With such alarming numbers, it is no surprise that Alzheimer's is considered a serious public health concern, and increasing public awareness has become a significant public health issue (Cahill, Pierce, Werner, Darley, & Bobersky, 2015). In 2011, the National Alzheimer's Project Act was put into law, requiring the federal government to coordinate a national plan to attack Alzheimer's and improve care and services for those in the U.S. In 2012, The National Plan to Address Alzheimer's Disease was unveiled and has acted as the foundation of concentrated efforts in research, clinical care, and services to fight this disease (Peterson, 2014). The impact that this deadly disease has made on Americans, researchers, and federal policy is quite substantial, and clearly, there is a collaborative effort being made to increase awareness to this disease for those living in the community. But what is happening to address this issue behind bars?

Dementia in prison

Currently, there is no nationally representative data on health and health care among America's prisoners (Wilper et al., 2009), and the prevalence rate of dementia within the criminal justice system, at both the state and/or federal level, is unknown (Feczko, 2014; Maschi, Kwak, Ko, & Morrissey, 2012). This paints a vastly different picture than the efforts being made to understand, educate, and treat non-incarcerated older adults in the U.S., and it also makes it difficult to understand the scope of the problem behind bars. Researchers agree that the greatest predictor for dementia is increasing age (Simmons, Hartman, & DeJoseph, 2011), and according to the U.S. Census Bureau, those who are considered "elderly" are 65 and older. Using prevalence rates within the general public as a baseline for correctional populations, Wilson and Barboza (2010) speculated that, in 2010, there were over 41,000 prisoners living with dementia, which they estimated would rise to over 127,000 by 2030. However, given common risk factors and the "accelerated aging" associated with prisoners, some prediction models call for prevalence rates to be doubled or even tripled that of the baseline rate of the general public (Wilson & Barboza, 2010).

Research has found both protective and risk factors for developing dementia. Many prisoners have pre-incarceration risk factors that predispose them to developing dementia 10 to 15 years younger than the general population, hence the term "accelerated aging" (Machi et al., 2012). These risk factors included a history of substance abuse, head trauma, low educational attainment, poor health care, and low socioeconomic status (Williams, 2012a; Wilson & Barboza, 2010). Research has also found a link between mental illness and dementia (Feczko, 2014), and it is well known that there are high prevalence rates of mental health disorders in prison (Abramsky & Fellner, 2003). James and Glaze (2006) discovered that approximately 50% of

inmates between the ages of 50-54 and 36% of inmates 55 years and older had mental health problems. Research has also noted that comorbidities of dementia and mental health issues are under diagnosed, and there is currently only limited understanding of their relationship (Regan, 2016). Therefore, it seems only logical to infer that, with the high proportion of older adults in prison who experience “accelerating aging,” as well as the high prevalence rates of mental illness, the correctional system is likely caring for many prisoners whose dementia has not been diagnosed.

One problem contributing to the unknown rates of dementia in prison is the lack of an overall consensus as to when a prisoner is considered elderly and should be screened for dementia. In fact, there is no national consensus, even among BOP institutions, for the age at which an inmate is considered “elderly” or “aging” (Chiu, 2010; Feczko, 2014; OIG, 2015). According to the National Institute of Corrections, a prisoner is considered to be an older adult at 50 years old (OIG, 2015), while the Bureau of Justice Statistics (BJS) has used 55 years as the point of demarcation (Williams et al., 2012b). According to a national survey, 27 states have a definition for individuals considered an “older prisoner;” fifteen states used 50 years as the cut off, five states used 55, four states used 60, two states used 65, and one state used 70 (Chiu, 2010). Consequently, the lack of standardized and comprehensive data poses a problem for research efforts, as well as the implementation of evidence-based solutions to increase cost effective quality care (Williams et al., 2012b). A clear cut-off age would enable researchers to more consistently describe the needs of this population within the prison environment, as well as enable guidelines for screening tools to assess for early warning signs of dementia.

Another concern is the limited understanding of early warning signs of dementia within the incarcerated population. In the beginning stages of dementia, instrumental activities of daily

living (IADLs) are most often the first to become impaired (Simmons et al., 2012). IADLs, such as preparing meals, balancing a check book, or managing medicine, are the more complex skills that require calculation and planning and are needed to live independently, but these are tasks that most prisoners do not perform on a daily basis. Activities of daily living, or ADLs, are generally more intact during early stage dementia and do not become impaired until the disease progresses (Simmons et al., 2012). ADLs include basic self-care tasks such as grooming, showering, dressing, using the bathroom, and functional mobility. Therefore, some researchers have used PADLs or “prison activities of daily living,” as a more appropriate means of understanding functional impairment and the unique demands of the prison environment (Williams et al., 2006, p. 702).

Williams et al. (2006) completed a cross-sectional study examining functional impairment among geriatric women in California state prisons. Functional impairment was defined according to ADLs and five specific PADLs, including dropping to the floor for alarms, standing for head counts, ambulating to the dining halls for meals, hearing orders from staff, and climbing up and down from the top bunk. Researchers collected 120 questionnaires from female prisoners over the age of 55 and found that when PADLs were measured, functional impairment was much more common than if only measures of ADLs were used. Their analysis found that 69% of women reported at least one impairment in PADLs whereas only 16% of women would have been identified as functionally impaired using a more traditional ADL measure. (Williams et al., 2006). Further research on early warning signs of dementia and PADL’s is needed to truly understand early warning signs of dementia in prison.

Another important consideration for the incarcerated elderly is the increased risk of victimization. In the aforementioned study, Williams et al. (2006) found that 38% of the elderly

participants reported physical abuse by other prisoners. Prisoners with dementia are also at an increased risk of being bullied, sexually assaulted, and abused by other inmates (Fellner, 2012; Maschi et al., 2012), and are less able to defend themselves. However, if they were to respond in self-defense and become violent, it might result in disciplinary action. This brings up many potential legal concerns for violations of the Eighth Amendment.

Legal mandates

The responsibilities of the correctional system go beyond simply providing housing for the incarcerated. Prisons and jails are legally mandated to provide ethical and appropriate care to prisoners (Steadman, Osher, Robbins, Case, & Samuels, 2009). The Eighth Amendment of the United States Constitution protects individuals against cruel and unusual punishment, and in the decision of *Estelle v. Gamble* (1976), the Supreme Court found this amendment sufficiently flexible to include certain claims to medical care by state prisoners (Maschi et al., 2012). The court agreed that “deliberate indifference” to an inmate’s “serious illness or injury” was in fact a violation of the Eighth Amendment (*Estelle v. Gamble*, p. 105; Newman & Scott, 2012). Deliberate indifference was further defined in *Farmer v. Brennan* (1994) after a transgender female was housed in general population with males, even after prison officials were aware of her gender identity. She was repeatedly raped and beaten by other inmates, acquiring HIV as a result. Under this ruling, deliberate indifference was expanded to include knowing that an individual was at substantial risk of serious harm and disregarding the information (*Farmer v. Brennan*, 1994; Newman & Scott, 2012). Given the rise in elderly prisoners, the known correlation between age and dementia, and elderly prisoners’ increased risk of victimization, the correctional system is at risk of practicing “deliberate indifference” if those with dementia are not identified and allocated proper medical care.

Prisoners have a right to timely access to medical care for serious medical and mental health issues, and class action lawsuits have forced reform within the correctional system. For example, in *D.M. v. Terhune* (1999), the New Jersey Department of Corrections (DOC) was ordered by a federal court to amend DOC regulations for gross civil rights violations against inmates with mental illness, requiring that all mentally ill inmates complete a mental health evaluation within 72 hours of incarceration. This came after the New Jersey DOC was found to be providing insufficient mental health services to prisoners, lacked appropriate mental health housing facilities, and had harsh disciplinary practices that caused significant injury to inmates with mental health issues (*D.M. v. Terhune*, 1999). The plaintiffs alleged that denying medical treatment for mental health disorders was a violation of the Eighth Amendment, as well as discrimination on the basis of disability (Maschi et al., 2012).

Similar class action suits have been brought against other states for inhumane treatment of inmates with mental illness. In *Brown v. Plata* (2011), the United States Supreme Court ruled in favor of inmates, finding egregious violations of prisoners' constitutional rights to medical and mental health treatment in California prisons due to overcrowding (Newman & Scott, 2012). Justice Kennedy was quoted as stating, "A prison that deprives a basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society" (Liptak, 2011. p.1).

Dementia affects the way an individual thinks and behaves. However, the structure and routine of day-to-day life in prison may lead an inmate with dementia to go unnoticed for an extended period of time since there is little requirement to act independently, make decisions, and coordinate one's daily life. Under those circumstances, symptoms of dementia may not be observed until the behavioral changes related to the disease reduce the prisoner's ability to cope

with the demands of the prison environment. As those symptoms increase in severity, a prisoner will have difficulty following rules, socializing, appropriately interacting with peers and correctional staff, and performing activities of daily living. In addition, they will also be at an increased risk of victimization. If a prisoner has not been identified by correctional staff as someone suffering from dementia, they may be subjected to disciplinary action and be punished for the symptoms of their disease, which has the potential to meet criteria for “cruel and unusual punishment.”

Recognition of the problem

The correctional system and researchers have identified the rates of aging incarcerated adults as a problem, noting additional training as one factor among many that will help the correctional system meet the demands of this population (OIG, 2015; Williams et al., 2012b). In 2011, a roundtable meeting was held at John Jay College of Criminal Justice in New York City to identify knowledge gaps, with the goal of proposing a policy agenda to improve care for aging inmates. Twenty-nine experts in correctional health care, academic medicine, nursing, and civil rights convened for this event and, together, they identified nine priority areas to be addressed; one identified area was “training staff and health care providers on common health conditions and needs of older adults” (Williams et al., 2012b, p. 1477). Experts called for geriatric training programs to be adapted within the correctional settings and more training programs for custodial staff (correctional, parole, and probation officers) be developed and implemented (Williams et al., 2012b). One area of focus in which researchers suggested that custodial staff be trained was “common age-related clinically diagnosed cognitive conditions,” such as dementia and delirium (Williams et al., 2012b, p.1477). These guidelines were an important first step towards creating a comprehensive agenda to address the health care needs of older prisoners. While there is no

research or direct response to this roundtable meeting in the literature, it is assumed that this call for change precipitated discussions and movement towards change by the system at large.

The Office of the Inspector General (OIG) U.S. Department of Justice conducted a review of BOP sites to assess the impact of aging inmates on the organization at large, including costs, health care services, staffing, housing, and programming. One of the many concerns illuminated by the OIG review was limited institution staff and inadequate staff training. For example, they mentioned that aging inmates require assistance with ADLs; however, there is not enough staff to help them with these tasks. It was also recognized that the growing numbers of elderly inmates required more frequent medical trips outside of the facility, and the average wait time to be seen by an outside specialist was 114 days (OIG, 2015).

The OIG (2015) made a number of recommendations to the BOP to address the problems exposed in their report, which were presented in a formal letter dated April 27, 2015. The third OIG recommendation was to “provide all staff training to identify signs of aging and assist with communicating with aging inmates” (p. 63). This was the initial response from the BOP:

The BOP concurred with the recommendation, stating that the Health Services Division and the Learning and Career Development Branch would jointly develop a training curriculum to teach employees to identify signs of aging and assist in communicating with aging inmates. (p. 64)

At the time this paper was written, there was no available information on the developed training curriculum.

The Human Rights Watch also examined the problems associated with the aging prison population in the United States in *Old Behind Bars* (Fellner, 2012). This report was based on research conducted in 2011 in twenty prisons in nine states. Researchers visited each prison,

spoke with custodial staff of various ranks, and interviewed inmates. They also consulted with experts in gerontology and corrections and conducted an extensive review of the academic literature (Fellner, 2012). Based on their assessment of correctional facilities, one of their recommendations to the U.S. correctional system was to “provide training for corrections officers working with older persons, including training in changing physical and mental health conditions, and appropriate means of communication” (p. 13).

It has been agreed that additional training is needed for those who oversee the care of the aging prison population (Fellner, 2012; OIG, 2015; Williams et al., 2012b). Currently, there has not been a written response with a proposed curriculum as to how these trainings are being carried out. Therefore, this paper aims to bring attention to this gap in the research and address the importance of training correctional officers beyond the current guidelines set forth by the American Correctional Association (ACA). It is thought that additional training for correctional officers on the medical and mental health care needs of the population they oversee will increase the safety and security of the institution, decrease the potential of civil rights violations against prisoners, and improve the psychological health of correctional officers.

Correctional officers

Correctional officers play a vital role within correctional institutions. They have the responsibility of maintaining order within the environment, with the primary goal of ensuring containment and safety for both staff and inmates (Scott & Gerbasi, 2005). The culture within corrections entails “regimentation, universally applied rules, implicit authority of security staff, and punitive sanctions for violations by inmates” (Appelbaum, Hickey, & Packer, 2001, p. 1344). Therefore, rules and order take precedence, and in many ways, correctional officers function like law enforcement, maintaining order and charging inmates with violations when they break the

rules. However, correctional officers are afforded some level of discretion when deciding which rule violations are formally written up. It is hypothesized that by educating officers on the early warning signs and stages of dementia, incidents that may initially warrant sanctions could instead serve as a referral for appropriate care. For example, if an inmate demonstrates difficulties remembering PADLs such as where to stand for head count, how to drop to the floor, when it is all right to get up, or repeated difficulty following orders, this incident could trigger a referral to medical or mental health services for further assessment, rather than a potential sanction.

The U.S. criminal justice population already requires correctional officers to play additional roles beyond what is predicated by the culture, particularly in relation to assessment and treatment of mentally ill inmates. It is well-known that mental illness is disproportionately represented in U.S. prisons and jails (Vogel, Languillon, & Graf, 2013). A widely cited report by the BJS found that prisoners with mental health problems represented approximately 56% of inmates in state prisons, 45% of inmates in federal prisons, and 64% of inmates in local jails (James & Glaze, 2006). Other studies have discovered that over 700,000 adult jails have inmates with symptoms consistent with major mood and psychotic disorders (McPherson, 2008).

Given the rates of mental illness within containment facilities, correctional officers must also learn to maintain the safety and security of the institution while managing inmates with mental illness. They are undoubtedly the staff members with the greatest degree of interaction with prisoners on a daily basis (Appelbaum et al., 2001), which grants them a different type of relationship and insight into a prisoner's level of functioning. Correctional officers are often the first to observe significant changes in an inmate's mental status and daily routines (Dvoskin & Spiers, 2004). This makes them a valuable member of any mental health or multidisciplinary

team, further predicating the necessity of specialized training on the demographic conditions and needs of the population they oversee

Training correctional officers.

According to the Bureau of Labor Statistics' *Occupational Outlook Handbook 2016-2017*, correctional officers are trained according to guidelines set forth by the American Correctional Association (ACA). Trainees receive instruction on a wide breadth of topics, including self-defense, institutional policies, regulations, first aid/CPR, and custody and security procedures. After they receive formal academy instruction, federal, state, and local correctional agencies provide on-the-job training, including instruction on legal restrictions and interpersonal relationships. However, on-the-job training varies widely from agency to agency, and correctional officers receive minimal training on working with mentally ill prisoners (Parker, 2009). This has slowly been changing over the years, although the exact number of correctional facilities training officers in mental illness is unknown.

Training correctional officers on how to support the needs of inmates with severe mental illness improves both the safety and security in prisons. According to Parker (2009), inmates with mental illness are more likely than those without to be cited for institutional rule violations, are more likely to be charged with assaults, and are more likely to be housed in restrictive settings. However, when correctional officers have received specialized training on mental illness, reported outcomes have included a decrease in use of force by staff, decreased assaults on staff by inmates, and improved collaboration between correctional staff and institutional mental health care providers (Compton, Bohora, Watson, & Olive, 2008; Parker, 2009)

Correctional institutions that are training correctional officers on mental illness are seeing positive effects. For example, in Indiana, the National Alliance on Mental Illness (NAMI), an

advocacy group “dedicated to improving the lives of people afflicted by serious and persistent mental illness” (Parker, 2009, p. 641), developed a ten-hour mental health training program for correctional officers working in special housing units in a supermax prison. Results showed that the NAMI-Indiana program was successful at reducing the number of incidents in which force was used by correctional officers, as well as the number of attacks by inmates on the officers (Parker, 2009). This suggests that providing comprehensive mental health training to all of the correctional officers can lead to safer working conditions for those officers and safer living conditions for prison inmates.

According to the report by the Human Rights Watch, very few correctional institutions provide trainings for custodial staff that address the special needs of aging offenders, and many correctional officers working in dementia-specific units are not trained in how to communicate with those who suffer from dementia (Fellner, 2012). For example, one correctional officer working in a specific unit for demented and developmentally delayed prisoners was questioned about any specialized training he received for working with individuals in his unit. He responded, “None. I’m just learning it as I go along” (p. 63). This exposes a serious negligence on the part of correctional institutions if those working with already identified demented prisoners are not even trained in the basic medical and mental health conditions of those within their units.

Given the fact that the prison population is aging at a rapid rate, correctional institutions would benefit from training correctional staff to identify early warning signs of dementia. They also need to be trained in how to effectively communicate, decrease challenging behaviors, and interact with prisoners suffering from dementia. However, dementia is just one of the many serious mental health conditions impacting the prison environment. Therefore, it is proposed

that federal and state correctional agencies adapt their on-the-job trainings to mirror that of the Crisis Intervention Team (CIT) model. CIT has proven to be a valuable tool for improving knowledge and crisis de-escalation communication skills for law enforcement working in highly stressful and demanding environments with individual suffering from various mental health conditions (Compton et al., 2008; Franz & Borum, 2010).

Recommendations

The Crisis Intervention Team program

The Crisis Intervention Team (CIT) program is a model of specialized training designed to help law enforcement respond to individuals experiencing a mental health crisis. It was created in 1988 following a tragic incident in which police officers fatally shot a man holding a knife who had a history of mental illness and substance abuse. This event exposed a lack of police alternatives to resolving crises, and through the efforts of the University of Tennessee and the Memphis Police Department, the CIT program was established (Compton et al., 2008).

CIT focuses on the need for advanced training for first responders and the immediacy of response during a crisis. It places emphasis on officer and civilian safety as well as appropriate referrals for those in crisis (Dupont & Cochran, 2000). The CIT program also involves collaboration between law enforcement, mental health care providers, hospitals, academics, and advocates for people with mental illness (Compton et al., 2008; Franz & Borum 2010). From a systems perspective, this model is designed to divert individuals with mental illness away from the criminal justice system and into mental health treatment.

CIT typically involves forty hours of specialized training that is provided by various disciplines within the local community. Trainings are meant to be dynamic and engaging, and they typically incorporate lectures, role-plays, hands-on demonstrations, video, and vignettes.

Topics usually include an overview of mental illness, psychopharmacology, communication and de-escalation skills, suicide prevention, and stress management (Compton et al., 2008). CIT programs tend to be either locally or regionally organized, and each program is adapted to meet the needs of the organization being trained.

At the time of CIT's development, this method of training police officers to deal head-on with psychiatric emergencies was the least utilized mental health emergency model in the country (Compton et al., 2008). Since then, it has been established as the predominant model that is used not only around the country, but also the world (Franz & Borum, 2010; Kohrt et al., 2015; RiCharde, Wilson, & Tilawen, 2015).

Research on CIT has found it to be effective in connecting individuals with mental illness to appropriate psychiatric services (Compton et al., 2008; Tyuse, 2012). Compton et al. (2014b) found that CIT increased the likelihood that an emotionally disturbed person would be referred and transported to mental health services as well as decreasing the likelihood of arrest. CIT-trained officers were found to have improved communication skills, more self-confidence, and decreased apprehension when interacting with people with a mental illness or substance abuse problem (Prince, 2014). Research also discovered that trained officers experienced positive effects on knowledge, attitude, and skills in diverse areas regarding mental illness when compared to non-trained officers (Compton et al., 2014a). While there has not been enough research to consider CIT an evidence-based practice, it has been called both a "gold standard" (RiCharde et al., 2015, p. 9) and "best practice model" for training law enforcement (Franz & Borum, 2010, p.2).

CIT and corrections.

Correctional officers are first responders within correctional institutions. As previously mentioned, they are typically the first to observe significant changes in a prisoner's routine or mental status (Dvoskin & Spiers, 2004), and they are routinely called to respond to and ward off crisis situations (Appelbaum et al., 2001). Hence, specialized, intensive training on the populations they oversee is clearly warranted.

Currently, the CIT model remains largely unknown within the world of corrections. However, it has successfully been adapted into some correctional institutions around the country (Cattabriga, Deprez, Kinner, Louie, & Lumb, 2007; Hodges, 2010; McPherson, 2008). The first state to adapt a CIT program for correctional officers was Maine. In that program, a full day was designated for participants to visit local mental health facilities to learn from and interact with individuals with mental illness in a calm setting (Cattabriga et al., 2007). This type of experiential learning is at the core of CIT. Prior to the training, Maine correctional officers reported that they did not feel adequately prepared to manage a crisis situation when encountering prisoners with mental illness. However, afterward, they reported:

. . . a higher degree of comfort when encountering people with signs of a mental illness, more confidence in their own ability to recognize maladaptive behaviors 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 illness and had become more familiar with community resources. (Cattabriga et al., 2007, pp.4-5)

Another successful CIT program for correctional officers was implemented in Florida. However, the Broward Sheriff's Office (BSO) designed the training program, *Managing and*

Communicating with Inmates and Offenders, for correctional officers working in special mental health housing units. This forty-hour advanced mental health training was required beyond the standardized training mandated by the state (McPherson, 2008). After its completion, the BSO's Department of Detention saw improvements in security, operation, staff performance and morale, and inmate management. They also found a significant decrease in the reported number of violent and behavior issues among inmates within the mental health units of the jail (McPherson, 2008). In discussing the successes of this program, the head of the BSO was quoted as saying, "While initially costly, this investment in training has paid enormous benefits of enhancing staff performance and morale and in reducing negative incidents" (McPherson, 2008, p.66)

One of the advantages to using the CIT model is that it can be adapted to meet the needs of the organization and still produce similar results. For example, in 2014, the Oklahoma Department of Corrections developed the *Corrections Crisis Resolution Training (CCRT)* to improve the outcomes of correctional officer, probation, and parole officer interactions with individuals' experiencing a mental health crisis (Hodges, 2010). CCRT was adapted to fit a more correctional intervention approach while maintaining core CIT learning principles. This two day, sixteen-hour training was designed to better equip correctional officers with the knowledge and communication tools necessary to safely and effectively manage mentally ill prisoners. Correctional officers who received the training reported a higher level of confidence recognizing and responding to individuals diagnosed with mental illness; increased ability to safely and compassionately respond to people in crisis; increased options for how to handle a crisis situation; and increased comfort discussing mental illness (Hodges, 2010). Additionally, correctional officers described feeling like the training was applicable to other areas of their lives (Hodges, 2010).

Lastly, the CIT-based model of intervention has been used to successfully address a significant public health concern. In 2013, Kohrt et al. (2015) developed a CIT-based training curriculum for law enforcement and mental health professionals in Liberia. In 2014, not long after the curriculum was developed, the country was affected by the Ebola breakout. Training topics were then modified to educate professionals on the warning signs and symptoms of this disease. As a result, infected individuals were referred by law enforcement and mental health professionals to the appropriate medical services (Kohrt et al., 2015). This highlights the fact that CIT can be of benefit in multiple areas of public health, which further indicates that correctional institutions would benefit from training correctional officers on dementia through this model.

CIT is an effective way to enhance the knowledge and skills of correctional staff while aiding administrators in improving management and care for correctional populations. It is clear from the research that CIT has helped not only law enforcement and correctional officers, but also individuals with mental illness in crisis. This model of training produces successful outcomes because it incorporates a broad range of evidence-based adult learning principles including lectures, vignettes, role plays, video and hands-on demonstrations. This helps trainees retain a high degree of information that is then transferred and used within the workforce (Compton et al., 2008).

After implementing a CIT training program that includes a module on dementia, it is hypothesized that correctional officers' ability to identify, successfully communicate, and de-escalate crisis situations involving prisoners with mental illness and dementia will improve. Systemically, training correctional officers in this fashion is also thought to assist with identifying rates of dementia within prisons and diverting inmates to the appropriate care. In

return, this is thought to prevent incidents of deliberate indifference whereby an institution could be in violation of an inmate's Eighth Amendment rights. Lastly, CIT programs seem to be the best training model for addressing the demands of the current correctional environment and further protecting the security and safety of the institution for both staff and prisoners.

Starting a CIT program.

Community partnerships are the key to a successful CIT program. For information on developing a CIT program, The University of Memphis CIT Center has comprehensive resources available to help start a program, including step-by-step guidelines for building partnerships and developing a model curriculum that meets the needs of the organization. There is also additional information about upcoming trainings and CIT programs nationwide, which can be found at www.cit.memphis.edu.

Once correctional institutions are ready to develop a CIT program, it is recommended they start by creating a team of individuals who are both knowledgeable and interested in program development. Collaborating with correctional institutions that have already developed CIT programs will also be helpful. Organizations are also encouraged to reach out to their local NAMI chapter for help with fundraising efforts. In many areas, community partnerships between local mental health and medical agencies will need to be established, and correctional institutions should consider partnering with law enforcement agencies to share knowledge and expenses.

Training on dementia.

Based on the strong foundation of CIT and the numerous resources available for organizations developing CIT programs, adding a training section on dementia should be relatively straightforward. The most effective approach would be for correctional organizations

to collaborate with medical organizations in their area. Trainings would ideally be led by professionals well-versed in dementia and include various adult learning principles; the following are suggestions for discussion points, role plays, and vignettes that could be utilized in the training.

The purpose of the training section on dementia would be to provide correctional staff with the tools and skills needed to identify warning signs and symptoms, refer to appropriate care, and effectively manage prisoners experiencing symptoms of dementia. Discussion topics for lectures and PowerPoint materials are suggested to include background information on dementia and current prevalence rates; explanations of accelerated aging and risk factors for dementia with incarcerated populations; descriptions and examples of the different stages of dementia with associated personality and behavioral changes; and communication tools for behavioral management. These discussions would also need to be tailored to the needs of the group being trained. For example, if the training was being given to correctional officers working in general population units, more emphasis may be needed on identifying the symptoms of early stages of dementia and the referral process, rather than communicating skills with identified demented prisoners.

The Proper Care of Offenders with Dementia is the only published training manual for correctional officers on dementia (Coleman et al., 2013). It was created in 2013 by the Kentucky Public Health Leadership Institute Group for correctional officers working with prisoners who had already been diagnosed with dementia. While this manual would not directly apply to all trainings for correctional officers, it is a useful resource that incorporates many of the adult learning principles necessary in CIT, such as role plays and vignettes. The following is one example taken from the manual.

Role play #1

Inmate with dementia

You are waiting for your mother to come visit. You do not remember that she has passed away 10 years ago. You insist that she is coming to visit you today and you want to wait on a chair in the hallway so that you will see her when she arrives.

Correctional staff person

You know that this inmate's mother is deceased. It is necessary that the hallway be cleared, so you need to get the inmate to move from his chair. You are fairly certain that the inmate does not want to leave the hallway.

Discussion points

1. Do you inform him that his mother is no longer alive?
2. Is there a way to improve the likelihood that he will move from the hallway without becoming agitated?
3. How can you use what you know about dementia to work with this inmate?

Suggestions:

If he believed that his mother is alive, it is likely that he will grieve her death all over again if you inform him that she has passed away. He does not remember that she passed away.

One approach is to engage him in a conversation about his mother. Ask him to tell you about her. What are some special things about her? If he mentioned something such as his mother's delicious pies, listen to him and have a conversation about that.

Then you might suggest that a snack is available and ask him to walk with you to the cafeteria. If he still wants to wait in the hallway, you could reassure him that staff will let him know when his mother arrives. (Coleman et al., 2013, p. 19)

Role plays and vignettes for the CIT training would need to pertain to the gaps in correctional health care and help educate correctional officers on the goals of the correctional institution. For example, a role play may include a correctional officer observing a prisoner exhibiting potential early warning signs of dementia, which results in a referral to the appropriate department for further assessment. Discussion points following this role play should review correctional institutions goals for identifying current rates of dementia. Another scenario may include a correctional officer writing a violation for a 52-year-old prisoner with repeated difficulty maintaining PADLs as well as alternative methods for thinking about and approaching this violation. It would also be helpful for role plays and vignettes to include incidents in which prisoners with dementia were being victimized by other prisoners and discussions on how correctional officers should handle the situation, for both the victim and the perpetrator.

Advantages and challenges.

Integrating CIT training into jails and prisons across the United States is believed to be the most effective way to provide correctional officers with the skills they need to manage prisoners with mental illness and dementia. One advantage of using the CIT training model in correctional settings is that agencies would not have to re-invent the wheel; CIT has been vetted, refined, and successfully implemented in thousands of law enforcement agencies across the United States and the world (Compton et al., 2008; Prince, 2014), as well as correctional facilities (Cattabriga et al., 2007; McPherson, 2008; Reuland, Draper, & Norton, 2010). The forty-hour training component covers topics that are relevant to correctional officers, such as

recognizing mental illness and developing de-escalation skills (Reuland et al., 2010). CIT also involves collaborative planning and is focused on tailoring the training to the needs and resources of a particular institution (Reuland et al., 2010). This would allow for dementia to be a specific topic discussed during trainings.

There are many institutional challenges that make implementing this intervention difficult. First, the program is both timely and costly (McPherson, 2008). Asking correctional officers to participate in a weeklong training also places a burden on the institution. Additionally, high turnover rates associated with correctional officer positions make it challenging for administrators to sustain the CIT program without the support of agency leaders (Cattabriga et al., 2007). It also requires collaboration between multiple sources within the community and significant planning. Establishing correctional officer buy-in might also be problematic, and institutions might need to develop a system for identifying specific persons to be trained initially.

Conclusion

The current population within prisons is changing, and correctional institutions will be required to make reforms to meet the demands of its demographics and preserve the integrity of their institutions. Given the prevalence of mental illness and the rise in aging prisoners, the introduction and expansion of CIT training programs in correctional institutions is a logical and practical extension of its success in training law enforcement. This model is thought to help address identified gaps in correctional health care while promoting the safety and security of correctional institutions.

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