July 2026

Crime Victims' Institute
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Enhancing Trauma-Informed Corrections: The Role of Behavioral Health Training for Correctional Officers in Reducing Retraumatization and Revictimization

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Behavioral health is a multidimensional construct that includes mental health and substance use disorders, the impacts of life stressors and crises, and physical symptoms linked to psychological stress (American Medical Association, 2022), all of which intersect more prevalently in correctional settings (Johnson et al., 2016). In these settings, incarcerated individuals often present with a wide range of interrelated needs that extend beyond mental illness alone, including trauma exposure, substance use disorders, cognitive impairments, intellectual and developmental disabilities, physical health concerns, and crisis-related behaviors such as self-harm and suicide (Appelbaum, 2008; Crole-Rees et al., 2024). Correctional environments are marked by a high concentration of individuals with these overlapping needs, resulting in elevated prevalence of behavioral health challenges and heightened risk for adverse outcomes (Armstrong & Griffin, 2004; Griffin et al., 2012). Importantly, these challenges also shape the experiences of correctional staff, who work in chronically high-stress environments (Logan et al., 2022).

Trauma exposure among the incarcerated population frequently stems from multiple sources and is both pervasive and cumulative. Traumatic experiences often occur during childhood, continue through adolescence, and extend into adulthood, where they influence criminogenic behavior resulting in arrest, detention, imprisonment, and recidivism (Fox et al., 2015; Morrison et al., 2024; Sadeh & McNiel, 2015). Large-scale studies show that a large percentage of incarcerated individuals report exposure to one or more potentially traumatic events (Baranyi et al., 2018; Facer-Irwin et al., 2019; Wolff et al., 2014). For instance, the lifetime prevalence of post-traumatic stress disorder (PTSD) in prisons far exceeds community rates, with 30–60% of incarcerated men reporting lifetime or current PTSD symptoms (Wolff et al., 2014), making trauma a near-universal experience for this population (Pettus, 2023). The International Society for Traumatic Stress Studies (2024) also affirms that elevated PTSD rates and complex comorbidities, including overlapping mental health disorders and suicidality, are prevalent within correctional settings.

Correctional officers (COs) often serve as the primary point of contact for incarcerated individuals and are uniquely positioned to influence behavioral health outcomes (Quinn et al., 2025). Their continuous interaction with incarcerated individuals makes their response to behavioral health needs critical for institutional safety and well-being. Exposure to trauma, chronic stress, and repeated crises can also negatively affect officers' mental health, contributing to burnout, emotional fatigue, and reduced job performance (Logan et al., 2022). As a result, behavioral health training has implications for both the well-being of incarcerated individuals and staff resilience. Despite this, correctional staff are often required to navigate behavioral health situations with fragmented and inconsistent training.

The purpose of this report is to examine how behavioral health training for correctional professionals can lead to more trauma-informed interactions within correctional settings. Specifically, we suggest that comprehensive behavioral health training can reduce retraumatization and revictimization among incarcerated individuals and staff. Expanding training beyond narrow mental health frameworks to include trauma, substance use, crisis response, and behavioral regulation allows correctional professionals to better recognize underlying drivers of behavior and respond in ways that de-escalate rather than exacerbate crises, making the correctional environment safer for all.

Overview of Current Behavioral Health Programs

In correctional settings, behavioral health is particularly relevant because it directly impacts safety, compliance,

and interpersonal interactions (Armstrong & Griffin, 2004; Griffin et al., 2012). However, despite its importance, behavioral health has historically been underutilized as a framework for training professionals, with most programs focusing on isolated components rather than a holistic approach (Appelbaum, 2008; Gaber et al., 2025; Miller & Najavits, 2012). Table 1 presents the most common behavioral health training models in correctional settings, highlighting their primary foci and respective strengths and weaknesses.

Table 1. Common Behavioral Health Training Models in Corrections

Training Type	Primary Focus	Strengths	Limitations
Crisis Intervention Training (CIT)	Responding to acute crises	Improves crisis response skills	Often reactive rather than preventative
De-escalation Training	Reducing conflict and escalation	Enhances communication and safety	May lack behavioral health depth
Suicide Prevention Training	Identifying and responding to suicide risk	Strong focus on high-risk outcomes	Narrow scope (does not cover broader BH domains)
Mental Health First Aid	Awareness and recognition	Reduces stigma, increases knowledge	Limited skill application in corrections
Specialized Modules (Trauma, Substance Use)	Targeted domains	Deepens knowledge in specific areas	Often fragmented and not integrated

Holistically, these programs continue to face major limitations. First, many existing training programs maintain a narrow focus on mental health, often excluding other critical behavioral health domains such as substance use, trauma, and cognitive impairments (Appelbaum, 2008; Gaber et al., 2025). Second, numerous programs fail to incorporate trauma-informed principles, limiting their effectiveness in addressing the needs of individuals with extensive trauma histories (Crole-Rees et al., 2024; Miller & Najavits, 2012). This gap increases the risk of re-traumatization during routine interactions. Third, current training models are frequently fragmented, with different behavioral health topics addressed in isolation rather than integrated into a cohesive framework (Gaber et al., 2025; Quinn et al., 2025). This limits COs' ability to apply knowledge holistically in real-world situations.

Behavioral Health Training as a Mechanism for Trauma-Informed Practice

Currently, the existing literature reflects a lack of comprehensive, evidence-based models that address behavioral health as an integrated system. As a result, most training remains inconsistent across jurisdictions and often lacks clear connections to measurable outcomes (Johnson et al., 2016). Among the work on training outcomes, trauma-informed approaches prioritize transparency, safety, trustworthiness, empowerment, collaboration, and peer support (Crole-Rees et al., 2024; Miller & Najavits, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2026). For instance, by minimizing unnecessary use of seclusion, restraint, and avoidable uses of force, correctional practitioners can avoid retraumatizing vulnerable populations, which directly applies to successfully reducing triggers that are endemic to correctional environments (SAMHSA, 2026).

Behavioral health training integrates trauma-informed guidance for security operations and mental health treatment to increase responsivity of the incarcerated population to successful graduation from programming (Gaber et al., 2025; Miller & Najavits, 2012). From a rehabilitation standpoint, the Risk-Need-Responsivity (RNR) framework remains the global standard for matching the intensity and content of interventions to risk and criminogenic needs, using cognitive-behavioral methods for higher-risk clients. Care needs to be taken to ensure the quality and rigor of implementation, especially as behavioral health concerns drive behavior and decision-making. Without strong behavioral health crisis intervention training woven into RNR-based practice, the system cannot fully achieve the responsivity needed to improve behavioral outcomes in custody or support successful reintegration in the community.

When programs are designed for high-risk individuals, consistently maintain quality, and include crisis intervention and verbal de-escalation training rooted in behavioral health principles, they significantly enhance the effectiveness of deterrence-based interventions. A landmark meta-analysis by Landenberger and Lipsey (2005) demonstrated that cognitive-behavioral programs incorporating anger control and interpersonal problem-solving skills for higher-risk clients, when delivered with fidelity, achieve the greatest reductions in recidivism. While it is beneficial to provide mental health and behavioral health treatment programming for the incarcerated population, it is important to focus on skill-building for correctional professionals. Behavioral health crisis intervention training builds verbal de-escalation skills, reducing the need for constant direct observation, fostering a safer environment, and enabling staff to better manage behavioral crisis situations (Price et al., 2015; Price et al., 2024).

Interdisciplinary collaboration among security staff, non-security staff, qualified mental health professionals (QMHP), medical and nursing staff, chaplaincy, case managers, and administration improves communication,

continuity of care, and reinforces professional boundaries. SAMHSA's (2026) implementation guidance emphasizes organizational readiness, and fidelity supports to improve and sustain institutional safety and behavioral outcomes. Behavioral health training is not ancillary but is the core infrastructure for safe, evidence-informed, person-first correctional professional security practices. The high trauma load that affects corrections and community supervision will not decrease without intentional practices trained into the fabric of everyday operations. Well-trained, collaborative teams that operate outside of silos with equal voices enhance mental health treatment and programming to improve reentry prospects while safeguarding staff and institutional integrity. Behavioral health training serves as the primary mechanism for operationalizing trauma-informed principles within correctional environments. Table 2 presents many of these principles.

Table 2. Trauma-Informed Principles

Domain	Definition	Relevance to Corrections	Training Implications
Mental Health	Disorders affecting mood, thinking, and behavior	High prevalence in incarcerated populations; linked to crisis events	Identification, symptom recognition, referral procedures
Trauma	Exposure to violence, abuse, or chronic stress	Drives behavioral dysregulation and crisis escalation	Trauma-informed communication, trigger awareness
Substance Use	Misuse of drugs/alcohol and withdrawal effects	Linked to behavioral instability, health crises	Recognition of withdrawal, behavioral indicators, response protocols
Self-Harm & Suicide	Intentional self-injury or suicidal behavior	Major safety concern in facilities	Risk assessment, monitoring, intervention strategies
Cognitive and Developmental Disorders	Impairments in thinking, learning, or functioning	Affects compliance, understanding of rules	Adapted communication, behavioral management
Crisis Behavior	Acute emotional or behavioral escalation	Directly impacts safety and order	De-escalation, decision-making under pressure

While policies may endorse trauma-informed care, frontline correctional professionals must translate these principles into daily human interactions. Thus, comprehensive behavioral health training can expand officers' ability to: (1) recognize trauma-related behaviors, (2) understand the relationship between trauma, substance use, and mental health, (3) apply de-escalation strategies that reduce perceived threats, and (4) respond to crises in ways that prioritize stabilization over control. By integrating trauma education with crisis response and behavioral management strategies, training can bridge the gap between security operations and behavioral health awareness, in turn reducing retraumatization and feelings of revictimization.

Reducing Retraumatization and Revictimization

Retraumatization occurs when individuals are exposed to situations that replicate elements of past trauma, triggering emotional or physiological responses similar to the original experience (International Society for Traumatic Stress Studies, 2024; Miller & Najavits, 2012). In correctional settings, retraumatization may occur through aggressive verbal commands, physical restraint or use of force, isolation or confinement, or perceived loss of control or autonomy—experiences that are common in correctional environments (Crole-Rees et al., 2024; Pettus, 2023). Without adequate training, correctional professionals may unintentionally contribute to these dynamics, reinforcing cycles of distress and behavioral escalation (Griffin et al., 2012; Johnson et al., 2016).

Behavioral health training that incorporates trauma-informed practices and principles can reduce re-traumatization in several ways (Crole-Rees et al., 2024; Miller & Najavits, 2012). First, training can emphasize the need for effective communication strategies that minimize perceived threat. Additionally, impactful training can promote awareness of triggers and behavioral cues, enabling professionals to better detect and respond promptly to these issues, thereby supporting proportional and appropriate responses to behavioral incidents. Ideally, training would also emphasize de-escalation before force, thus decreasing the likelihood that the individual would be retraumatized in such an event (Price et al., 2015; Price et al., 2024).

Similarly, revictimization refers to the process by which individuals experience repeated victimization over time, often due to underlying vulnerabilities (such as cognitive impairments) or environmental factors. In correctional settings, individuals with trauma histories are at heightened risk for further victimization through stressful, aggressive, or violent interactions with staff or other incarcerated persons (Kennedy et al., 2021; Listwan et al., 2014; Worthey et al., 2022). Thus, behavioral health training can play a critical role in reducing revictimization by improving staff capacity to identify vulnerable individuals, enhancing monitoring and intervention strategies, and reducing reliance on punitive responses that may increase risk (Griffin et al., 2012; SAMHSA, 2026). Moreover, training can promote consistent and fair treatment across individuals. In essence, by addressing behavioral health needs that contribute to vulnerability, training can disrupt cycles of victimization and improve overall institutional safety. Of note, these practices are not meant to compromise security; in fact, they should enhance it by reducing the likelihood of escalation and improving compliance (Crole-Rees et al., 2024; Miller & Najavits, 2012).

Why Behavioral Health Training Matters

Correctional professionals must understand mental health conditions, intellectual and developmental disabilities, substance use, trauma, suicide risk, and their own attitudes and reactions to reduce burnout, maintain professional boundaries, and ensure safe, consistent operations (Armstrong & Griffin, 2004; Schultz & Ricciardelli, 2025). At the same time, recognizing and addressing the behavioral health needs of incarcerated individuals is essential for preventing crises, intervening effectively when they occur, and sustaining long-term, multidisciplinary solutions that extend beyond the immediate moment (Appelbaum, 2008; Johnson et al., 2016; Miller & Najavits, 2012). To move from reactive to proactive practice, correctional systems must equip staff with behavioral health-informed crisis-intervention and verbal de-escalation skills that strengthen safety, enhance program effectiveness, and support a more stable correctional environment (Price et al., 2015; Price et al., 2024; Quinn et al., 2025).

Victimization in correctional environments is often repeated and multi-type (polyvictimization), with risks shaped by both individual factors, such as prior trauma, mental illness, and institutional conditions, such as overcrowding and supervision practices. Studies of releases of incarcerated individuals confirm these patterns and their policy relevance (Listwan et al., 2014; Pettus, 2023). For example, sexual victimization, witnessing violence, and physical assaults occur both prior to custody and among the incarcerated and affect both men and women (Listwan et al., 2014). Clusters of polyvictimization in childhood are strongly associated with suicidality, psychosis, and dissociation during custody (Kennedy et al., 2021). Prolonged, repeated, interpersonal trauma increases risk for complex post-traumatic stress disorder (CPTSD) symptoms, which affect self-regulation, the development of a negative self-concept, and interpersonal challenges, which make resident management, security, and rehabilitation efforts less effective. Chronic traumatic experiences predict the development of CPTSD and higher levels of functional impairment, which present an opportunity for correctional environments to focus on trauma prevention and mitigation efforts to increase the chances of positive outcomes for the incarcerated population (Maercker et al., 2022; Psychotraumatology, 2025). It is imperative that multi-component therapies that are phase-based and tailored to CPTSD are utilized for incarcerated populations where ongoing triggers are common (Crole-Rees et al., 2024; Faust et al., 2024; Lee et al., 2026).

Justice-involved populations have an elevated exposure to community violence prior to incarceration and, while they are in custody, may witness or experience assaults, suicide attempts, self-harm, fires, and pervasive threat factors that are linked to aggression. An aggregate of these traumatic situations is correlated to relapse and rearrest (Favril et al., 2020; Novisky, 2024; Worthey et al., 2022). The local jail environment, in particular, is characterized by a rapidly rotating population: 7.6 million individuals enter jail annually on average, and they stay an average of 32 days (Zeng, 2025). Heterogeneous conditions and limited programming combine to raise stress, disrupt continuity of care, and magnify trauma exposure both for residents and staff.

In Texas, oversight by the Texas Commission on Jail Standards (TCJS) has documented persistent overcrowding and staff shortages, which complicate efforts to maintain behavioral health continuity of care and effectively maintain a safe environment for crisis prevention and intervention efforts (Morris & Edwards, 2022). Jail suicide rates remain a critical issue, with historical analyses in Texas indicating that suicides comprise a disproportionate amount of jail deaths (Farris & Holman, 2024; Pishko, 2024). Suicide is the only cause of death occurring at a higher rate in local jails than in the general population, which underscores the need for robust suicide prevention policies, effective training, and a multi-disciplinary team approach to improve operationalization of behavioral health as a core competency of the correctional professional. Compounding factors, such as mandatory overtime, non-custodial staff being pulled into security roles, and high staff turnover, undermine behavioral health services and create a volatile work environment (Schultz & Ricciardeli, 2024).

Current Efforts

The Texas Department of Criminal Justice (TDCJ) has implemented a comprehensive competency-based education (CBE) model to strengthen behavioral health crisis intervention skills across correctional operations (TDCJ, 2026). Because behavioral health is inseparable from institutional safety, the agency's current approach centers on building measurable competencies through scenario-based learning, multidisciplinary collaboration, and continuous skill reinforcement. The model aligns with validated behavioral health core competencies and is designed to ensure that knowledge learned in the classroom transfers into consistent, on-the-job crisis prevention, intervention, and resolution. These

competencies currently guide the structure of in-service, supervisor training, advanced Behavioral Health Crisis Intervention Training (BHIT), and train-the-trainer programs, with ongoing work to validate additional competencies in decision-making and crisis management to further enhance training fidelity and evaluation.

TDCJ's competency-based framework defines clear learning objectives and performance expectations at each training level (TDCJ, 2026). Pre-service training emphasizes foundational recognition of behavioral health conditions, crisis indicators, legal and ethical responsibilities, and basic de-escalation communication. Cadets must demonstrate communication skills that preserve safety and professional boundaries, apply structured crisis-response decision-making, and verbally express empathy and validation in scenario-based evaluations. In-service and supervisor in-service training reinforce these skills while elevating expectations for behavioral cue analysis, advanced verbal de-escalation, trauma-informed practice, collaborative crisis response, and complex decision-making in ambiguous situations. Staff are assessed on their ability to integrate crisis-management principles into daily operations and to apply behavioral health intervention techniques to reduce avoidable uses of force and enhance institutional safety.

Advanced BHIT training serves as the capstone experience. It prepares staff to lead crisis response efforts, coordinate within multidisciplinary teams, and apply advanced behavioral health strategies in high-risk situations. Participants are expected to accurately identify behavioral patterns, triggers, suicide and self-harm indicators, and to execute sophisticated crisis-intervention strategies during intensive scenario-based exercises. This training represents the highest operational level of behavioral health competency development within TDCJ. Finally, the BHIT Train-the-Trainer program develops instructional leaders capable of evaluating performance, facilitating structured after-action reviews, training in-service and advanced BHIT courses, ensuring program fidelity, and mentoring fellow staff in person-first, trauma-informed practices. Monthly shift-turnout refresher training provides the micro-learning needed to ensure knowledge retention and reinforce a shared culture of behavioral health awareness across each BHIT facility.

Behavioral Health Crisis Intervention Model

TDCJ is actively expanding its BHIT program as a core component of operational readiness (TDCJ, 2024). The Advanced BHIT course is a five-day, 40-hour in-person training that integrates a suicide prevention certification (AS+K? Suicide Prevention Gatekeeper Training), APEX virtual reality scenario-based immersive learning, a voices simulation experience that replicates auditory hallucinations, and extensive performance-oriented training to enhance empathy and strengthen verbal de-escalation skills for working with vulnerable populations. Participants also receive in-depth training in mental health and illness, intellectual and developmental disabilities, substance use disorder, trauma, crisis recognition, and crisis resolution.

This intensive training is targeted to senior correctional officers, sergeants, lieutenants, captains, laundry managers, food service managers, self-harm prevention officers, and crisis management staff. These groups serve as critical leaders on the unit and reinforce the philosophy that behavioral health is security. This principle is central to creating safer environments for staff and incarcerated individuals. The curriculum emphasizes non-escalation, preventative problem-solving, effective communication, and leadership strategies that contribute to a healthier institutional culture. It also orients ranking staff to their roles in crisis identification, prevention, and effective resolution, which are essential components of maintaining safety and reducing use-of-force incidents across the agency.

As of FY25, TDCJ operates 27 BHIT units statewide, with a layered expansion planned to reach 47 units by Fall 2026 (TDCJ, 2026). In addition, the BHIT model is now being delivered to parole professionals. This cross-system expansion supports responsivity across the full correctional continuum from institutional settings to community supervision to ensure consistent crisis-intervention expectations regardless of the setting. TDCJ has established a system of multidisciplinary teams to ensure that training is effectively translated into operational practice. These teams serve as the "bridge" between the Training and Leader Development Division (TLDD) and the day-to-day operations of the Correctional Institutions Division (CID). Each BHIT unit's team includes an evaluator, Senior Warden, Assistant Warden, Majors, self-harm prevention staff, mental health and nursing managers from the University of Texas Medical Branch (UTMB) or Texas Tech University, and a designated BHIT unit champion.

Their role is to assess behavioral health incidents, develop prevention strategies, coordinate crisis response, reinforce positive staff interactions, and ensure that standard operating procedures reflect behavioral health

best practices. They analyze incident data, track behavioral trends, and support the implementation of intervention plans tailored to individuals at higher risk. Teams also maintain open communication with leadership and provide feedback for ongoing program improvement. Outcomes tracked across units include uses of force, staff assaults, suicide attempts, self-harm incidents, staff well-being, staff retention, and the institutional climate, which are all critical indicators of program effectiveness.

The ongoing expansion of the CBE framework aims to bridge theory to practice by ensuring behavioral health crisis intervention skills are deeply embedded in daily operations within institutions and parole officer community supervision through the BHIT model (TDCJ, 2026). A validated evaluation framework that aligns core competencies, learning objectives, institutional procedures, and training outcomes ensures that training quality and behavioral health professionalism are consistently maintained across the correctional workforce. As the model grows, its purpose remains to strengthen professional conduct, reduce preventable harm, improve outcomes for staff and the incarcerated population, and close longstanding gaps that affect safety and quality of life across the correctional system.

Conclusion

It is important to acknowledge that behavioral health should be more than a peripheral concern within correctional systems, as it is a key driver of safety, stability, and effective operations. The high prevalence of preexisting trauma, mental health conditions, substance use, and cognitive impairments among incarcerated populations underscores the limitations of traditional, fragmented training models that address these issues in isolation. By contrast, comprehensive behavioral health training, which is grounded in trauma-informed principles and implemented through structured, competency-based approaches, can provide correctional professionals with the tools necessary to recognize underlying drivers of behavior, respond proportionally to crises, and reduce cycles of retraumatization and revictimization. In doing so, behavioral health training becomes a mechanism through which correctional institutions can move from reactive, incident-driven responses to proactive, prevention-oriented practice.

The broader implication of this report is that strengthening behavioral health competencies is essential to advancing both institutional safety and long-term outcomes for justice-involved individuals and staff. Systems that invest in integrated training frameworks, interdisciplinary collaboration, and ongoing skill development are better positioned to reduce avoidable use-of-force incidents, improve staff well-being, and enhance care across institutional and community settings.

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