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# Correctional Officer Mental Health Training: Analysis of 52 U.S. Jurisdictions

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## Abstract

Research indicates correctional officer (CO) mental health training may be effective in facilitating the safety and security of both inmates and COs. We assessed Department of Corrections' CO preservice (requisite for beginning an official post) mental health training requirements in 50 states, the District of Columbia, and the Federal Bureau of Prisons. We obtained information regarding instruction method, training duration, and courses required. Descriptive statistics showed that all jurisdictions require mental health training, ranging from 1.5 to 80 hr ($M = 13.54$, $SD = 14.58$, $Mdn = 8$). When considering course titles, the most common course topic is crisis intervention ($n = 44$, 84.62%). The next most frequent course topics are general psychoeducation ($n = 24$, 46.15%), special populations ($n = 12$, 23.08%), specific clinical interventions ($n = 7$, 13.46%), institutional procedure specific to mental health ($n = 6$, 11.54%), and CO mental health and self-care ($n = 4$, 7.69%). Future research should examine whether CO mental health training is related to positive mental health outcomes and other important institutional metrics, as well as variations in training and its impact at the national and international levels.

## Keywords

mental health training, mental illness, offenders, correctional officers

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The United States has the highest population of incarcerated individuals in the world (Carson & Anderson, 2017), and research suggests that mental health is a major concern within incarceration settings. Compared with the general population, individuals in jails and prisons report disproportionately high levels of serious psychological distress (Bronson & Berzofsky, 2017) and are more likely to meet criteria for major psychiatric disorders (Steadman, Osher, Robbins, Case, & Samuels, 2009). Although this imbalance is well documented, we know little about how correctional officers (COs)—those on the "front lines" in incarceration settings—are trained to work with incarcerated individuals with mental illnesses (IMI). To address this research gap, we examined required preservice mental health training for COs (i.e., training requisite prior to beginning an official post) for all 50 U.S. states, the District of Columbia, and the Federal Bureau of Prisons.

## Mental Illness in Incarceration Settings

Some research exists on the prevalence of mental health problems among individuals who are incarcerated. James and Glaze's (2006) report on those incarcerated by U.S. state and federal correctional facilities revealed that about 14% in federal prisons, 20% in local jails, and 34% in state prisons endorsed mental health problems (diagnosed by a professional, hospitalized for psychiatric reasons, prescribed medication, and/or received professional psychotherapy) in the past year. In Maryland and New York State, Steadman et al. (2009) attended specifically to gender differences and found that 15% of males and 31% of females who were incarcerated met criteria for at least one severe mental illness—such as major depressive disorder, bipolar disorder, schizoaffective disorder, or schizophrenia. Another study found that about 35% of individuals in jails met criteria for co-occurring mental health and substance use disorders (Sung, Mellow, & Mahoney, 2010). More recently, research found that about 14% of individuals incarcerated in state and federal prisons and 26% of individuals incarcerated in jails experienced serious psychological distress (as measured per Kessler et al.'s (2003) measure) within 30 days preceding a clinical interview (Bronson & Berzofsky, 2017). These results underscore that individuals incarcerated in the United States have higher rates of serious mental health problems than the general public.

Research suggests that once incarcerated, individuals often lack access to critical mental health services. Slightly more than a decade ago, a survey found that among 134 jails across 39 states, only 40% contained special purpose mental health units (Ruddell, 2006). IMI can experience greater difficulty adjusting to incarceration and commit more infractions than incarcerated individuals without mental illnesses (Appelbaum, Hickey, & Packer, 2001). As noted by Adams and Ferrandino (2008), infractions for IMI often lead to punitive measures such as physical restraint and secure housing, which may exacerbate anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis. Furthermore, this increase in the number of disciplinary incidents may contribute to longer lengths of stay, including being less likely to earn early release, probation, or parole and serving an average of 12 months longer than incarcerated individuals without mental illnesses (see Amrhein &

Barber-Rioja, 2010). Among a sample of individuals incarcerated in New York City and placed in solitary confinement, Kaba et al. (2014) found that approximately half engaged in self-harm behavior. Within this group, half engaged in potentially lethal self-harm behavior.

## Mental Health Training of COs

COs are considered integral to the safety and security of jails and prisons. In one study, COs reported that compared to specialized mental health staff, they have more responsibility in monitoring and correcting inmate behavior (Antonio, Young, & Wingeard, 2009). COs most frequently interact with IMI (Haney, 2003; Lavoie, Connolly, & Roesch, 2006) and play key roles in monitoring and informing medical and administrative staff of symptom exacerbation or inappropriate behavior, as well as de-escalating crisis situations (Appelbaum et al., 2001; Dvoskin & Spiers, 2004). Crichton and Ricciardelli (2016) found Canadian COs prefer to avoid force by using communication to de-escalate crises, when possible. These duties do not go unnoticed. In a study that surveyed jail administrators regarding the most effective interventions for working with IMI, training COs in mental health ranked third in effectiveness following initial admission intakes and suicide risk screenings (Ruddell, 2006).

Pompili et al. (2009) conducted a literature review of best practices for preventing suicides in prisons and jails and identified successful strategies derived from inpatient psychiatric units. These include ongoing training programs, development of thorough screening and documentation procedures, encouraging communication between staff, and debriefing staff following inmate suicide. They advocated for training programs on suicide and for COs to learn to attend to signs of suicidal ideation or intent, such as how to conduct brief mental health checks during critical periods (e.g., sentencing, incident reports, family visits, active psychiatric symptoms).

In a Canadian study, COs reported that IMI require more attention, more discretion, and a different approach to management than incarcerated individuals without mental illnesses, frequently due to IMI's difficulty in understanding or adhering to institutional routines (Lavoie et al., 2006). Furthermore, 81% of COs reported IMI added stress to their job, 80% did not feel prepared to manage IMI, and 90% felt the need for more mental health training. Despite the high rate of contact and added stress reported, fewer than half of the sample reported receiving mental health training. Building research shows that COs themselves may be at higher risk of symptoms of mental disorder, particularly those that are anxiety-related, than the general public and other public safety personnel (Carleton et al., 2018a; Carleton et al., 2018b). Potentially, providing COs with additional training could reduce stress on the job and subsequently reduce the risk of CO mental disorder.

Although COs in Lavoie and colleagues' (2006) study reported viewing IMI more positively and indicated the need for additional mental health training, other research has found that COs are not as interested in IMI treatment (Lambert & Hogan, 2009). This suggests that there are potentially wide-ranging views among COs regarding their role in mental health treatment and management. Stigma reduction in incarceration

settings is an important endeavor, as IMI face the double stigma combination of mental illness *and* offender (see West, Yanos, & Mulay, 2014).

Regardless, the current literature suggests that mental health training has potential benefits for reductions in CO stress and IMI distress, and consequently reductions in infractions and punitive measures. Thus, mental health training can potentially increase the safety and security of both IMI and staff. In civil psychiatric contexts, for example, staff training in crisis de-escalation (using a detailed training manual, training video, and in-person 1-day training) along with the implementation of patient-generated advanced psychiatric directives was associated with an almost 99% decrease in physical restraint of patients (Jonikas, Cook, Rosen, Laris, & Kim, 2004).

Some researchers studied CO mental health training implementation in various settings. Following a basic 2-hr training program on correctional treatment programs and operant behavioral principles (modeling and correcting inmate behavior; Antonio et al., 2009), state facility COs in Pennsylvania reported that it benefited their understanding of treatment concepts. Pan, Deng, Chang, and Jiang (2011) instructed COs on conflict resolution (solution-focused approach [SFA]) with individuals who are incarcerated in Taiwan. Training emphasized the strengths (as opposed to vulnerabilities and dysfunction) of individuals who are incarcerated and instructed COs to encourage individuals who are incarcerated to adopt problem-solving skills. About 90% of their CO sample found SFA training helpful, and 93% believed SFA should be implemented to create behavioral change among individuals who are incarcerated. At 2-month follow-up, COs reported that SFA techniques were moderately difficult to implement but were important nonetheless. A limitation of this research is that it only looked at COs' perceptions of training, without assessing training impact on correctional mental health or administrative outcomes (e.g., symptomatology, number of infractions, physical restraints).

Researchers have not yet conducted randomized controlled trials of CO mental health training. However, the sole quasi-experimental study, adopting a pre–post design, showed promising results. Parker (2009) conducted an effectiveness study of CO mental health training in a special housing unit. The training intervention was developed and delivered by the National Alliance on Mental Illness (NAMI) Indiana chapter. NAMI is the largest grassroots mental health organization in the nation helping to educate the community, advocate on behalf of IMI, and provide resource support for those who live with a mental illness (NAMI, n.d.). The organization includes IMI, their families, advocates, and mental health professionals. The training consisted of 2-hr sessions over five 2-hr consecutive weeks. Course content included the biology of mental illness, psychiatric symptoms, treatment of mental illness, and how to effectively interact with IMI. Nine months after the COs completed the training, Parker compared pre- and post-training frequency of use of force and assaults by bodily waste by inmates. Findings indicated that COs' use of force decreased by 55% and the number of assaults by bodily waste by inmates decreased by 29%. Given that the unit housed individuals with and without mental illness, findings may not generalize to all incarcerated samples. Still, the ability for mental health training to decrease use of force and assaults *in general* is important and encouraging.

Although there is scant research on CO mental health training, we can look to community law enforcement research to examine the effects of mental health training on meaningful metrics, such as reducing punitive encounters, referring individuals in crisis to mental health services, enhancing procedural justice perceptions, and increasing officer understanding of mental illness while reducing mental health stigma. Crisis Intervention Team (CIT) training has demonstrated success along these outcomes. The primary purpose of CIT training was to instruct law enforcement on how to navigate situations with persons in emotional distress. Typically, CIT trainings involve 40 or more hours of in vivo mental health and crisis training, including role-play and in-the-moment feedback from trained instructors (Tucker, Mendez, Browning, Van Hasselt, & Palmer, 2012). Pearce and Snortum (1983) conducted one of the first CIT studies, considering whether police officer CIT training affects disturbance calls. CIT-trained officers reported fewer arrests, in that they believed they were able to de-escalate crises without arrest intervention. The researchers were able to contact 16 individuals who placed the disturbance calls to assess their satisfaction with the officer response. Relative to officers who did not receive CIT training, those who did were more often described as calm, reassuring, and competent in managing the crisis. Other research indicated CIT-trained officers were more likely to link individuals in crisis with mental health services, whereas those without CIT training were more likely to take these individuals into custody (Teller, Munetz, Gil, & Ritter, 2006; Watson et al., 2010). Ellis (2014) found that CIT training can lead to a significant increase in law enforcement officers' knowledge of mental illness.

In addition to decreasing problematic outcomes, officers in Ellis' (2014) CIT study reported increased comfort interacting with IMI, as well as more positive attitudes toward this group. More recent research shows that CIT training can reduce stigmatizing attitudes toward mental illness across diverse settings (Strassle, 2019). Tucker et al. (2012) observed parallels between community law enforcement and incarceration settings and strongly encouraged implementation of the community CIT model in jails and prisons.

## *The Current Study*

There is a significant number of IMI that are incarcerated in the United States, and COs spend a significant portion of their time interacting with them. However, COs report little training in working with this group, and many COs wish for additional mental health instruction (Lavoie et al., 2006). Furthermore, incidents borne out of mental health problems can impede the safety and security of individuals who are incarcerated as well as staff (Appelbaum et al., 2001; Callahan, 2004; Dvoskin & Spiers, 2004). Potentially, CO mental health training could reduce stress and improve safety for both individuals who are incarcerated and COs. Yet, despite some support for CO mental health training, there is little systematic research that examines training requirements. Thus far, researchers surveyed mental health training and services among isolated correctional facilities. To elucidate the frequency and nature of CO preservice mental health training, we sought preservice CO mental health training

requirements in all 50 U.S. states, the District of Columbia, and the Federal Bureau of Prisons. Clarifying the prevalence of mental health training is a first step in evaluating mental health training adequacy and areas for future research. We focus on CO training for prisons, given that the U.S. prison population is approximately 2 times larger than the jail population (Kaeble, Glaze, Tsoutis, & Minton, 2016) and assessing mental health training at the prison level would account for the practices that affect a large number of individuals who are incarcerated. Furthermore, pragmatically, there are more than 3,000 jails in the United States with no unifying training requirements (Wagner & Rabuy, 2019). We anticipated that all jurisdictions would require mental health training, but analyses were largely exploratory and there are no other a priori hypotheses.

## Method

We contacted the Department of Corrections (DOC) in all 50 states, the District of Columbia, and the Federal Bureau of Prisons using information gathered from respective websites from October 2017 through March 2018. Data were collected via telephone and email contacts with administrative and training staff and/or Freedom of Information Act requests. We obtained mental health training requirements from all 52 jurisdictions (100% response rate). For each jurisdiction, we requested (a) instruction method (e.g., instructor qualifications), (b) hours of preservice mental health training, and (c) the title of mental health courses required.

Using guidelines set forth by qualitative experts (e.g., Levitt et al., 2018; Nowell, Norris, White, & Moules, 2017), we report steps of our qualitative approach for analyzing the instruction method and course titles. Thematic analysis is a commonly conducted, intuitive approach to analyzing qualitative data. When sifting through the data, researchers can code themes deductively ("top-down") or inductively ("bottom-up"). Our coding approach was inductive, that is, we allowed the data (instruction methods and course titles) to inform theme development rather than begin data analysis with a priori coding themes.

We used NVivo v.12 (2018) software to conduct thematic analyses with our qualitative (instruction method and course title) data. Two researchers, a licensed clinical psychologist and clinical psychology doctoral student, independently coded method of instruction and course title data. Thematic analyses revealed five categories for instruction method: training facilitated by *mental health professionals* (psychiatric nursing staff, and master's and doctoral-level clinicians), *training academy personnel* (individuals employed within a respective prison system, who were not mental health professionals), *contracted agencies, online modules*, and *other.* Training approach was classified as *other* in the event that instruction modality or instructor credentials were unclear. Although the actual course content was not reviewed for the purpose of this article, six course title themes emerged: *general psychoeducation, specific treatments and programs, CO mental health, crisis intervention, institutional procedure specific to mental health, and special populations.* Across these 11 variables (five categories for instruction method and six categories for course titles), the average initial kappa =

.82, with percent agreement ranging from 89.53% (*general psychoeducation*) to 100.00% (*CO mental health*), with an average of 96.50%. Coders met to reconcile coding differences for 100.00% agreement.

Regarding our quantitative data—length of training—we summed individual course hour requirements to calculate total duration. When jurisdictions provided a range, for instance, 4 to 8 hr of required training, we used the average (6 hr). When jurisdictions reported training lengths in "days," we adopted the conventional rule for a full workday (i.e., 8 hr training per day). We calculated descriptive statistics for all variables of interest.

## Results

Training programs most often utilize mental health professionals ($n = 37$, 71.15%) and training academy personnel ($n = 31$, 59.62%) for course instruction. Two (3.85%) jurisdictions reported using online modules. Training facilitation falls into an other modality for nine (17.31%) of the jurisdictions. In many cases, jurisdictions use multiple forms of instruction ($n = 23$, 44.23%), such as pairing mental health professionals with training academy personnel, for providing education on varying mental health topics.

With respect to mental health training duration, hour requirements range from 1.5 (Tennessee) to 80 (Florida) hr of instruction (Table 1). Across jurisdictions, COs are required to complete a mean of 13.54 hr ($SD = 14.58$, $Mdn = 8$). Jurisdictions often cite additional required mental health training for COs assigned to special housing units or appointed to special force teams. Several contacts report that their jurisdiction was in a time of transition and anticipate longer requirements in upcoming years.

All 52 jurisdictions require some form of preservice mental health training (Table 1). Regarding specific topics, crisis intervention is the most commonly required ($n = 44$, 84.62% of jurisdictions). It is important to note that while not all training programs dedicate a specific course to suicide prevention and response, all report providing education on the topic. The second most common course is general psychoeducation ($n = 24$, 46.15%; mental health broadly as well as awareness and decreasing stigma programs), followed by special populations ($n = 12$, 23.08%; for example, *correctional practices with elderly individuals, individuals with special needs, females*). Required coursework on specific treatments and programs, such as *dialectical behavior therapy, motivational interviewing*, and *trauma-informed care*, is relatively rare ($n = 7$, 13.46%). Institutional procedure *specific* to mental health ($n = 6$, 11.54%), which includes courses such as *psychiatric restraints* and *operational procedure of inpatient mental health care*, is also uncommon. Of note, four (7.69%) jurisdictions require courses in CO mental health.

## Discussion

Research indicates that a significant number of IMI are incarcerated in the United States (Bronson & Berzofsky, 2017), that COs play a key role in working with this

**Table 1.** Required Preservice CO Mental Health Training.

| | Training duration | Required preservice mental health training course topic | | | | | |
|---|---|---|---|---|---|---|---|
| Jurisdiction | Hours | General psychoeducation | Specific treatments and programs | CO mental health | Crisis intervention | Institutional procedure | Special populations |
| Federal | 7.5 | X | | | X | | X |
| District of Columbia | 4 | X | | | X | | |
| Alabama | 8 | | | | X | | |
| Alaska | 16.33 | X | | | X | | |
| Arizona | 3.5 | X | | | X | | |
| Arkansas | 4 | X | | | | | |
| California | 38 | | | | X | | |
| Colorado | 22 | X | X | | X | | |
| Connecticut | 7 | | | X | X | | |
| Delaware | 8 | | | | X | | |
| Florida | 80 | X | X | | X | | X |
| Georgia | 6 | X | | | X | | |
| Hawaii | 46 | | X | | X | | |
| Idaho | 4 | | | | X | | |
| Illinois | 8 | X | | | | | |
| Indiana | 20.5 | | X | | X | | |
| Iowa | 8 | X | | | | | |
| Kansas | 6 | | | | X | | |
| Kentucky | 10 | X | X | | X | | |

*(continued)*

**Table 1. (continued)**

| Jurisdiction | Training duration | Required preservice mental health training course topic | | | | | |
|---|---|---|---|---|---|---|---|
| | Hours | General psychoeducation | Specific treatments and programs | CO mental health | Crisis intervention | Institutional procedure | Special populations |
| Louisiana | 4 | X | | | X | | X |
| Maine | 26 | | | | X | | |
| Maryland | 8 | | | | X | | |
| Massachusetts | 8 | X | | | X | | |
| Michigan | 2 | | | | X | | |
| Minnesota | 2 | | | | | | X |
| Mississippi | 52 | X | | | X | X | |
| Missouri | 4 | | | | X | | X |
| Montana | 10 | | | | X | | |
| Nebraska | 9 | X | | | | | |
| Nevada | 7.5 | | | X | X | | |
| New Hampshire | 4 | | | | X | | |
| New Jersey | 12 | | | X | X | | X |
| New Mexico | 16 | X | | | X | | |
| New York | 24 | X | | | X | | |
| North Carolina | 10 | | | | | | X |
| North Dakota | 4 | | | | X | | |
| Ohio | 16 | X | | | | X | |

*(continued)*

**Table 1. (continued)**

| Jurisdiction | Training duration | Required preservice mental health training course topic | | | | | |
|---|---|---|---|---|---|---|---|
| | Hours | General psychoeducation | Specific treatments and programs | CO mental health | Crisis intervention | Institutional procedure | Special populations |
| Oklahoma | 4 | | | | X | | X |
| Oregon | 8 | X | | | X | | |
| Pennsylvania | 10.5 | | | | X | | |
| Rhode Island | 15 | | | | X | | X |
| South Carolina | 12 | X | | | X | | |
| South Dakota | 14 | | X | | X | | |
| Tennessee | 1.5 | | | | X | | |
| Texas | 41 | X | X | | X | X | X |
| Utah | 6 | | | X | X | | |
| Vermont | 16 | X | | | X | | |
| Virginia | 24 | X | | | | | |
| Washington | 4 | | | | X | | X |
| West Virginia | 11 | | | | X | | X |
| Wisconsin | 6 | X | | | X | | |
| Wyoming | 6 | | | | X | | |
| | $M = 13.54$ | *n* (%) | *n* (%) | *n* (%) | *n* (%) | (%) | *n* (%) |
| | $SD = 14.58$ | 24 (46.15) | 7 (13.46) | 4 (7.69) | 44 (84.62) | 6 (11.54) | 12 (23.08) |

*Note.* CO = correctional officer.

group (Dvoskin & Spiers, 2004), and that CO mental health training can be effective in improving safety and security in correctional environments (Parker, 2009). We surveyed DOCs for all 50 U.S. states, the District of Columbia, and the Federal Bureau of Prisons regarding CO preservice mental health training. It is encouraging that all jurisdictions require this training to some degree. However, there is marked variation according to length of training, instruction, and course content. Our findings represent an important step in continuing the discussion on training adequacy, as well as implications for practice and research.

## *Mental Health Training Instruction*

Mental health professionals most frequently teach training courses, which suggests that COs often are instructed by individuals with some level of mental health specialization. Slightly more than half of the instructors are identified as training academy personnel. Although these instructors may hold expertise in incarceration settings, they may lack a comprehensive understanding of mental illness. In Parker's (2009) study, which found a decrease in officer use of force and assaults by bodily waste by individuals housed on the unit, mental health training was developed and taught by NAMI instructors. Potentially, NAMI instructors may better understand mental health nuances and intervention approaches. It is important to note, however, that research has yet to examine the effectiveness of training based on instructor knowledge, background, and discipline, and we do not assume that individuals experienced specifically with mental health are more effective *correctional* mental health instructors than academy personnel. Partnerships between academy personnel and mental health professionals may be the most effective approach to training.

The collaboration approach may result in more effective training, but it is not without challenges. One state reports that clinical psychologists once instructed its mental health courses, however, "it was difficult to get the applied aspect since (the psychologists) were outside of the DOC." A potential remedy is to specifically seek psychologists with forensic or correctional mental health specialization and who have extensive experience with criminal justice contexts. For those jurisdictions with limited finances and mental health resources, they may look to the National Institute of Corrections (NIC; https://nicic.gov/), the website of which includes broadcasts, videos, webinars, and empirical reports and implementation recommendations, with topics such as *Inmates with mental illness; Mental illness and violent events: Identifying, managing, and reducing risks; Mental health of prisoners: Prevalence, adverse outcomes, and interventions; Correctional officers and the incarcerated mentally ill*; and *Responses to psychiatric illness in prison.* The American Correctional Association (ACA) also has multiple online modules on mental illness and treatment in correctional settings at www.aca.org. DOCs can adopt a "train-the-trainer" approach in which mental health professionals train CO academy instructors in issues specific to mental health, which the instructors can use when providing preservice training to new COs.

## Mental Health Training Duration

Jurisdictions are markedly different in the length of required mental health training, but training is typically described as lasting between 1 and 2 days and likely comprises only a small portion of CO training overall. We found the average duration of mental health training across jurisdictions is slightly lower than the 10 hr of training COs received in Parker's (2009) study and one fifth the duration of traditional CIT training. Recall that Parker's work suggested that even 10 hr of mental health training may reap safety benefits in correctional settings. In the community, law enforcement departments that adhere to the CIT model provide 40 training hours. We do not suggest that "more" training is better or that quantity is more important than quality. Still, corrections administrators may consider increasing the duration of preservice mental health training to allow time for sufficient content coverage, thereby increasing the opportunity for new COs to develop a refined understanding of the interface of mental illness and the correctional environment.

For COs, maintaining custody while considering mental health may be at odds with each other, and COs may consider custody as incompatible with treatment. Placing increased emphasis on mental health training could help to create a culture of understanding and compassion and decrease stigma of mental illness. In Lambert and Hogan's (2009) study, commitment to organizational goals was one of the strongest predictors of support for IMI treatment. Developing a shared value system through CO mental health training may boost staff morale and willingness to practice learned skills, and ultimately promote effective implementation of their mental health training.

## Mental Health Training Content

We found that all jurisdictions require some form of mental health training, and many requirements were recommended by Parker (2009): education regarding psychiatric disorders, treatment of mental illnesses, and crisis de-escalation. Parker also recommended instruction on biology of mental illness, although this is not identified as a specific course provided by any of the jurisdictions surveyed in this study. The most commonly required course is specific to crisis intervention, with well over three fourths of jurisdictions requiring this course. Courses on general psychoeducation dovetail with this tactic, in that COs may be taught in both courses how to identify signs of suicidal ideation and agitation. This trend appears in line with recommendations in the literature.

Very few jurisdictions require courses explicitly dedicated to specific treatments and programs available for IMI and special populations. We might expect that for CO staff to be successful in implementing their mental health training, they must be familiar with the services available and how to, at least informally, refer individuals who are incarcerateed and in need of mental health treatment. In Dear et al.'s (2002) study, individuals incarcerated in prisons were less likely to approach COs regarding their personal or emotional problems than COs expected. On average, they approached COs

with their concerns about half of the time. If individuals who are incarcerated are aware that COs can direct them to needed services, they may be more likely to engage COs. As a result, COs may have more opportunity to monitor mental health symptoms and IMI may be more likely to utilize mental health services.

Several jurisdictions require instruction on institutional procedures *specific* to mental health. These procedures are likely addressed to some degree in general training, just as other topics (e.g., communication techniques) likely overlap across mental health–specific and general trainings. We commend these jurisdictions for spending reserved time to discuss these procedures with IMI in mind. Very importantly, a handful of jurisdictions require unique programming with a focus on CO mental health. Requiring CO mental health training may be a wise tactic, in that some COs may feel uncomfortable volunteering for a topic that is, unfortunately, stigmatized. It should be noted that although not required, Minnesota offered a particularly rich array of programming on CO mental health: *correctional fatigue, benefits of stress, stress management for officers, and managing depression.*

Stigma appears to be a relatively novel topic in prison settings, despite past work indicating COs are misinformed of IMI and that stigma reduction instruction shows promise in other settings. Specifically, Ellis' (2014) study on the effectiveness of community CIT training found that training improved law enforcement personnel's reported perceptions of IMI. As previously noted (West et al., 2014), IMI are at particular risk of experiencing stigma. One Floridian training staff states that in her jurisdiction, the *Hearing Voices that are Distressing* course was particularly "eye opening for a lot of staff" and increased COs' understanding of the challenges faced by IMI.

## *Practice Implications*

Scholars and researchers underscored that mental health training is needed for COs to effectively execute job duties and that COs indicate a need for training specific to mental health (Appelbaum et al., 2001; Callahan, 2004; Lavoie et al., 2006). It appears that all COs in the jurisdictions surveyed receive *some* mental health training, although duration and course content varies. Of note, instructors and agencies responsible for developing and implementing mental health training are also heterogeneous. Overall, we are unsure how consistently course content is taught across jurisdictions. To ensure adequate training, prison policy makers might consider seeking uniform CO mental health training, potentially from professional organizations such as the NIC or the ACA. Each institution has unique policies, procedures, and resources that are unlikely to be covered by broad ACA mental health training, and so supplemental training specific to the employing institution would also be necessary. Broad mental health training could include psychoeducation, identifying risk and crisis de-escalation techniques, suicide prevention, and mental health stigma reduction. Site-specific mental health training could focus on DOC mental health services and procedures regarding psychiatric restraints and use of force.

In Antonio et al.'s (2009) study, COs reported they felt burdened with greater responsibility in managing IMIs compared with other staff. The authors speculated

this might explain high rates of CO "burnout." Somewhat similarly, COs in Lavoie et al.'s (2006) study reported IMI added significant stress to the job. Although several jurisdictions required courses on CO mental health and self-care, training departments might consider enhancing instruction on stress and coping for COs, given their risk for mental disorder (Carleton et al., 2018a; Carleton et al., 2018b). Stress reduction may help COs to maintain optimal mental health and job performance and to offer additional skills they can provide to IMI in times of crisis.

## *Future Research*

Although this study represents an important first step in assessing preservice CO mental health training, it is only a descriptive "snapshot" and cannot offer insight into the effectiveness of training programs. Given prior research indicating mental health training has institutional benefits and COs have a desire for training, future research should examine mental health training effectiveness, CO satisfaction, and the availability of continuing education specific to mental health. They may also assess whether mental health training (regarding IMI and CO mental health) increases positive outcomes for COs, including decreased work-related stress (e.g., CO mental health) and employee turnover. Researchers might consider a replication of Parker's (2009) study in various correctional contexts, and in particular, assessing whether such a training intervention can reduce behavioral incidents of injury for COs and IMI. Outcome metrics such as frequency of infractions, administration segregation, crisis interventions, acts of self-harm, and completed suicide are also important outcome measures. Skills acquisition, retention, adherence to mental health training, and its efficacy can be examined using longitudinal study designs. Future research should also examine the impact of training in jails specifically, as they generally have a greater number of annual admissions and constitute a unique criminal justice population. Quantity and content of mental health training may differ according to whether specific facilities are accredited by national bodies (e.g., Commission on Accreditation for Corrections, National Commission on Correctional Health Care). Finally, mental health training effectiveness in improving communication between individuals who are incarcerated and COs, reducing mental health stigma, decreasing the emotional labor of CO work, and training adherence are novel and important research areas to explore.

## *Study Limitations*

These data were collected from October 2017 through March 2018, and the requirements reported here might not be in place at this time. For example, some jurisdictions, such as Alabama, update trainings yearly. Furthermore, these data reflect broad preservice CO mental health training requirements at the individual state, District of Columbia, and Federal level. COs serving in individual jails may receive different or additional training within that state (e.g., as reported by Louisville Metro staff, personal communication), and these training practices should be documented in the future.

An additional limitation is that while the COs may be receiving mental health training, they may not be retaining the knowledge or utilizing it in their day-to-day interactions with individuals who are incarcerated. Furthermore, it would be important for future research to examine content retention and use as well as the impact of ongoing and in-service mental health training on metrics relevant to incarceration.

Perhaps the biggest study limitation is the difficulty faced when categorizing course content. However, while we saw variability in course titles, training themes emerged and were used accordingly. Importantly, we were only able to examine course *titles* rather than course materials and content. We acknowledge that despite the discrete categorization used for this study, there was almost certainly content overlap across courses. Course titles alone cannot detail all training content. Despite these limitations, our study is the first survey of CO mental health training and is nevertheless informative.

## Conclusion

COs have the most interaction with IMI in jail and prison settings and are on the "front lines" for de-escalating inmate crises. Research indicates CO mental health training is an important endeavor that can help maintain safety and security in jails and prisons. Although much research has focused on high rates of mental illnesses within incarceration facilities and their association with violations and infractions, little research has examined CO mental health training in prison settings. In our survey of 52 U.S. jurisdictions, we found a high degree of variability in mental health training delivery, duration, and content. Overall, it appears mental health training comprises a small portion of CO training. We encourage jurisdictions to consider placing increased importance on this issue and hope our findings serve as a benchmark for future work examining CO mental health training.

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