CHAPTER 13

Mental Health Professionals as Institutional Consultants and Problem Solvers

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The incarcerated population in the United States continues to grow at an exceptional rate. From the end of 1990 to mid-1999, federal, state, and local correctional institutions took in an additional 83,743 inmates each year, or 1,610 new inmates per week (U.S. Department of Justice, 2000a). By the end of 1999, state prisons were reported to be operating between 1% and 17% over capacity, while the federal prison system was estimated to be operating at 32% over capacity (U.S. Department of Justice, 2000b).

Commensurate with the increasing correctional population is the number of prisoners with mental illness (see Chapter 6). According to the American Psychiatric Association (2000), researchers estimate that 20% of prison and jail inmates are in need of mental health care. Unfortunately, as the incarcerated population continues to grow, the availability of resources to serve this population lags further and further behind. Fiscal constraints drain the minimal resources available, and to date, correctional systems have been largely unable to keep pace with

AUTHORS' NOTE: The authors thank Irwin Grossman, Sandra Williamson, Jason Dana, and Jason Lewis for their thoughtful comments and suggestions during the preparation of this chapter.

the dramatic increase in the populations they serve (Veysey, Steadman, Morrissey, & Johnsen, 1997). In fact, correctional personnel cite inmates with mental illness as one of their most significant concerns, second only to overcrowding (Lamb & Weinberger, 1998). Although the overall number of mental health professionals working in corrections is increasing (Ferrell, Morgan, & Winterowd, 2000), the estimated psychologist-to-inmate ratio is approximately half of what it was during the 1980s (Boothby & Clements, 2000). The incarceration of mentally ill offenders in facilities ill prepared to manage and treat them has negative ramifications not only for inmates with mental illness but also for correctional and security staff as well as the community at large (Morris, Steadman, & Veysey, 1997). Nevertheless, confronted with unprecedented growth and insufficient revenue, correctional systems are forced to make due, often with inadequate facilities, limited staff, and ineffective or less than adequate institutional programs. Environmental stressors lead to individual stress, which leads to interpersonal tension, which in turn creates a volatile atmosphere for both inmates and staff.

In addition to the abundant overt stressors, covert pressures further complicate matters. Correctional professionals are constantly faced with complex, and at times competing, objectives. Punishment has long been the fundamental purpose behind jails and prisons, and confinement itself remains the most common and (absent the death penalty) serious sanction imposed by our judicial system (Carlson, 1999a). Imprisonment incapacitates offenders, thereby precluding the commission of further free world crimes (at least for the duration of incarceration) and protecting society from further victimization (Gottfredson & Gottfredson, 1988).

Public perception dictates that the role of prisons and jails is primarily to provide secure housing to offenders, including those who are mentally ill (Dvoskin & Patterson, 1998). However, correctional institutions must do more than warehouse offenders. Law and social policy mandate ethical and humane treatment of inmates and require appropriate and adequate mental health care (Metzner, Cohen, Grossman, & Wettstein, 1998). Finally, it is anticipated that correctional institutions will "treat" inmates in such a way as to decrease the likelihood of future criminal acts. In essence, as organizations, correctional systems are expected to serve a punitive function, a protective function, and a rehabilitative function simultaneously (Carlson, 1999b).

Like correctional staff, there are several mechanisms by which mental health professionals can make important and cost-effective contributions. The bulk of consultation between security and mental health staff is related to the correctional management of inmates or detainees (Brodsky & Epstein, 1982). Several of the more complex inmate-management decisions (e.g., classification, work assignments, educational and vocational opportunities, disciplinary sanctions) can be managed successfully with a commitment to interdisciplinary communication and collaboration. It is incumbent on all prison employees, including mental health professionals, to take proactive steps toward the resolution of conflict and the development of an institutional climate conducive to safety, security, and the well-being of all inmates and staff. To be successful, mental health professionals need not, and in fact cannot, limit the scope of their activity to traditional treatment modalities and the provision of direct service. Rather, they must consider expanding

the scope of their practice to include institutional consultation and problem solving if they are to be maximally effective correctional mental health practitioners. This chapter discusses several areas in which mental health professionals have served as effective institution consultants and problem solvers.

Assessing Institutional Climate

Correctional facilities are inherently stressful environments. Inmates and staff alike are subject to the constant pressures of overcrowding, extremes of cold or heat, noise, and filth. Information is often sparse, unreliable, and dependent on rumors. Inmates are typically forced to share their living spaces with strangers they might not like, respect, or trust. In addition, they fear for their personal safety on a daily basis. Generally speaking, jails tend to be even more stressful than prisons because most detainees have recently entered the system and are often uncertain as to the outcomes of their legal status. Furthermore, the high turnover in jails precludes the formation of predictable social groupings. Former inmates returning to prison after extended periods in the community are confronted by an ever-changing inmate subculture, with new rules and social demands that they might not understand (Hunt, Riegel, Morales, & Waldorf, 1998). For first-time offenders and new officers alike, expectations are likely to be colored by television or movie dramatizations stressing violence in corrections. For repeat offenders, particularly those who spent time under "old school" rules, modern prison life can be dramatically different from what they had come to expect.

Dvoskin (1994) has long favored conceptualizing the correctional setting as a community. Correctional facilities consist of groups of interdependent people, often divided along social and/or racial lines, living and working in close proximity and under the same conditions. In fact, it could be argued that inmates and staff in a correctional setting are significantly more dependent on one another than are civilians in most communities. Inmates are dependent on correctional staff to provide safety, security, and structure. Similarly, staff are dependent on inmates (who far outnumber them) to behave according to the rules and to provide a labor force necessary for daily facility functioning. Although interdependence does not imply equality, *it is important to remember that all individuals in a jail or prison, staff and* inmates alike, are subject to the same environmental stressors. Power differential notwithstanding, it is clearly in the best interest of the "community" if relations are good and morale is positive.

If one is to work effectively in a correctional setting regardless of professional capacity, then it is essential to have an adequate appreciation for the character or climate of the facility. As noted by McGee, Warner, and Harlow (1998), "There is an undeniable character associated with any prison that is hard to define . . . , yet *it importantly affects what can be done within the institution" (p. 104).* Understanding an institution's climate requires an appreciation of the nuances of inmate behavior and an understanding of the social and political structure that governs the correctional subculture. In fact, accurate assessment depends to a much greater extent on interpersonal skill and experience than on clinical acumen. To the

seasoned professional, it is often readily apparent whether significant tension exists either between or within the staff and inmate populations. Some facilities are well known for tense relations, while others enjoy a sense of rapport among those living and working within their walls.

Although a given facility may maintain a reputation for its atmosphere, psychic tension within correctional institutions is dynamic in nature. On any given day, innumerable factors directly affect the state of relations. Broad variables such as legislative policy, departmental mandates, and unit-specific issues (e.g., changes in management or line staff) can have a direct impact on the quality of interpersonal relations. Widespread institutional unrest can also arise from a single incident with a single inmate, and tensions can build rapidly as a result of countless, seemingly random and unpredictable factors (e.g., gang activity, race relations, changes in operating policy). Nevertheless, disturbances that potentially place the safety and integrity of an institution in jeopardy often, but certainly not always, follow a clear course of escalation (Useem, Graham-Camp, & Camp, 1996). In other words, correctional catastrophes do not occur in a vacuum. Retrospectively, there are often clearly identifiable red flags signaling impending danger.

Cooksey (1999) accurately emphasized the importance of *listening* to inmates' complaints and concerns. Although it is true that some inmates will complain chronically, others conduct their daily activities in a respectful manner, working well with staff and peers. Trusted staff working directly with inmates will inevitably hear from the latter group when tensions are mounting or problems are developing in the facility. It is imperative that staff take inmate reports seriously and that administrators in turn take staff reports seriously. Understanding the nature of inmate complaints and the importance of attending to rumors is critical. It is also important to recognize each inmate as an individual and as a member of the broader social environment or correctional community.

Correctional staff have, by far, the most significant amount of contact with inmates on a daily basis. Consequently, they are the most likely observers of changes in institutional climate, escalating tension, and overall unrest. A well-trained, conscientious correctional officer is more likely to be responsible for defusing a potential problem than is any member of the mental health staff (Armstrong, 1999). Nevertheless, mental health professionals can contribute by taking a hands-on approach, maintaining a visible presence on the unit, walking the yard, and communicating openly with all levels of staff and inmates. Paying attention to details, observing interactions, and assessing nonverbal cues all are key to understanding the facility's atmosphere. Ultimately, mental health professionals could then offer assistance relevant to their primary area of expertise, that is, human behavior. For example, attending to what the inmates *do not* complain about may be even more telling and informative than attending to what they *do* complain about; if the inmates at a given facility complain primarily about their menu selection, then it is less likely that they are under extreme duress or fear of abuse by staff or peers. Conversely, if inmates in a facility offer no complaints at all, then it might signal content residents or, conversely, captives who have been brutally intimidated into silence.

Implications associated with an institution's climate extend beyond monitoring the ebb and flow of tension in the interest of elevating morale. Mental health

professionals also have a vested interest in the accurate assessment of institutional climate as it relates to the placement of correctional programs (McGee et al., 1998). As programs continue to develop to meet the changing needs of the correctional population, administrators and policymakers are faced not only with identifying at-risk groups but also with determining where within the system to locate them. Designation of a program will be based on several factors, including physical plant, available staff, access to community resources, and institutional climate. Clearly, it would be detrimental for a program comprised of particularly vulnerable inmates (e.g., physically handicapped, geriatric) to be housed in a facility where the institutional climate would not support the program. By talking to one another and sharing observations and recommendations, mental health and correctional staff can work together toward selecting an institution that will optimize the potential for a program to succeed.

Consultation Within the Institution

Mutual distrust between mental health and correctional professionals has been cited as one of the largest barriers in caring for offenders (Roskes & Feldman, 1999). Apprehension and skepticism between disciplines are exacerbated by the challenges associated with complex and often competing demands of security and mental health systems (Kauffman, 1988; Ziegenfuss, 1985). Correctional administrators and line staff who have learned to trust their mental health personnel are more likely to value advice and attend to presented concerns. However, it is essential that consultation be viewed as interactive and mutually beneficial. In other words, trust is something that mental health professionals must earn. Mental health professionals would be well served to heed the advice of seasoned correctional staff who have a much greater appreciation of how to interact with inmates.

Classification

Classification is one of the most crucial steps in determining the course of a given inmate's incarceration. According to Cooksey (1999), "Classification can best be defined as the systematic grouping of inmates into categories based on shared characteristics and behavioral patterns" (p. 75). More specifically, the classification process is the mechanism by which the inmate's physical, medical, educational, vocational, spiritual, and mental health needs are weighed in the context of necessary security precautions to determine a "best fit" for offender and organization alike (Ziegenfuss, 1985). Accordingly, a thoughtful classification policy can be the key to heading off many potential institutional problems (Brennan, 1998). It is also one of the processes in which the involvement of mental health professionals is most important. Careful consideration of whether a given inmate will be capable of negotiating the demands of a given institution, as well as the treatment and/or growth opportunities available, will go a long way toward preventing unnecessary difficulties down the line.

Similar to most other areas of correctional management, the classification process is confronted with competing demands and divergent priorities. Maintaining bed space and guaranteeing security often take precedent over psychosocial needs and/or personal growth (Bartollas, 1985). When participating in classification procedures, mental health professionals must be mindful of the context in which they are working. Institutional safety and security must ultimately prevail; thus, the interest of the broad community will likely outweigh individual needs. Through participation in classification, mental health professionals have the opportunity, from the beginning, to offer opinions and/or suggestions that may defuse potential crises, thereby saving precious time, energy, and resources. Ideally, a representative from the mental health staff should participate in all classification decisions. However, given staffing constraints, psychological expertise may be in short supply and, if so, should be used strategically (e.g., for offenders with mental illness, with repetitive violent behavior, and/or with severe personality disorders). Formal written policies requiring trained mental health participation in classification decisions is not the norm (Morris et al., 1997). Nevertheless, within the context of a mutually respectful and esteemed relationship, informal consultation can be quite effective as well. In many cases, a simple decision, such as changing an inmate's work assignment, schedule, or housing status, can prevent significant problems, for example, impending assault or psychiatric decompensation (Dvoskin, Spiers, Metzner, & Pitt, in press). By heading off such potential disruptions, the institution will continue to function smoothly without unnecessary expense and escalating tension.

Case Management/Unit Teams

Traditional Case Management. Case managers (as well as correctional counselors) are responsible for a significant part of an institution's daily operation (Carlson, 1999a). An effective case management program is essential to the successful management of day-to-day institutional functioning. Case managers monitor and support the inmates on their caseloads, forestall potential crises, and reduce stress and pressure on correctional staff. The influence of case management extends both within and without the institution and spans the duration of incarceration. Within the institution, case managers link inmates with correctional services and programs and they serve as a liaison between inmates and various institutional departments. The correctional setting is laden with detailed policies and stringent procedures that may be difficult for even the most mentally healthy inmate to negotiate. Often, a simple question (e.g., how to facilitate visitation, how to order mailing material, how to enroll in educational programming) will result in an inmate being referred to several different staff members before an answer is provided. One of the most important yet often overlooked needs of the inmate population is simply to be heard. Getting the runaround is frustrating for anyone but can be particularly problematic for an already fragile inmate. Case managers serve as a single point of contact, allowing inmates the opportunity to address concerns, obtain information, and request services throughout their incarceration. Often, the

simple provision of accurate information can dramatically decrease disruptive anxiety or frustration, and the refuting of rumors or offering of support can often significantly improve an inmate's response to an otherwise distressing situation (Dvoskin et al., in press).

In the absence of supportive services, the collective pressures of incarceration can intensify to the point of crisis. Crises of any kind are extremely disruptive to the institution, and after-the-fact intervention is often expensive. Fortunately, through active case management, such crises can usually be averted. In fact, for many inmates, case managers can supplement or even replace costly clinical contacts. Verbal counseling not only is the least intrusive intervention available but often also is the most effective, especially when the difficulty is in response to a specific event or the novelty of the incarceration itself. With general training in human relations, nonclinical staff can serve in a supportive capacity. Nevertheless, case managers must often rely on the expertise of mental health professionals to address concerns beyond the scope of their training. Depending on the size and staffing ratio of a given facility, case managers may be assigned to work with a designated mental health professional. Within this arrangement, informal consultation will also occur on a regular basis. Regularly (but infrequently) scheduled meetings/staffings are another useful mechanism to keep all parties apprised of inmates' status. The management of inmates who are repetitively violent or who have serious mental illness or severe personality disorders will require a collaborative effort. To this end, mental health professionals can contribute their knowledge of behavior toward the development of an effective treatment plan. Like security staff, mental health professionals should be readily available to *advise*, as well as to *listen to*, case management staff. Case managers should feel confident that if they seek consultation from mental health staff, their concerns will be met with attention and respect. Moreover, mental health staff should consistently provide feedback to case managers following receipt of referrals. Ultimately, it is the *mutual* sharing of impressions, ideas, and suggestions, with each discipline learning from the expertise of another, that is most beneficial for everyone.

Unit Management. Many correctional systems, including the Federal Bureau of Prisons, employ an integrated or team approach to institutional management. Inmates are generally designated to a unit team on the basis of their housing assignment. Team members include correctional counselors, case managers, and a team leader whose offices are usually located within the unit. Positive professional relationships are supported by the daily interaction between staff and team members facilitated by this modality. Moreover, by their nature, treatment teams create a sense of cooperation and unify effort. Allowing security staff to participate in treatment/programming decisions, as well as allowing treatment staff to participate in security decisions, generates continuity for inmates and staff alike. In institutions that have adopted the unit team modality, mental health professionals can function either as official team members or as consultants to the team. Mental health professionals can offer insight toward the management of special needs inmates and share knowledge regarding the behavioral sequelae of various mental illnesses.

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institution but also can create an invaluable sense of self-worth and accomplishment for the inmate.

Disciplinary Proceedings

Every correctional system maintains formal policy dedicated to the secure and orderly management of inmates (Flanagan, 1998). Inmates who fail to abide by institutional rules and regulations will ultimately face some form of disciplinary action within the facility. However, the procedures by which inmates are served disciplinary reports (sometimes referred to as "write-ups" or "tickets"), appeal charges, and receive punishment vary significantly across correctional systems. In general, inmates who break rules are written up at the discretion of security staff. On receipt of a disciplinary report, the inmate will face some sort of in-house court or disciplinary panel. The disposition may include withdrawal of privileges (e.g., commissary, recreation), change in housing or custody status (e.g., movement to a higher custody status), or loss of "good time" toward early release.

Mental health involvement in disciplinary proceedings can be formal and mandated by institutional policy or informal and based on case-specific consultation. One example of a formal system involves the routine review of disciplinary reports received by inmates with documented mental illness. If a mentally ill inmate receives a ticket, a member of the mental health staff will first review the charges to determine whether or not the infraction was directly related to mental illness. For example, consider that an offender with a long history of schizophrenia is charged with talking out of place. The mental health professional would be faced with determining whether or not the inmate's rule breaking was volitional. If the mental health professional concludes that the ticket received was a direct result of the inmate's mental illness (analogous to an insanity defense), he or she would have the authority to dismiss the charge.

Another method of policy-driven, formal mental health participation allows inmates to compel mental health staff to testify during disciplinary proceedings (Hafemeister, Hall, & Dvoskin, 2000). Mental health professionals could then be called by inmates to provide testimony regarding the inmate's mental status. For example, if an inmate with documented mental illness is charged with refusing to obey an order, then the inmate can call mental health staff to testify about the possible influence of his or her mental status on the behavior in question.

Although either one of the aforementioned approaches may initially appear to serve the inmate's best interest, direct mental health involvement in disciplinary proceedings can create significant tension between security and mental health staff (Cohen, 1998). Moreover, the participation of in-house mental health staff may compromise their treatment role and divert resources from direct service provision (Hafemeister et al., 2000). In the interest of minimizing these problems, administrative policy in the state of New York bars mental health professionals employed by an institution from participating as "expert witnesses" in disciplinary processes (Dvoskin, Petrila, & Stark-Reimer, 1995), although they are encouraged to provide informal mental health consultation to the disciplinary officer. This policy was

upheld by the Second Circuit of the U.S. Court of Appeals (*Powell v. Coughlin*, 1991). Mental health staff are also allowed to testify as "fact witnesses" (e.g., to report an eyewitness account of an assault) as necessary (Hafemeister et al., 2000). The goal is to provide meaningful psychological input into the decision-making process without compromising the role of the institution's mental health professionals.

Finally, Colpe (1999) emphasized the importance of identifying well-defined goals prior to the establishment of institutional disciplinary policy. In keeping with that sentiment, interdepartmental involvement in disciplinary policy and decision-making processes should be grounded in ethical, reasonable, and attainable goals. The most obvious goal of mental health participation in institutional disciplinary action would be to avoid the exploitation or unnecessary punishment of mentally ill offenders. A second, less overt goal would be to minimize unnecessary tension within the institution.

These authors contend that informal involvement of mental health professionals in disciplinary proceedings is most effective. Informal mental health involvement protects the rights of inmates by allowing mitigating information into the process without compromising mental health professionals' role with either inmates or staff. Open discourse and mutual respect between security and mental health staff remains the hallmark of effective intervention on virtually every level. In an atmosphere of cooperative collaboration, members of the disciplinary panel could consult informally with mental health staff and solicit opinions or advice on a case-by-case basis. When mental health professionals engage in the unilateral dismissal of charges brought by security staff, officers are (perhaps appropriately) likely to feel as though their authority and judgment have been called into question. Therefore, in some instances, even the best-intentioned mental health professionals and the most conscientious of security staff could conceivably present conflicting opinions. Given that the goal is to reduce, rather than elicit, interdepartmental tension, it seems prudent to refrain from developing policy that would inherently result in dissent. In the long run, the respectful submission of a recommendation, as opposed to an authoritative determination, is far more beneficial to everyone.

Conflict Resolution

Given the day-to-day tensions and competing demands inherent in the correctional setting, it is not uncommon for intra-institutional conflicts to arise. If the mental health department has established an atmosphere of trusting collaboration, then personnel from the department(s) in conflict are more likely to seek out the assistance of mental health staff. Alternatively, upper management or supervisory staff may enlist the support and/or advice of mental health personnel toward conflict resolution within an institution. In these cases, mental health professionals can function in the role of mediator. Drawing on their expertise in human behavior and conflict response, mental health professionals can assist in the development of an appropriate and constructive discussion of the issues. Ideally, each party would first have the opportunity to express its concerns and articulate its objections on a

individual basis. Subsequently, all parties in question would meet together in the interest of achieving an appropriate resolution. Mental health professionals can be beneficial to this process because they can assist in setting the tenor of the meeting and facilitating an atmosphere conducive to cooperative effort. Ideally, the outcome will be such that neither side feels shortchanged.

When in the role of mediator, it is important for mental health professionals to be mindful that some individuals may attach undue weight to their judgments because of their perceived professional stature. At the same time, mental health professionals are not immune from becoming blinded by personal biases. Although it may be tempting to lend opinions, particularly in the area of departmental conflict resolution, mental health professionals must strive to remain objective and limit their involvement to their area of expertise.

Conflict between staff and inmates can be even more problematic than interdepartmental discord. Every problem and/or conflict is embedded in both the physical and psychological aspects of the institution that creates the context in which inmates live (Ziegenfuss, 1985). As discussed previously, a hostile institutional climate can have a substantial and deleterious effect on everyone. On an institutional level, innovative strategies aimed at increasing communication can minimize the potential for conflict. Cooke (1998) cited a Scottish program developed, in part, by a mental health professional. The program included the implementation of staff-inmate committees. These committees met at regularly scheduled intervals to facilitate communication and provide an open forum to address concerns, grievances, and mutual goals. As a result, they noted a significant reduction in violence at that facility. The Scottish program is just one example of the impact that mental health professionals can have toward improving the quality of life behind bars.

Fundamental principles of human behavior and interpersonal relations can be applied in a variety of ways toward the prevention or resolution of conflict in the correctional setting. With a little creativity and a commitment to cooperative effort, seemingly insurmountable obstacles can be overcome.

Staff Screening and Selection

The selection and retention of qualified motivated personnel is critical to any professional enterprise. However, the high level of interdependence and structure necessary to operate a correctional facility successfully magnifies the importance of effective staffing procedures. In some jurisdictions, mental health professionals routinely participate in assessments, interviews, and staff selection decisions. Depending on the setting, mental health professionals may participate in selecting candidates for positions across all disciplines of correctional service.

Whenever mental health professionals play a role in human resource decision making, they must clarify the purpose and parameters of their involvement. To this end, staffing issues should be classified as one of two very distinct tasks: screening or selection. *Screening* refers to the process by which negative characteristics or problem behaviors are identified so as to remove an inappropriate candidate from further consideration. *Selection* involves selecting a candidate based on his or

her likelihood of demonstrating positive performance over time. Screening is an evaluation of the candidate's immediate status, while selection focuses on future performance (Hibler & Kurke, 1995). Behavioral science is far more adept at determining an individual's current psychological state than it is at predicting an individual's future behavior. As a result, several authors have suggested that mental health professionals are more useful in terms of screening out problem candidates than of selecting effective employees (Chandler, 1990; Parker, Meier, & Monahan, 1989).

Notwithstanding the fact that there is a significant body of research dedicated to the reliability and validity of various personnel assessment measures, results thus far have been inconclusive. In any setting, psychological assessment of potential employees remains controversial, and researchers continue to work toward the development of accurate measures of performance (Hogan, Hogan, & Roberts, 1996; Landy & Shankster, 1994; Martin & Davis, 1991; Tenopyr, 1996). Regardless of the venue, when used for preemployment purposes, psychological instruments must be reliable and valid for the specific task for which the candidate is being evaluated (Chandler, 1990; Schofield, 1993). Although courts have routinely supported law enforcement agencies' ability to use psychological assessment instruments (Schofield, 1993), the selection of measures, identification of criteria, and interpretation of results must be carried out with caution (DeCicco, 2000) to withstand judicial scrutiny (Chandler, 1990). Candidates may pursue legal action if they believe that they were screened out inappropriately or subject to discrimination (Chandler, 1990; DeCicco, 2000), and members of the public can hold law enforcement agencies accountable for negligent hiring (Hibler & Kurke, 1995).

An overwhelming majority of the related personnel research to date has focused on police and community law enforcement populations (Blau, 1994; Kornfeld, 2000; Parker et al., 1989; Sarchione, Cuttler, Muchinsky, & Nelson-Gray, 1998; Varela, Scogin, & Vipperman, 1999). Inwald (e.g., 1985, 1990) has long been at the forefront of research related to law enforcement personnel, actively advocating and researching psychological screening programs (Chandler, 1990). Suggested guidelines for preemployment screening of law enforcement officers are readily available in the literature (Blau, 1994; Chandler, 1990; Inwald, 1992). Preemployment psychological assessment may include a clinical interview, intelligence testing, personality testing, or any combination thereof. In law enforcement arenas, the Minnesota Multiphasic Personality Inventory and the Inwald Personality Inventory are among the most commonly used (Blau, 1994; Chandler, 1990; DeCicco, 2000; Parker et al., 1989) and empirically investigated personality assessment instruments (Scogin, Schumacher, Gardner, & Chaplin, 1995). The California Psychological Inventory is another frequently used preemployment screening tool for law enforcement (Hargrave & Hiatt, 1989).

Despite the plethora of research addressing the screening and selection of law enforcement officers, relatively little attention has been paid to screening and selection issues specific to correctional officer selection. In one of the few studies available, Shusman and Inwald (1991) found preemployment Inwald Personality Inventory item responses to be a valid predictor of correctional officer absence, tardiness, and disciplinary problems over time.

Given the paucity of literature examining correctional staff selection, it may be tempting to apply broader law enforcement research in correctional decision making. However, as Blau (1994) appropriately cautioned, the duties and demands of police and correctional officers are very different, and these two populations are unlikely to be adequately served by using identical criteria for staff selection. Thus mental health professionals must be mindful of the inherent limitations to generalizing law enforcement research to the correctional setting. Any interpretation and application of such data should be undertaken with caution until such time as a more substantive research base is developed.

Whether psychological assessment instruments are used for screening or selection purposes, it is imperative that they never be used as the sole determinant of a hiring decision. As is the case with a clinical evaluation, data from a variety of sources must be integrated and considered cumulatively before any conclusions are drawn. It is incumbent on mental health professionals to be proactive in ensuring that psychological test data are used only in a capacity consistent with the limitations of the instruments used.

The value of mental health input in personnel selection is further clouded by policies that require the *presence* of mental health professionals in the *absence* of valid objective testing measures. Mental health staff may be perceived as having some unique or innate ability to determine the viability of a candidate solely as a result of his or her professional background. Of course, training in behavioral science does not, in and of itself, provide anyone with the ability to make such a decision. As such, there is no indication that mental health staff are any better (or worse) than anyone else at determining the ideal candidate for a given position.

Often, the most telling means of determining a given candidate's suitability for correctional work is through actual job performance. To that end, it is very helpful for institutional policy to include, and for institutional practice to make use of, a probationary period for all new hires. The use of a probationary period provides the new employee and supervisory staff with the opportunity to assess more accurately the appropriateness of a given personnel placement.

It is also worth noting that the use of in-house mental health staff to assist in personnel selection takes these professionals away from their clinical duties and may, at times, be an undesirable allocation of limited resources. As with any department in a correctional setting, mental health staff should be available to assist on an as-needed basis or when the interviewee in question is applying for a job in their department. If mental health professionals elect or are compelled to participate in correctional staff selection, it is important that they do so only with an appreciation of their limitations.

Program Development and Evaluation

Morris et al. (1997) postulated that insufficient mental health services in jail might result simply from a lack of knowledge related to the development and implementation of services. Mental health professionals have much to offer correctional administrators regarding the development, implementation, and evaluation

of institutional programs. Regardless of nature or context, preliminary research and follow-up evaluation are integral to the development of quality programming. Data must be used in decision making around the creation and implementation of a program as well as in evaluating the program's effectiveness. Information gleaned from ongoing quality assessment and quality improvement efforts should be used to guide all decisions and to improve all phases of institutional programming (e.g., assessment, referral, treatment). Data collection is critical not only to ensuring quality and effectiveness of care but also to minimizing fiscal waste. Taxpayers expect that their dollars will be used to protect the public and reduce the likelihood of future crime (Elliott, 1997). The absence of effective institutional programs significantly limits the opportunity for inmates to learn new skills and strategies for improved decision making in the community (Dvoskin & Steadman, 1989). Research is a critical component in the evaluation of correctional programs.

Mental health professionals can contribute to institutional program development from both within and outside of the correctional system. In either case, correctional researchers will inevitably confront numerous practical and methodological difficulties associated with criminal justice settings (Megargee, 1995). Nevertheless, empirical investigation is a critical endeavor that provides information necessary to improve all areas of corrections. External consultants can assist with the implementation of sound research, and program developers should be prepared to provide consultation to interested institutions (Rice & Harris, 1997).

Crisis: Prevention and Response

Nowhere is the importance of consultation and collaboration more apparent than in a correctional emergency. Administration and staff must be vigilant in their preparation for potential crises. Staff must be adequately trained, and crisis plans must be tested and continually revised to meet the changing needs of the facility (Stepp, 1999). Historically, crisis response plans and training exercises were geared primarily toward the resolution of hostage situations. More recently, however, trained negotiators are increasingly equipped to address a variety of issues (e.g., suicidal individuals, barricades, standoffs). Although crisis negotiation teams are often primarily composed of law enforcement and/or security personnel (Burke, 1995; Hammer, Van Zandt, & Rogan, 1994), mental health professionals can play an instrumental role in preparing their institutions for the most serious of crises.

Training

The most commonly cited reason for including mental health consultants in crisis response plans is to support post-incident counseling activities (Hammer et al., 1994) (see Chapter 11). However, mental health professionals also frequently serve as on-scene advisers during crisis negotiations and in the selection and training of team members. Only a small percentage of teams use mental health professionals as primary negotiators.

Although mental health professionals do not typically serve as frontline negotiators, they have much to offer in the way of teaching therapeutic communication skills. The resolution of a crisis through negotiation is the "dominant philosophy of all modern crisis management training" (Burke, 1995, p. 50) and is the "principal tool of negotiators is the ability to communicate with subjects in a way that resolves the incident with a minimum of injury or loss of life" (Slatkin, 1996, p. 3). Therefore, strong interpersonal skills are a prerequisite for any effective negotiation team. In a crisis situation, verbal skills are negotiators' most powerful weapon; therefore, it is critical that negotiators are armed with a substantive repertoire of communication techniques.

Communication in a crisis differs from routine conversation in that, during a crisis, each exchange is calculated, deliberate, purposeful, and focused (Slatkin, 1996). Active listening skills, commonly used in therapy settings, can be beneficial for crisis negotiators. Mental health professionals can share their expertise on verbal communication; basic techniques, when applied appropriately, can go a long way toward safely resolving a critical incident. Paraphrasing, reflection, clarification, primary empathy, and summarization all are useful skills for negotiators that, if used correctly, will engage offenders and help the negotiation team to gain a better understanding of the meaning behind an offender's behavior. In addition to teaching communication skills, mental health professionals should provide negotiators with an overview of expected behavioral responses to stress and trauma as well as with an introduction to the signs and symptoms of mental illness.

Consultation

Mental health professionals can also be very useful to crisis negotiation teams via on-site consultation. The Federal Bureau of Investigation classifies all critical incidents into one of two categories: hostage situations or nonhostage situations (Noesner, 1999). As Noesner (1999) explained, hostage situations involve the holding of another person or persons to use as leverage against a third party in the interest of fulfilling demands. Offenders in hostage situations are typically goal directed in their behavior. Although they will often threaten to harm their victims if their demands are not met, these offenders are aware that harming hostages will lessen the likelihood of a positive outcome. Nonhostage situations may also involve the holding of another person against his or her will. However, in these incidents, the offender does not have well-defined goals and is more likely to behave in an erratic or self-destructive manner. Here, the offender is more likely to be acting out of anger, frustration, confusion, or depression. The offender's emotional reactivity may be directed toward a third party or toward the person he or she is holding. In such cases, the offender is more likely to have had a relationship with the person being held, and there is a greater risk of harm to that individual (Noesner, 1999).

When discussing strategy and negotiation tactics, the importance of the preceding distinction is critical. A hostage situation can be conceptualized primarily as a bargaining interaction, while a nonhostage situation is more in keeping with traditional crisis intervention (Noesner, 1999). Through active consultation, mental

health professionals can help to assess the dynamics of a given incident, determine the category to which the event belongs, and assist in strategic planning.

Regardless of the type of critical incident, the presence of a mental health professional is crucial when confronting a suicidal or mentally ill individual. In these cases, knowledge of mental illness and its behavioral sequelae is of utmost importance in the development of an appropriate intervention. Mental health professionals can advise negotiators about the symptomatology associated with the offender's diagnosis. This is important not only in terms of strategic planning but also to avoid fear and confusion on behalf of negotiators unfamiliar with mental illness.

Negotiation is a labor-intensive and time-consuming proposition. Although the passage of time affords negotiators an opportunity to develop rapport and gain the trust of an offender (Noesner, 1999), it can also wear down even the most diligent member of a crisis negotiation team. In the interest of providing a step-by-step framework for negotiators, Fagan (2000) outlined the following six-step model: (a) establishing contact and opening a line of communication; (b) restoring calmness to the situation; (c) exploring precursors, motives, and demands; (d) developing a plan or negotiation strategy; (e) selling the plan to the perpetrator; and (f) preparing for surrender. Fagan's model was intended to allow negotiators to focus on one step at a time, thereby decreasing frustration and emphasizing the *process* rather than solely anticipating the end, ultimately minimizing stress and enhancing performance.

Post-incident Response

The most traditional avenue for mental health involvement in correctional crises is during the aftermath of a critical incident. Hostage taking in any context is a terrifying and traumatic event. In the correctional setting, however, a hostage incident can be especially horrific for those involved. The unique reversal of roles and shift in power can have profound implications for victims (Campbell, 1992). Officers involved in hostage incidents have described their experiences as among the most traumatic events in their lives (Kauffman, 1988).

In addition to "crisis negotiation" teams, each facility should have designated and equally well-trained "crisis response" teams to address the needs of victims and their families during and after critical events. In this venue, mental health professionals can be instrumental in the training of staff and in the provision of services. Crisis response teams are usually comprised of mental health professionals, pastoral staff, and medical personnel. However, many systems include line staff who volunteer their services in the event of a crisis. All crisis response staff should be provided with training that includes acute stress management, crisis support, the signs and symptoms of trauma, and defusing and debriefing procedures (Fagan, 1994).

In correctional crisis or hostage situations, victims' families often become secondary victims, confronted first with their own fear for the safety of their loved ones and then coping with their subsequent responses to the trauma (Campbell, 1992). Planning should include the designation of a family command center that provides loved ones with a place to gather, receive information and intelligence, and

gain access to emotional support (Fagan, 1994; Noesner, 1999). The long-term ramifications of a correctional crisis are difficult to measure. Some staff may return to work immediately, while others may take extended leaves or terminate their employment entirely. Individual responses to trauma vary tremendously, and correctional administrators and mental health staff must be mindful of the diverse needs of staff and their families. There is no right way in which to recover from a traumatic event.

Mental health personnel should take an active role in all facets of crisis response. However, their involvement is especially important immediately following a traumatic incident. Debriefing sessions that include all correctional personnel involved in the incident (regardless of capacity) provide an opportunity for frank discussion of the event. These sessions also provide mental health professionals with an opportunity to educate victims about post-traumatic symptoms and coping skill development (Fagan, 1994) (see Chapter 11 for a detailed discussion of debriefing procedures).

Mental Health Professionals as Correctional Administrators

The need for correctional mental health services is growing at an unprecedented rate and is unlikely to decline in the foreseeable future. Consequently, the demand for creative programming and innovative policy continues to rise (Dvoskin & Patterson, 1998). The responsibility for providing an environment capable of managing the demands of taxpayers, inmates and their families, and correctional staff ultimately rests with the uppermost management personnel (Elliott, 1997). Those in leadership positions must constantly negotiate conflicting demands in terms of punishment versus rehabilitation and in terms of safety versus liberty while simultaneously enduring constant scrutiny from the media, lay public, and politicians (DiIulio, 1999).

Correctional administrators must have a deep understanding of human behavior and interpersonal relations. To be effective in a correctional setting, administrators must have problem-solving, communication, motivation, and conflict resolution skills—skills that are part of the training, experience, and personal makeup of many mental health professionals. However, the position requires expertise beyond that which prepares mental health professionals for clinical work. Correctional administrators must also be competent in areas including, but not limited to, managerial ability, budgeting, strategic planning, and supervision. Although some mental health professionals may make excellent correctional administrators, mental health credentials alone do not imply that one will be competent or equipped for effective correctional management.

Conclusions

The demands of a correctional institution are complex. Unnecessary tension in an inherently stressful setting can create a dangerous and volatile milieu. By virtue of their training, mental health professionals are well versed in the nuances of human behavior and interpersonal relationships. Notwithstanding their expertise, to maintain institutional equilibrium, mental health professionals must work in concert with correctional staff skilled in the technical aspects of maintaining a secure environment. To this end, by modeling and fostering open communication across disciplines and between members of this unique and stressful community, mental health professionals can play a significant role in contributing to the improvement of a correctional institution's productivity, morale, and safety.

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