Case Examples of Working with a Felony Correctional Population: The Usefulness of ACEs

The descriptions below have been altered to protect the rights the offenders have to confidentiality. The essence of the vignettes is wholly true and accurate.

I would begin by pointing out that nearly all offenders I have supervised appear to have experienced a large number of ACEs. In interviewing over a thousand offenders being sentenced for felonies (for the Pre-Sentence Investigation) I inventoried the discipline used in their home. In each case I asked about physical abuse, sexual abuse and nutritional neglect, as well as the relationships between the parents (separation and divorce) and sexual abuse. I also asked for specific information about the parents history of alcoholism and other substance abuse, and domestic violence. My inventory did not include all of the categories covered in the ACEs research. It was rare that I found someone who, by the ACEs standard, had not been physically abused. Parental substance abuse, domestic violence, separation/divorce and mental health problems were also frequently reported. My observations of offenders, both male and female, were also suggestive of high ACE scores among most offenders. However, this is not an evidence based reflection, but rather an anecdotal observation.

My interviews of those offenders and also of offenders under supervision commonly saw offenders who were quick to react to challenges, confrontations or disagreements regarding their behavior. This is characterized by a common refrain among correctional staff: “felonious stupidity.” The offenders’ behaviors’ in the community (their criminal behavior) was usually characterized by impulsive responses to stressful situations. The carefully planned burglary, for example, was a rarity. Offenders’ abilities to reflect on their own behaviors and personalities were usually quite limited, at least prior to any form of counseling, or for offenders who had “grown up” and out of the offender population, i.e., offenders who were 35 years or older, and had spent long periods of time incarcerated. The correctional research suggests that offenders to change lifestyles at about age 35, when they “burn out” on lives of crime. This is significant in what it says about resiliency.

So, in the case examples that follow, I cannot give precise accounts of the ACEs in individuals histories, usually, but rather surmise based on their personal histories and interview behavior that they have cognitive impairments probably attributable to their childhood ACEs. Sometimes, specific information was known regarding rearing and childhood experience, and that information is recounted in the descriptions below. I mention this because someone reading this information might challenge the assertion that I didn’t know for sure what the ACEs were for individuals, and they would to some extent be correct. The value of this is probably not in connecting real life ACEs with adult behavior, but rather to show how understanding of ACEs can modify a correctional officer’s approach with some success.

1. The first offender was a Native American who was raised in the harsh environment of a state in the Northern U.S. He was raised by his grandparents from age 9, because his own parents were alcoholic and did not provide for him. He did however, have clear recollection of his early life, which included physical abuse, emotional abuse, alcohol addicted parents, malnutrition, parents absent from the home, etc. He had been under correctional supervision for many years, and had established a reputation as a hard core drug addict, who ended up in Seattle, when came here for a rock concert, and was arrested after he bought some drugs, and sold some of leftover drugs to an undercover cop. He ended up in prison, was released homeless, and because he was convicted here, his home state refused under the probation rules to accept him back until he had completed substance abuse treatment, had established employment in Washington, but had promised employment in the receiving state, and had a family willing to accept financial responsibility for his maintenance when he returned if his job fell through. His family lived 50 miles from the nearest town, and the nearest employer.

With nowhere to go upon release on parole, he was immediately homeless, and the only friends he had were former prison releasees, who were now homeless, but taught him how to survive on the street. This included using alcohol and drugs, which resulted in 20+ arrests for violation of his condition to remain substance free. He had been supervised by over a dozen officers before he reached my caseload. He was know to them, largely because of his appearance, as a drunken angry Indian. “Watch out for him. He’ll go off when you aren’t expecting it.” His violence history resulted when he shoplifted a case of beer from a convenience store, and since he brushed the security guard on the way out, the offense was 2nd Degree Robbery, rather than shoplifting. This was confirmed by file material.

I assumed he had had a harsh upbringing (lots of ACEs,) and this was confirmed by his file, as well as his retelling of his own background. I began by asking him early in our first interview to tell me about his tribe and it’s traditions. I don’t know whether any officer had ever asked him this before, and there was no mention of his heritage in the file, but he immediately opened up, and began speaking with pride: “My tribe is know because we are tough. We can handle any challenge….. We can do anything. It’s tough where we grew up and we had to be tough to survive.” This began a good relationship, in that he seemed to be relaxed during our interviews. Much to my surprise, and the surprise of the other officers who knew him well, he continued to report regularly.

As expected his urinalysis came up dirty for cocaine, and he admitted he had been drinking. The Department required sanctions for violations, and rather than arresting him and imposing jail time, I reached an agreement that he would begin reporting weekly, and he also had to drive around with me in an agency vehicle, and show me places where he spent his time in the streets, where he did drugs, etc. He showed me a vacant building with a stairwell to the basement, where he said he would light his crack pipe when the wind was to strong to light it on the streets.

I asked him about his conditions, (the usual 25 conditions) and he said he just realistically never saw himself quitting drugs and booze. He had made some half hearted efforts, but they always failed, and he thought his only hope was to go back to his grandparents home, someday, because it was 50 miles from the nearest source of drugs. Obviously, that possibility was not going to happen because of rules between the various state correctional agencies.

After a couple months dirty UAs, more sanctions, etc., he came in one day without an appointment, and pleaded with me to help him get into a detox program. He felt that he had to do this because his currently life was so miserable, he was tired of being sick, and he was willing to try anything. At no time had I ever discussed requiring an inpatient treatment program for him. This was initiated entirely by him. The detox program said they couldn’t take him until Tuesday of the following week at 10:45AM. A Department staff member had to bring him, with documentation, etc. I wondered whether I could expect him to remember and show over five days into the future…..

Basically, I applied what I knew about ACEs in my supervision strategy with him. I assumed, correctly I believe, that he had a high cortisol level from stress during the first eight years of life, and being confrontational would only increase his cortisol now, create impulsiveness and resistance and reduce the likelihood of his cooperation. As much as possible, I asked questions, and gave him the chance to respond in his own way, never indicating judgment of him, never giving orders, or trying to force him to do anything. (This approach had failed in the past many times.) Surprisingly he was anxious to talk about his tribe’s Native American traditions, his family, and indicated his grandfather was a famous American chief. (I wrote down and looked up the grandfather’s name on the internet, and there were hundreds of references to his grandfather.)

Tuesday came and he showed up, hung over, disheveled with backpack in hand. I took him to the detox center. We waited an hour before he was taken into the reception area, and I wished him well. That was the last I saw of him.

1. This female offender had been homeless since age twelve. She ran away after being raped by her grandfather for many years. Her own mother was an alcoholic drug addict, and she never knew her father. She had been under supervision for about two years. She appeared to be 16, but her age was actually 20. I first met her when I was advised that she had been picked up in a “street sweep” when a Department officer working with police found her in a drug stupor in downtown Seattle. I was called down to the paddy wagon, and I observed the Officer literally screaming at the offender for five minutes: “You’re high aren’t you… You’re gonna die…… When are you going to grow up?!.... etc.” This officer was renown for her tactics and beloved by the police because she was “tough” on offenders. I asked the officer why she spoke that way to the offender. She told me that since the offender was high on drugs, the only way you could get through to her was by yelling.

I took her up to my office where she sat down, and I quietly engaged her in a conversation. She survived currently as a prostitute for an Asian gang member pimp. She was five months pregnant, a drug addict and homeless. Her fingernails were dirt encrusted. She made little eye contact, and said very little. I asked her what she wanted to do, and she said, “leave.” We continued to make small talk, and I gave her my card, and asked her when she would like to come back to see me. She said tomorrow in the morning. I agreed, and said I was looking forward to seeing her again. I asked her to be thinking if there was anything I could do to help her.

She didn’t come back, and I issued a warrant for her arrest. The following week, I received a call from a jail counselor advising she had been arrested on the warrant, and she specifically asked to talk to me. I went to the jail to talk to her at the next opportunity. Her demeanor was similar to our first meeting but her message was different. She asked that I help her get into a program she had heard about for pregnant homeless women. She said she knew she had to do something to protect her unborn, and if she went back to her pimp, it would turn out bad. She knew now that she had to make a change. If she went back to her pimp, it would be just more of the same. She was calm but determined. She wanted to change. Would I help her.

She was accepted into the facility she had heard about with the help of a public health nurse. This was the first positive change ever recorded in her Department file. She was transferred to another caseload, because the home was outside my area. I never heard about her again.

As with the first case, I applied my understanding of ACEs by creating an environment deliberately intended to reduce stress and confrontation. I assumed that she would have difficulty making good decisions under those circumstances. I only hoped that by taking a different approach, there might be a different outcome.

1. This parolee was homeless at age 9 when he left his uncle’s case because, according to his three inch thick file, his uncle had repeatedly raped him from the time that he moved in after his parents abandoned him. He spent several years in foster care until he was convicted of repeated thefts and sent to a juvenile institution. While there, he put LSD in the staff coffee pot, a felony assault. When he was 16 and released from juvenile custody, he was soon arrested for robbery, and at 18 was convicted, and went to serve his time at the Washington State Penitentiary. The WSP at the time was governed by the inmates, guards had little control. Upon arrival, being a young, attractive male, he was raped by no less than 10 inmates.

You can guess how many ACEs he had. It’s all speculation, but undoubtedly he had many. I inherited the caseload of another officer who had transferred to another office. The parolee came into my office one morning. Now he was 55 years old, but looked closer to 70. He limped, and had trouble dragging his backpack, which contained all his worldly possessions. I offered and he accepted my offer to carry it for him back to my office, (much to the surprise of other officers, whose ethos is never touch possessions of offenders, unless you have to subsequent to search and arrest. But an act of kindness was out of the question.) He sat down in the chair, and gradually began talking quieter and quieter. Soon, he was unconscious. I telephoned 911. He had gone into a diabetic coma, I later learned, not a drug induced stupor. He had arthritis, diabetes, failing circulation in his legs kidney failure (on dialysis) and who knows what else.

He came to see me one morning the next week after being released from the hospital. When he sat down, I asked him whether he had had anything to eat or drink that morning he said no. I kept protein bars and energy drinks, soda pop and V-8 juice in my overhead credenza. I hoped it and asked if he would like something, thinking he would like soda or an energy drink. He wanted the V-8 juice. We spent the rest of the interview talking about his hospital stay, his kidney dialysis, and whether he would like to stay in a shelter. He declined, saying he preferred sleeping in an alley in downtown Seattle. The police had confirmed for me that they had tried to get him into a shelter, but he refused. It was January and those who knew him were afraid he would freeze to death. He was usually belligerant, even threatening the public health nurse once who was administering his dialysis. I did mostly listening. I didn’t tell him what he had to do. I didn’t give him orders. He really didn’t talk much, but his eye contact was actually good. He was looking directly at me as we talked. I thanked him for coming in, and asked him when he would like to come back. He chose a day next week, and we got ready to leave. I picked up his back pack to carry for him down the long hall to the waiting room. He walked ahead of me, as staff required of all offenders so we could subdue them from behind if they suddenly turned violent, or burst into another office and attacked an unsuspecting officer. As he walked, I said in a quiet voice, don’t you have a condition to have a mental health eval? I knew he had this requirement for years, and had never complied.

“Yeah,” he said. “And I should. I got things deep down, deep down I should talk to someone about…..” I said nothing after that. He left the office.

The next afternoon, I got a call from the Public Health nurse coordinating his dialysis and other health treatment. She said the offender had told her that he had a parole requirement for a mental health evaluation, and they had a female social worker in their office. She was not licensed, but would it be acceptable to the parole board for this nurse to interview him for that requirement. Yes, I assured her, it would.

The following week, I received a two page social history summery from the social worker regarding her interview with the offender. Some of the information was confirmed in his file, (juvenile history, etc.) but much of what he revealed had never been known before.

Approach this offender with the understanding that much of his mental and social functioning was the result of his childhood trauma (ACEs,) I think had much to do with helping him take a first step toward finding a new path, different from the one he had led most of his life.

1. This offender was a heroin addict. He also had some schizoid characteristics and would sporadically receive some counseling for them. He routinely failed to report to the office, because he would always test positive for heroin. He had been living in a residence in down town Seattle, but was kicked out because he had failed to return by curfew, and follow similar rules. He was homeless and struggling to find another place to live, which he did eventually find. When he did report to me the first time, he said his UA would test positive, and he was surprised when I told him I would not arrest him, because I respected his honesty. He visibly relaxed during the interview, probably because this was the first time he had ever been treated that way. Instead, I asked him to describe his struggles with heroin, when they began and what he would like to happen. He said he really wanted to quit heroin, but just couldn’t and he wanted to get back into mental health treatment, which he felt was helpful, but because he was always relapsing, he didn’t think it would help him.

As a sanction for his dirty UAs, I had him write short essays on topics such as: what situations lead him into when he uses, and what he would gain if he got into the mental health treatment program, and what he would like for his long term goals. The last was the most difficult for him, and like most offenders had great difficulty imagining a bright future, a future of dreams, let alone dream fulfillment.

One day he came into my office, and we made small talk, but I noticed that his leg was bouncing up and down, really jittery. After a few minutes, I asked him what it was with his leg. I imagined it was because he was wondering how long I would continue to allow dirty UAs before arresting him. I was wrong. He said, “I’m nervous, because this is the first time with DOC that I’ll ever give a clean UA, because I haven’t used any heroin since the last time I came in!”

1. The next guy I only interviewed about three times. He was really polite, but showed very little affect. Supervision seemed to him to simply be another hurdle he needed to pass over, and he was creating the best impression he could. Our first two interviews were really humdrum. Then I received a police report that during one afternoon, he was identified by a victim and police as having “keyed” a new Mercedez Benz in a large parking lot. The reporting officer commented that he smelled alcohol on the offender’s breath and he appeared obviously intoxicated. I made an appointment with the offender to discuss the incident and make plans for a hearing to determine whether he had violated any condition of supervision. He came in, and I thanked him as I usually do, and briefly described the report, which described him as appearing intoxicated. He immediately raised his voice, accused the police officer as lying in the report just because some man looked rich in his Mercedez, and the “victim” just wanted to get a new paint job.

I asked him about alcohol, and he said in a louder voice, “I’m not an alcoholic!” I said I wasn’t accusing him, and he repeated it again. I tried to change the focus of the interview to a more neutral aspect, asking him for his ideas about what should be done about the report. I explained it had to be handled either with a DOC hearing and sanction IF he were found guilty, or by reaching an agreement between ourselves. He persisted in his claim “I’m not an alcoholic….” Several more times, and I repeated I wasn’t accusing him, but it didn’t look like we could get much done to day (a Thursday.) I asked him to think about what we should agree upon, and to come back next Tuesday morning to talk further about it. He agreed and abruptly left the office with no further words exchanged.

Monday morning he called me, and he said he had been doing some thinking, and he had decided to go into an alcohol treatment program. Did I know about the Riverside program, a two yearlong religious based inpatient program. “Yes, I know about the program, but I don’t think a two year program would really be necessary to handle the situation arising from the parking lot. Usually, the DOC would recommend an outpatient evaluation, or at most a 21day inpatient treatment program.

He responded saying he had done a lot of thinking, and he knew that a 21 or 28 day program wouldn’t be enough for what he needed. He said he knew he needed help to reorganize his life and make some substantial changes. He said he had already contacted Riverside and applied, they had openings immediately, and he qualified for financial support for the program. Did I give him permission to change residence to Riverside? Yes, I said. He entered the program and after a few weeks, I transferred supervision to the office near Riverside.

Who knows what ACEs he might have had. I didn’t, but his behavior, his sudden response, his alcoholism, his underlying offense, (an altercation with roommates involving a rifle, whom he claimed tried to rob him of his personal savings kept in a box,) and his erratic change in behavior are all suggestive of cognitive impairment, only partially attributable in my opinion to alcoholism.