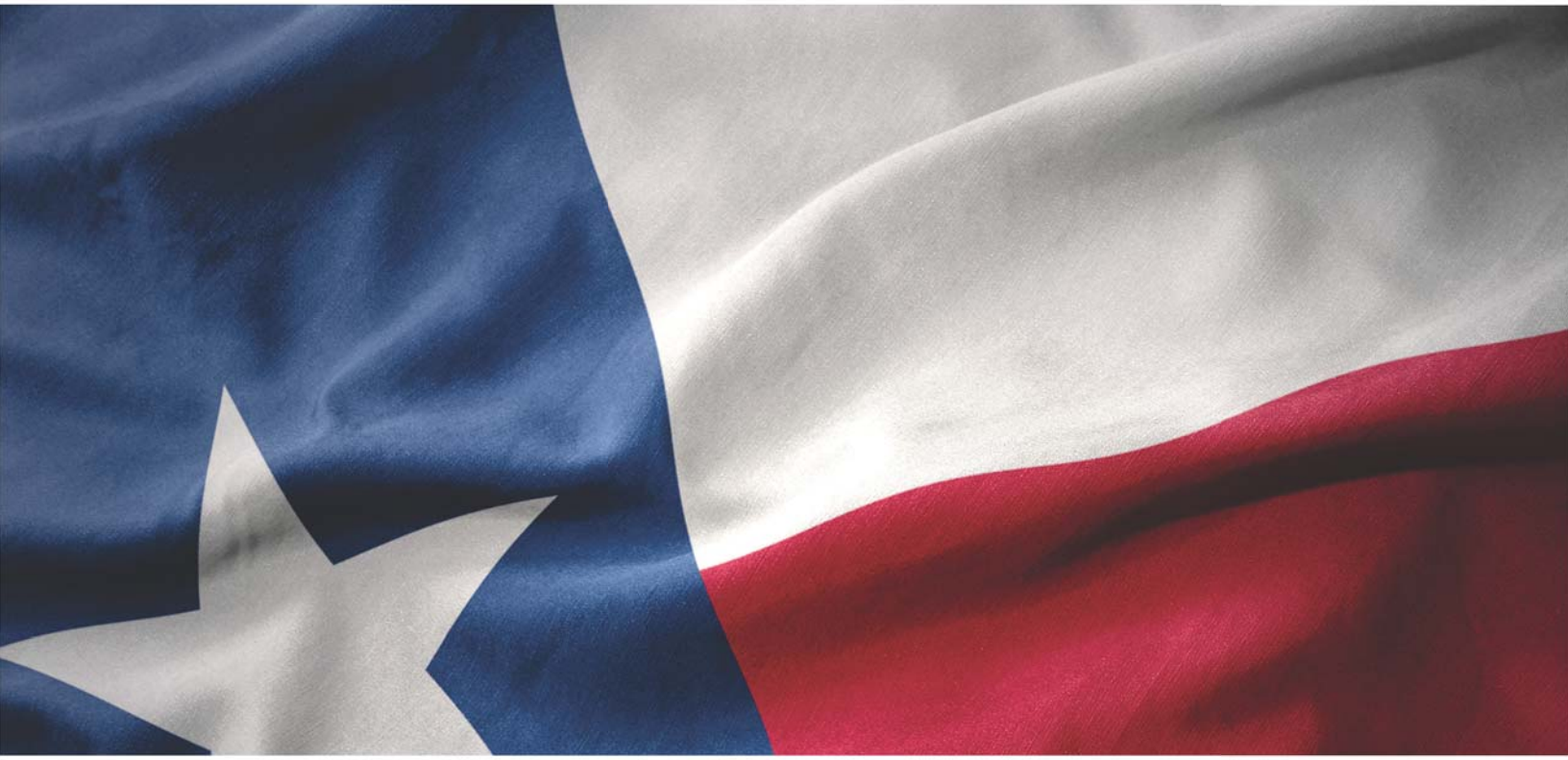
Jail Mental Health Officer

A Texas Mental Health Training Initiative for Jails



Participant Guide

Revised November 2018

To better serve the public and those in crisis entering the criminal justice system, a partnership was formed, with the Sheriff's Association of Texas spearheading the initiative, to create a crisis intervention training specific to Texas jails and its jailers.

A focus group was brought together by the National Institute of Corrections (NIC). Participants included Substance Abuse and Mental Health Services Administration (SAMHSA), the United States Marshal Service (USMS), Texas Department of Health and Human Services (HHS), Texas Correctional Office on Offenders with Medical or Mental Impairments, Texas Veterans Commission (TVC), Texas Commission on Jail Standards (TCJS), Texas Commission on Law Enforcement (TCOLE), Sheriff's Association of Texas, American Jail Association (AJA), Texas Jail Association (TJA), Correctional Management Institute of Texas (CMIT), clinical faulty from the Psychological Services Center, Sam Houston State University, Texas A&M Engineering Extensions Service (TEEX), Harris County Sheriff's Office, as well as representatives from Florida, Ohio, Nebraska, Wisconsin, and California jails.

Over 25 Sheriff's office in Texas committed to sending individuals to be certified and continue the "force multiplying" effect as master trainers. These trainers will return to their agencies as well as rural host agencies to train jailers throughout the State.

The Sheriffs of Texas understand the need for increased training for crisis intervention within a jail setting. As we are charged with the care and custody of those within our jails, we look for innovative methods to assist those under our care.

It has been with the leadership and commitment of the Sheriffs of Texas in pooling limited resources, building collaborations and providing trainers, this initiative will be the model for other states to follow.

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Copyright Information

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This publication was developed by the Texas A&M Engineering Extension Service and Harris County Sheriff's Office, Bureau of Mental Health and Jail Diversion. The Texas Mental Health Training Initiative for Jails wishes to thank the Sheriff's Office for their services and state recognized subject matter expertise for mental health crises dealt with by law enforcement.

The safety statements, procedures, and guidelines contained in this manual are current as of the publication date. Prior to using the safety statements, procedures, and guidelines contained in this manual, it is advised that you confirm the currency of these statements, procedures, and guidelines with the appropriate controlling authorities.

Table of Contents

Module 0

Course Introduction

Terminal Objective

Upon successful completion of this module, participants will be able to state the course goal and what is required to receive credit for participating in this course.

Enabling Objectives

1. State the course goal.
2. Describe the course administration requirements and techniques employed.

About This Course

Course Goal

Upon successful completion of this course, participants will be able to relate key mental health issues to their daily operations within a jail setting.

> **Note:** This course is not intended to replace medical personnel advice. The content in this course is presented for informational purposes. Always contact a medical professional or other certified mental health professional for further assistance and guidance.

Target Audience

Any individual who works in a jail setting.

Prerequisites

- Completion of Course #1120 - *2018 Basic County Correction Course*, OR
- Course #4900 - *Mental Health for Jailers*, OR
- Course #1850 - 40 HR. *Crisis Intervention*, OR
- Course #3841 - *CIT*, OR
- Course #3843 - *CIT Update*.

Recommended Training

Interpersonal Communications in the Correctional Setting Course #3503, Texas Commission on Law Enforcement

Course Length

40 hours

Instructor-to-Participant Ratio

1:24

Testing/Certification

The instructor will use oral questioning during the presentation of each module to assess participants' mastery of the material. Problem areas identified during questioning will be reviewed in further detail.

The use of scenarios and course activities throughout the course are used to assess participant understanding and application of knowledge and skills obtained throughout the training. Feedback and discussion of responses further allows the instructor to assess mastery of the material.

Registration and Attendance

Attendance is crucial in order to receive credit for this course. All participants must complete a registration form at the beginning of the course, sign the attendance roster for each day of the course, and complete the evaluation at the end of the course in order to receive a certificate of completion.

Evaluation Strategy

A course evaluation and an instructor evaluation are provided to the participants after the course to assess the quality of the course material and the instructor's performance. An After Action Review (AAR) is performed at the conclusion of the course by the instructor with the participants to determine if the course sufficiently met the overall goal and that the chapters met the course objectives. This allows the participants the opportunity to provide feedback for improvements to the course and its delivery.

Course Structure

Module 0: Course Introduction and Welcome	1 hour
Module 1: Introduction to Mental Health	2.5 hours
Module 2: Communication and De-escalation	3 hours
Module 3: Mood Disorders	1.5 hours
Module 4: Thought Disorders	2 hours
Module 5: Personality Disorders	2 hours
Module 6: Cognitive Disorders	1.5 hours
Module 7: Psychopharmacology	1 hour
Module 8: Substance Abuse and Co-Occurring Disorders	1.5 hour
Module 9: Intellectual and Developmental Disorders	1 hour
Module 10: Post-Traumatic Stress Disorders	1.5 hours
Module 11: Suicide	1.5 hours
Scenarios	14-16 hours
Mental Health Consumer/Medical Professional/Site Visit	1-4 hours
Module 12: Care Considerations for Officers	1.5 hours
	40 hours

Course Materials

Objectives

- Terminal Learning Objective (TLO) describes what participants should be able to do on the job after completing the module.
- Enabling Learning Objectives (ELO) describe what will be accomplished during the module.

Narrative

Each module includes a detailed narrative summary of all material covered in the module and is designed to be used as post-course reference materials. Embedded within the content are statements of support from individuals related to the training initiative.

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Module

1

Introduction to Mental Health

Terminal Objective

Upon successful completion of this module, participants will be able to outline how mental health and mental illness impact officers and the population they serve.

Enabling Objectives

1. Discuss the mental health crisis in the United States as it pertains to criminal justice personnel.
2. Define mental health, mental illness, functional deterioration, crisis, and insanity.
3. Explain the current statistics and realities of mental illness.
4. Explain the role of crisis intervention training (CIT) in mental health situations.

Criminal Justice and the Mental Health Crisis

Responding to the mentally ill, whether in a correctional facility or on the streets, is one of the most important criminal justice issues today. This training is designed to help keep you and the person(s) in a mental health crisis safe. Although it is not perfect or infallible, it will work in the vast majority of cases to meet the target goal which is to help you verbally de-escalate a situation rather than using physical force.

The Crisis Intervention Team (CIT) Program was developed by the Memphis (TN) Police Department after the fatal shooting of a male who was cutting and stabbing himself with a butcher knife. The shooting occurred in a public housing project on September 24, 1987. Due to the public outcry of the shooting, the police department worked with local universities and the National Alliance on Mental Illness (NAMI) to develop CIT. The concept has spread to law enforcement agencies across the United States and the world. More recently, the training is increasingly being implemented in jails and prisons.

De-institutionalization from state psychiatric hospitals coupled with a lack of community mental health resources has resulted in re-institutionalization to jails and prisons. An increasing number of incarcerated persons have a documented mental health diagnosis. According to the Treatment Advocacy Center, serious mental illness has become so prevalent in the US corrections system that jails and prisons are now commonly called “the new asylums” where law enforcement officers serve as social workers of the 21st century. The Los Angeles County Jail, Chicago’s Cook County Jail, and New York’s Riker’s Island Jail each hold more mentally ill inmates than any remaining psychiatric hospital in the United States (Figure 1.1). Approximately 20% of inmates in jails and 15% of inmates in state prisons are now estimated to have a serious mental illness.

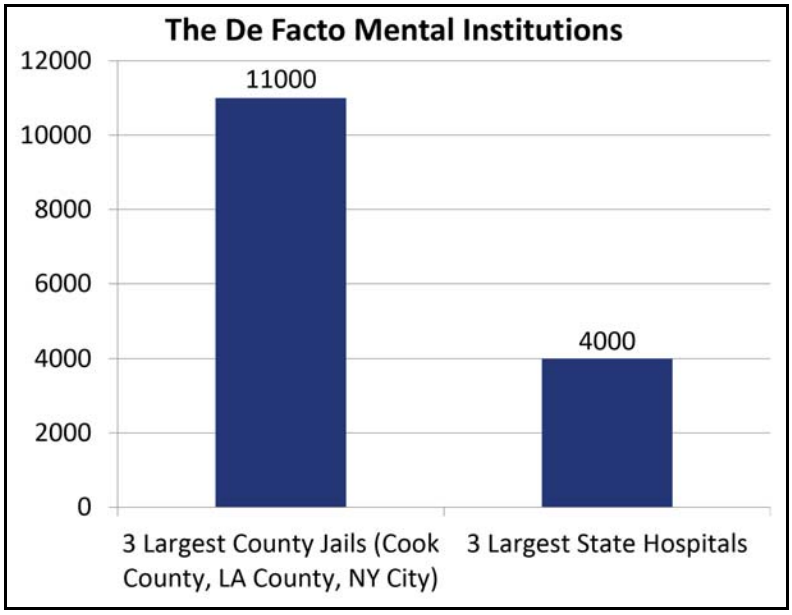


Figure 1.1: The De Facto Mental Institutions. *Source: The Wall Street Journal, 2013.*

Combining the estimated populations of jail and state prison inmates with serious mental illness produces an estimated population of 383,200 affected inmates. Since there are only approximately 38,000 individuals with serious mental illness remaining in state mental hospitals, this means 10 times more individuals with serious mental illness are in jails and state prisons than in the remaining state mental hospitals (Treatment Advocacy Center Serious Mental Illness Prevalence in Jails and Prisons Background Paper, September 2016).

The Treatment Advocacy Center in Washington, D.C. reports that the "risk of being killed when approached or stopped by law enforcement in the community is 16 times higher for individuals with untreated serious mental illness than for other civilians" (Fuller, D., Lamb, R., Biasotti, M. & Snook, J, 2015).

Potential Causes for Mental Health Crisis

The following types of events might result in a person feeling as though he/she is in a crisis situation:

- death of a loved one and/or a pet
- getting locked out of the house/car
- layoff or termination from work
- financial difficulty
- divorce, separation, or child custody
- legal difficulties
- being stopped by law enforcement
- being arrested
- incarceration itself

External factors that can contribute to a situation escalating into a crisis include:

- Expectations the person cannot meet, e.g. financial, work, family, school
- Lacking a sufficient support system or being disconnected from sources of support
- Substance abuse
- Rules and regulations of a jail, e.g. cell searches, communal meals, group shower setup
- Family giving up or disowning the individual due to their choices resulting in incarceration
- Involvement from regulatory agencies such as Child Protective Services (CPS)

Due to individual, environmental, cultural, and circumstantial factors, any one person might react to or perceive a crisis situation differently from another person. This might be especially true for an individual suffering from a mental illness due to the possibility of disrupted emotions or thought distortions.

Figure 1.2 shows the relationships between crime and imprisonment rates through 2008.

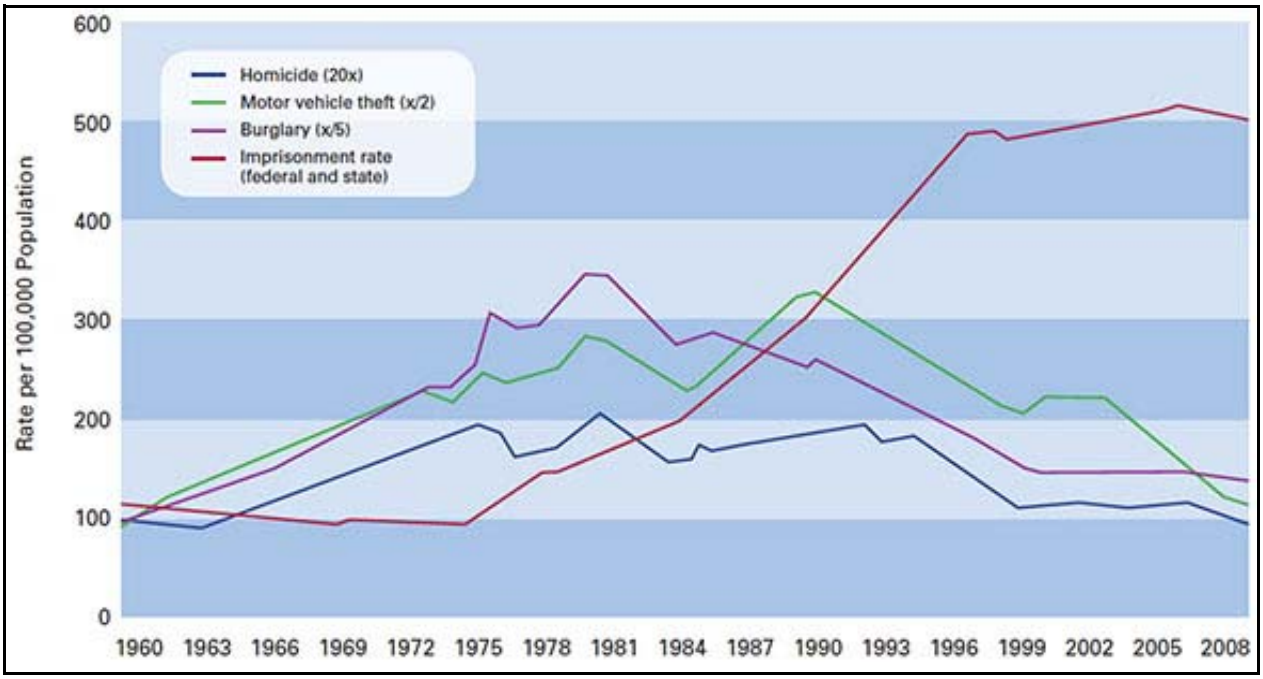


Figure 1.2: Crime and imprisonment rates 1960-2008. Source: The National Research Council, 2014.

Causes for Criminal Justice Involvement

With increasing frequency, criminal justice personnel are being called upon to respond to individuals in serious mental health crises in jails, prisons, and on the streets. Generally, the underlying element behind mental illness-related behavior is usually not criminal or malicious.

Director Doug Dretke

Executive Director

Correctional Management Institute of Texas (CMIT)

George J. Beto Criminal Justice Center

Sam Houston State University

Committee Member, Texas Mental Health Training Initiative for Jails

"A significant challenge for our corrections mission today is effectively and successfully managing our population of people suffering from some level of mental health illnesses. Nowhere is the challenge more critical than in our jails across our nation and here in our State of Texas. This mental health training program is the result of a tremendous collaboration with the National Institute of Corrections (NIC) through the initiative of our Texas Sheriffs and jail leadership. In their pursuit of making our jails and our communities safer and healthier, they recognized the need to better inform, train and equip the men and women who serve as jail professionals working with, and supervising this population.

According to a study by the National Sheriff's Association and the Treatment Advocacy Center (2010), "A seriously mentally ill person is three times more likely to be incarcerated than hospitalized." Why is the

shift from medical-centric response and care to criminal justice response and care occurring? Factors include:

- a decrease in the number of inpatient psychiatric beds,
- a decline in the availability of community mental health services, and
- with a lack of services, many of the mentally ill gravitate to the criminal justice system.

Figure 1.3 to Figure 1.5 show trends related to mental illness within the United States.

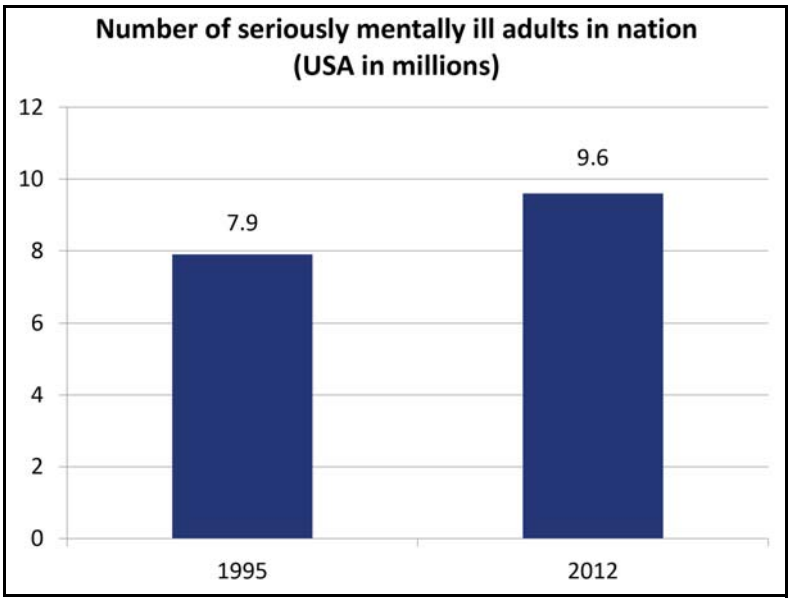


Figure 1.3: Number of seriously mentally ill adults in the nation. *Source: USA Today, 2014.*

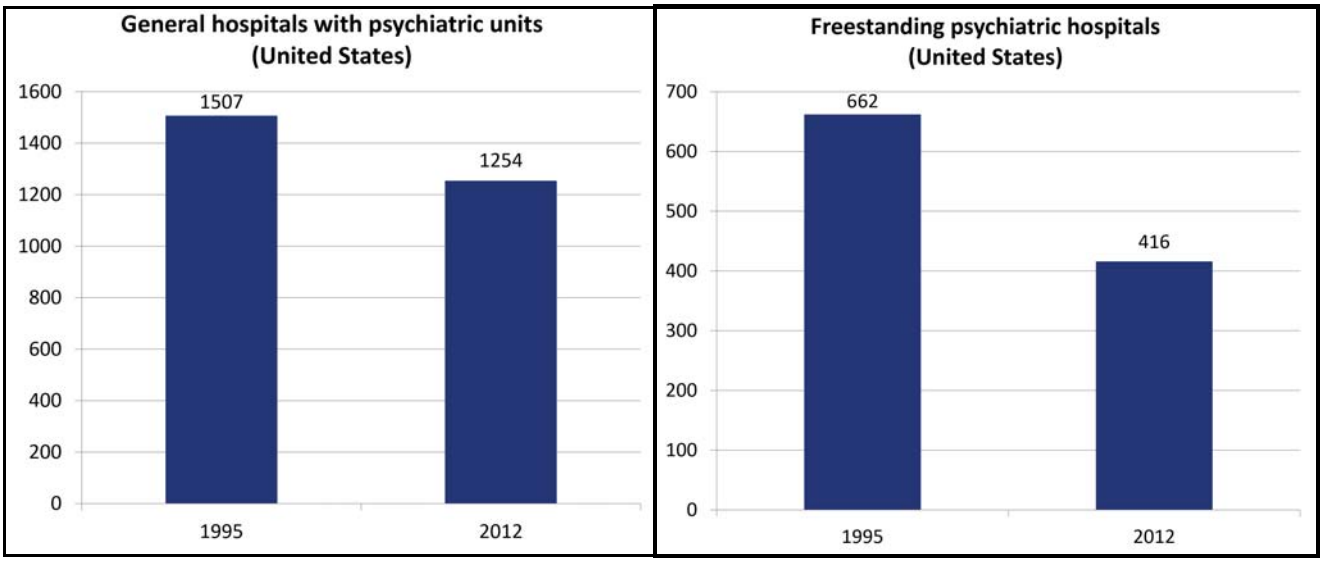


Figure 1.4: Left: General hospitals with psychiatric units in the United States. *Source: USA Today, 2014.* Right: Freestanding psychiatric hospitals in the United States. *Source: USA Today, 2014.*

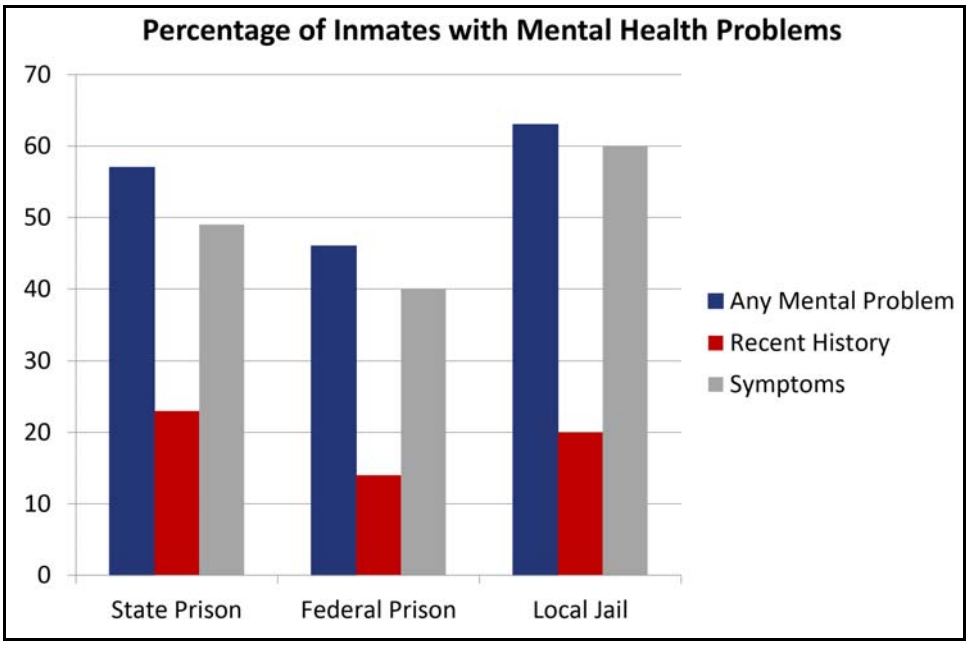


Figure 1.5: Percentage of Inmates with Mental Health Problems. *Source: Urban Institute, 2015.*

Challenges that the growth in the mental health population presents to criminal justice includes:

- Jail facilities are not designed for the mental health function
- Detentions personnel are not adequately trained to identify and respond to mental health situations
- Medical service often focuses on the immediate need for symptom relief and relapse prevention, not a full range of “treatment”

The environment inside jails can exacerbate mental illness, making treatment that much more difficult to deliver. The more chaotic the environment, the harder it is for an individual to organize their thoughts and behaviors into a proper response. Environmental stressors like living in poverty and being in jail are crucial to understanding how mental illness develops in the first place.

It is necessary for criminal justice personnel to understand mental illness, and the tactics and techniques that have been proven to work most effectively when responding to individuals in behavioral crises. These tactics and techniques are different than those routinely taught to criminal justice personnel to manage conflict. Utilizing the information from this course, and implementing effective strategies can help keep the officer safe, keep the public safe, facilitate a stable environment, and greatly reduce civil liability.

Definitions

Mental Health

Mental health is defined as “a person’s mental health condition with regard to their psychological and emotional well-being.” Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act and helps determine how we handle stress, relate to others, and make choices. Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Social structures and support, such as bosses and mentors

- Family history of mental health problems

Good mental health isn't the absence of bad times of emotional problems, rather it is about employing strategies to be emotionally and mentally strong so that you can go through difficult situations and maintain a positive attitude.

Mental Illness

Mental illness refers to a wide range of mental health conditions-disorders that affect your mood, thinking, and behaviors" (Mayo Clinic, 2017). According to Health and Safety Code (HSC) 571.003 (14), mental illness is defined as "an illness, disease, or condition that either:

- substantially impacts a person's thought, perception of reality, emotional process or judgment, OR
- grossly impairs a person's behavior, as manifested by recent disturbance behavior."

According to the National Alliance for Mental Illness (NAMI), 2017, mental illness is defined as "a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis."

Examples of mental illness include:

- depression,
- anxiety,
- schizophrenia,
- bipolar disorder,
- post-traumatic stress disorder;
- personality disorder,
- eating disorders, and
- addictive behaviors.

Behaviors are often the primary indicator of a mental illness as shown in the glacier metaphor shown in Figure 1.6.

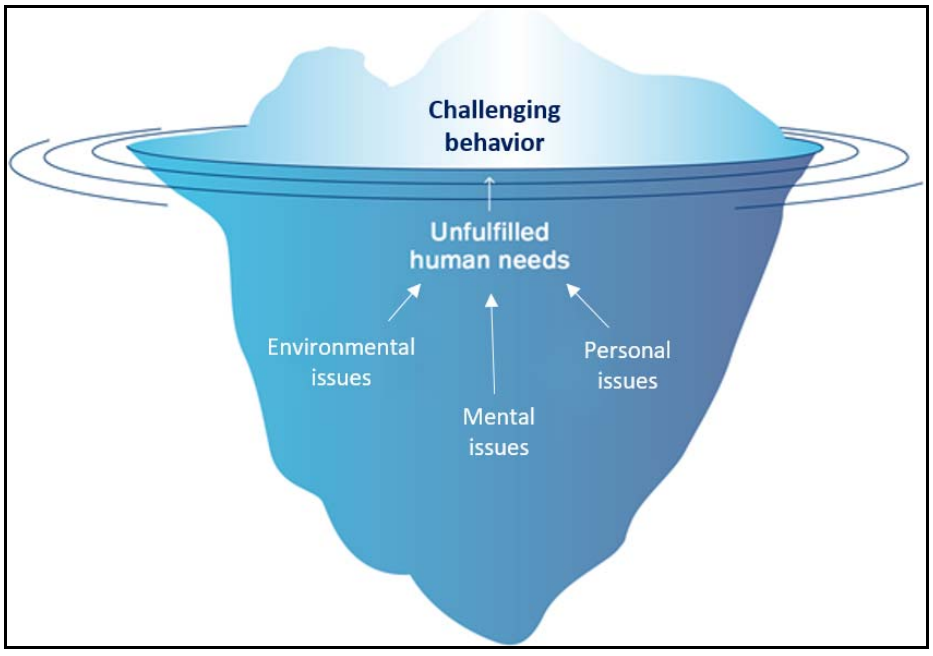


Figure 1.6: Behavior manifestation

Functional Deterioration

Functional deterioration is defined as “not being able to complete routine task(s) and provide self care.” The major factors that contribute to functional deterioration include:

- separation from family and friends,
- lack of privacy,
- fear of assault, and
- boredom.

Note: The four major factors listed above are all present in a jail setting.

By educating individuals on the symptoms of conditions like anxiety and depression, as well as the effects of those illnesses and stress, they can better understand their feelings. By acknowledging and taking necessary actions to address the issues, an individual can more readily respond to factors contributing to the deterioration.

Crisis

According to the Mental Health Crisis Response Institute, “a person has a mental health crisis when they are in a state of mind in which they are unable to cope with and adjust to the recurrent stresses of everyday living in a functional, safe way.”

A crisis can be precipitated by a loss or a challenging situation and may result in the person feeling confused, alarmed, overwhelmed, desperate, hopeless, helpless, enraged, or terrified.

A person in crisis may be more prone to acting instinctually (self-preservation) rather than with logical thought; non-compliance may be the result of a combination of these factors rather than an intentional act of defiance.

Insanity

Mental illness is a much broader and more inclusive term when compared to insanity. The term insanity is not a psychological term, but rather a legal term used as a defense to avoid criminal consequences for certain acts (varies state to state). A commonly accepted definition of insanity is “an unsoundness of mind or lack of the ability to understand that prevents one from having the mental capacity required by law to enter into a particular relationship, status, or transaction or that releases one from criminal or civil responsibility” (Merriam-Webster).

According to the Texas Penal Code, Section 8.01, insanity “is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong. The term 'mental disease or defect' does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.”

Mental Illness

Mental illness is diagnosed based on behaviors and thinking as evaluated by a psychiatrist, psychologist, licensed professional counselor, licensed social worker, or other qualified professionals most commonly using a tool known as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-V. There are more than 300 mental disorders listed in the DSM-V.

Mental illnesses can affect people's thoughts, mood, behavior, and the way they perceive the world around them. The severity of each condition varies from person to person and ranges from mild, moderate, to severe. Some individuals experience 'chronic' or long-term conditions, while others experience more 'acute' or immediate symptoms. Symptoms and their severity can change; occasionally

being acute, and then receding. Mental health conditions often occur simultaneously; for example, individuals often suffer from substance abuse issues in addition to other mental health conditions. Mental health conditions can also occur due to a person having a co-occurring mental illnesses, such as bipolar disorder and post-traumatic stress disorder.

Statistics

Research suggests that people with developmental disabilities and other mental health issues are seven times more likely to encounter law enforcement than without these issues. An International Chiefs of Police Association (IACP) 2014 report found that 10 times more people affected by mental illness are in prisons and jails than are receiving treatment in state psychiatric hospitals.

Recent published statistics show that approximately 20% of the population has a diagnosable mental illness. According to some studies, the number may be closer to 32% as there are many individuals who do not seek treatment.

- The Mental Health Association of Texas states that approximately half of all adults in the United States will experience a mental disorder at some point in their lives.
- According to the National Alliance on Mental Illness (NAMI), in 2017, approximately 1 in 25 adults in the United States (estimated 10 million) experience a serious mental illness in a given year that substantially interferes with, or limits, one or more major life activities (financial, occupational, social). Individuals may also suffer from persistent mental illness, which is indicated by long durations of impairment.

  Note: This number represents 1 out of every 5 adults in America and does not include substance use disorders, such as drug- or alcohol-related disorders.

Anyone can experience mental illness, regardless of age, gender, race, education level, or socioeconomic level. The majority of individuals with mental illness live productive lives. Mental illness can be situational in nature and due to stress, grief, or substance abuse. The duration and severity of these episodes is often based upon a number of factors including coping skills, social support, treatment, and substance use.

Realities of the Illness

No one is immune to mental illness. A combination of factors contribute to mental illness, including genetic predispositions, trauma, a history of abuse, medical illness, brain chemistry, and recreational drug use. More hospital beds are filled by individuals with mental illness than those with cancer, heart, and lung disease combined.

Mental illness is not a sign of weakness; it is often temporary and yet it can be cyclical over a lifetime. Many people have mental health concerns from time to time; however a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and impact an individual's ability to function. The impact of stigma is tragic because mental health challenges are actually very common.

About two-thirds of Americans who have a mental illness live in community settings. Many people with mental health diagnoses are extremely intelligent, creative, and innovative. Most people who have a disabling illness need treatment to return to optimal functioning. Physician oversight and physical therapy fills this role for a physical illness, just as therapeutic intervention is needed for those experiencing mental illness.

Behaviors

The concept of normalcy is based upon what is accepted in a society or culture. Norms are based upon numerous variables:

- Ethnicity

- Religion
- Occupation
- Social group
- Developmental level
- Education

A clearly delineated line between normal and abnormal does not exist. Social norms are based upon what is accepted within specific societies, cultures, and subcultures. If practiced in another culture or society, the 'normal' practice may be deemed 'abnormal.'

Stigma

Stigma is defined as a “mark of disgrace or shame.” It is made up of various components, including:

- Labeling someone with a condition
- Stereotyping people with that condition
- Creating a division (a superior 'us' and a denigrated 'them')
- Discriminating against someone on the basis of a label

There remains a stigma attached to mental illness and prejudices against individuals that suffer from mental illness because it is widely misunderstood by the general public. Stigmas encourage inaccurate perceptions as the term mental illness alludes to false information and reinforces distorted perceptions. The term 'mental' suggests a separation from a physical illness, when in fact they are entwined. A vast body of research supports the assertion that there are physical and measurable changes in the brain associated with mental illness, suggesting that a biological component exists.

Treatment

Mental illness can and should be treated. Unfortunately, some people do not seek or outright refuse treatment for fear of being labeled. Nearly two-thirds of all people with a diagnosable mental illness do not seek treatment. With recognition, proper treatment (to include medication and therapy), and a commitment to wellness, people who experience mental illness can live rewarding, satisfying, and productive lives.

Treatment refusal can be problematic for law enforcement. Individuals with access to medication may decline or discontinue medications for a variety of reasons, including:

- Many people feel that medications squash creativity, artistry, and remove the drive to create.
- The individual starts taking different medication(s), gains access to and partakes of alcohol or illicit drugs, or believes they are now allergic to the medication.
- The individual starts to feel better and believes their medication is no longer needed.
- Anosognosia, also called “lack of insight,” is a symptom of severe mental illness experienced by some that impairs a person's ability to understand and perceive his or her illness.

  Note: Anosognosia is the single largest reason why people with schizophrenia or bipolar disorder refuse medications or do not seek treatment. Without awareness of the illness, refusing treatment appears rational, no matter how clear the need for treatment might be to others. Abrupt medication cessation is a primary cause of crisis incidents.

Role of Crisis Intervention Teams (CIT)

According to *Police Magazine* (March 2000),

> *"The essential difference between suspect encounter training, that officers traditionally receive, and how to approach the mentally ill is the need to be non-confrontational...The same command techniques that are employed to take a criminal suspect into custody can only serve to escalate a contact with the mentally ill into violence.*
>
> *It is helpful for officers to understand the symptomatic behavior of persons who are afflicted with a form of mental illnesses. In this way, officers are in a better position to formulate appropriate strategies for gaining the individual's compliance."*

By taking a less physical, less authoritative, less confrontational, less controlling approach the officer has more control and authority over most individuals in a mental health crisis. Why is this? CIT training is diametrically opposite of the traditional police training model.

Goal

According to Jines (2013), "The primary goal of CIT involves calming persons with mental illness who are in crisis and referring them to mental health care services, rather than incarcerating them. This goal…includes lessening injuries to officers, alleviating harm to the person in crisis, promoting decriminalization of individuals with mental illness, reducing the stigma associated with mental disorders, and using a team approach when responding to crises."

A crisis intervention team serves to properly plan, implement, maintain, support, and evaluate the mental health response within the institution and community. The team (Figure 1.7) is made up of the following members:

- Corrections officers with specialized training
- Tactical partners (steering committee)
- Strategic and supportive partners (key leadership)

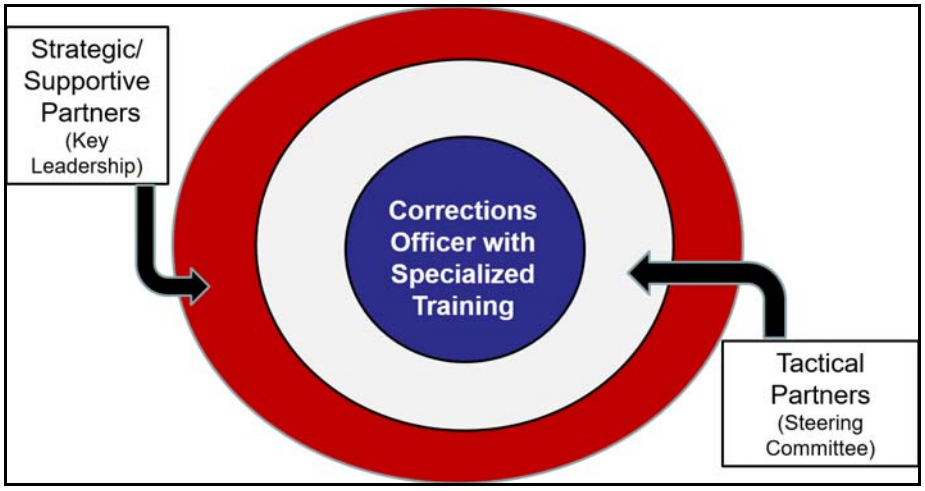


Figure 1.7: CIT Team Members

Difference in Approach

Table 1.1 outlines the differences in responses when using a traditional versus CIT approach.

Table 1.1: Traditional approach vs. CIT approach

Concept	Traditional Approach	CIT Approach
Time	Most agencies are under-staffed. Pressure is put on personnel to handle calls quickly. When an officer makes a request or gives a command the officer expects the person to respond quickly.	It will usually take longer to interact with a person in a mental health crisis. Patience is key. Many officers are not used to being patient. One reason it may take longer is psychosis. In a psychotic episode the frontal lobe of the brain is shut down and executive decision making is impaired. The person may not quickly comprehend questions asked. The person may also be hearing voices which makes it difficult to concentrate on what the officer is saying.
Demeanor	The traditional demeanor of an officer is firm, authoritative, and commanding. Most individuals understand this posture and respond respectfully.	The person in a mental health crisis usually does not respond well to an authoritative, firm and/or commanding presence. If the person is paranoid, for example, which is common with someone experiencing psychosis, he may believe the officer is there to harm him. The authoritative, commanding demeanor reinforces this delusion. The person may be having auditory hallucinations telling him the officer is going to harm him.
Acquiescence	Officers are not use to being told to do something by an individual or “give up ground.”	Individuals in mental health crisis may tell the officers to do things. It may be prudent for the officer to oblige. If the person is paranoid, for example, she may tell the officer to back up. It would be prudent for the officer to back up a few steps to demonstrate he is there to help, not hurt. If two officers are present, consumers will often take a disliking to one. The consumer may say “I will talk with you but not to her.” In this case, it would be prudent for the officer the consumer wants to talk with to do the communicating.
Physical contact	Officers often make physical contact with others; most do not react negatively to the touch of a shoulder or arm or the officer's hand on their back. Physical restraint is often required to apprehend a suspect.	Officers should avoid physical contact unless it is necessary for safety. The simple touch of the shoulder of a person in a psychotic episode can put that person into the fight-or-flight mode and result in physical altercation.
Sudden movement	Officers may have to move suddenly. This does not result in a problem in most situations.	Officers should not make sudden overt movements toward a person in crisis unless necessary for safety. The person in crisis can take the movement as a threat and respond in the fight-or-flight mode.

Table 1.1: Traditional approach vs. CIT approach (continued)

Concept	Traditional Approach	CIT Approach
Voice	Officers sometimes raise their voice to be heard, to get a person's attention, or to project command presence. Most individuals do not react negatively to this.	Officers should not raise their voice unless necessary for safety. Officers should instead talk in a calm, reassuring, conversational tone. Shouting may “set” the person in crisis off.
Commands	Officers are used to giving orders. It is a necessary part of the job in many situations. Most individuals respond appropriately to orders issued by officers.	Officers should avoid giving orders. A person in crisis will not respond well to orders. An officer has to take the time, in most situations, to persuade the person to do what the officer requests.

Source: Webb, F. M. (2017). Criminal Justice and the Mentally Ill: Strange Bedfellows. Texas Tech Law Review, Vol. 49, No. 4, Summer 2017, 817-845.

Purpose of Training

Crisis intervention training is foremost about officer safety and is designed to educate criminal justice personnel in the basic elements of specific mental illnesses and prepare them to utilize practical applications of de-escalation techniques. These techniques keep you and the person you are dealing with safe, help to reduce complaints, financial liability, and lawsuits as well as increase public trust and confidence in criminal justice personnel among people suffering from mental illness, their families, and the community at large.

Manging mental illness in jails is one of the most complex issues facing sheriffs today. This training is intended to assist officers in being able to recognize the signs and symptoms of mental illness and to respond effectively, appropriately, safely, and professionally to individuals experiencing mental health crises.

Sheriff Dennis Wilson

Sheriff Limestone County Sheriff's Office

President, Texas Mental Health Training Initiative for Jails

“Our Behavior Health Care System in Texas is rapidly changing and I am very excited seeing our Criminal Justice associates partner in the development of a new Training Instructor's Model that will help better train our Texas County Correctional Officers in the areas of Mental Health Issues we all face daily in the operations of our Texas County Jails. We must, at all levels of our criminal justice system, realize the overdue needed changes to IMPROVE and IDENTIFY the resources that are made available to each of us. Mental Health is an ILLNESS and should be recognized as just that, not a CRIMINAL OFFENSE.”

Module

2

Communication and De-Escalation

Terminal Objective

Upon successful completion of this module, participants will be able to articulate best practices related to communication and de-escalation in a jail setting.

Enabling Objectives

1. Explain crisis behavior and the relevance to CIT training and de-escalation.
2. Identify the elements of successful communication.
3. Identify behaviors and actions that facilitate effective communication.
4. List crisis intervention techniques.
5. Outline cultural competence and the relevance to communication and management strategies.

Crisis Behavior

One of the primary objectives of this training is crisis intervention/de-escalation techniques. These tactics and techniques have been proven to help detention personnel verbally de-escalate situations involving individuals in crisis. Started in Memphis, Tennessee in 1987, law enforcement agencies, jails, and prisons across the nation and in other countries have implemented these strategies.

As a detention officer, you are often called into action when something is wrong: when someone has been assaulted or injured or when there is a confrontation or the threat of a confrontation. You interact with people who are angry, emotional, injured, frightened, or traumatized. Some of these people welcome your presence, while others resent it. You face situations that are, or could easily become, violent and threaten you and your fellow officers with injury or death. Many of these incidents involve complex interpersonal and legal situations in which you must protect yourself and others while maintaining your authority and respecting the rights of the public.

Crisis intervention/de-escalation training is officer safety training designed to keep you and the person you are dealing with safe. It is not in conflict with officer safety and tactical training. It is one more tool to put on your tool belt of skills. We are not saying you will never have to use force in some of the situations you will find yourselves in. However, crisis intervention/de-escalation training has been proven to help you verbally de-escalate the majority of crisis situations preventing the need for physical force resulting in reduced liability.

Figure 2.1 represents the crisis cycle. People in mental health or other crises can be unpredictable and the situation can quickly escalate from a calm encounter to a violent encounter. Pay close attention to the body language of the individual and others in proximity to the interaction. Individuals experiencing crisis may be insensitive to pain and possess extraordinary strength.

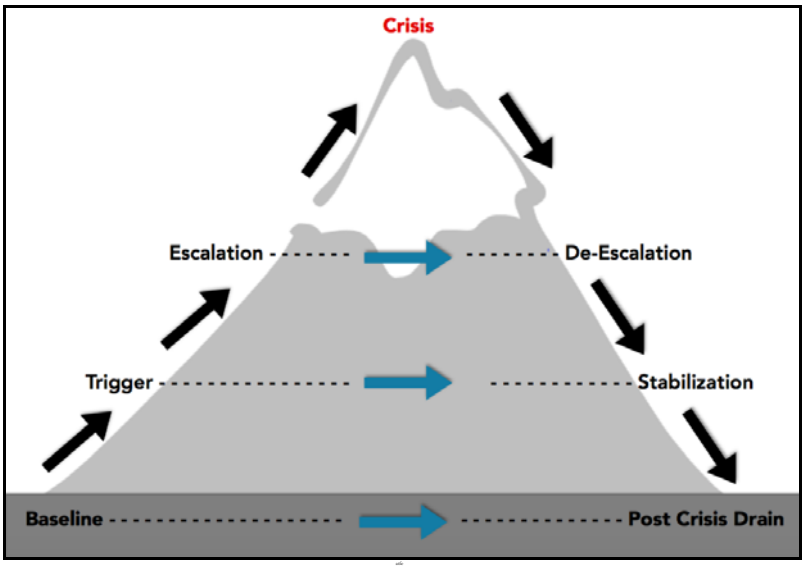


Figure 2.1: Crisis cycle. Source: CIT Partnership Training: Crisis Intervention Teams, 2016.

De-Escalation

Our job is “people working with people” for the safe, secure, humane performance of our duties and the protection of the public. The goal during all communications, especially during de-escalation is to communicate information so it is received and understood correctly. Instead of confrontation, one should always aim to achieve voluntary compliance during communications and persuasion.

Do not let past experiences dictate your current response.

- The person may have been cooperative and calm the last four responses, this does not mean he/she will be this time
- Do not have preconceived beliefs
- Expect the unexpected

Perceptions may differ than reality.

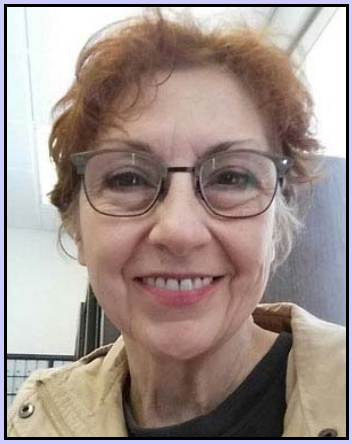
- The individual in crisis may not identify you as a detention officer, even if you are in uniform.
- The person may not realize he or she is mentally ill and/or in crisis.
- The person may not believe you have his best interest at heart.

Terri Lumley

Professional Actor

Plays the role of a CIT Inmate

"I'd bet most people have witnessed someone in mental health crisis and were unsure how to reach out safely and respectfully. We often ask Law Enforcement to respond to and resolve such events, and they do so daily. I support CIT because it offers them additional tools, options, and, importantly, a space to practice. Where de-escalation is appropriate, there's a better chance everyone gets home safely."



Critical Decision-Making Model

Good communication is critically important since lives, safety and liability are directly affected by it. Before communicating you should analyze the situation. Figure 2.2 represents the Critical Decision-Making (CDM) Model from the Police Executive Research Forum (PERF) and is provided as an example of the information to be analyzed before and during an interaction with an inmate.

Note: When reviewing this graphic, replace "police powers" with "detention officer powers."

The CDM is anchored by the ideals of ethics, values, proportionality, and the sanctity of human life. Everything in the model flows from this principled core.

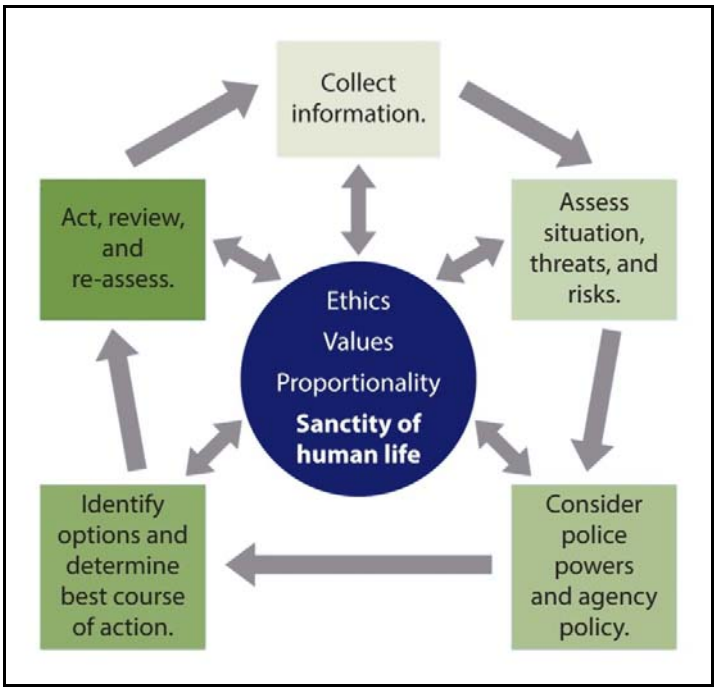


Figure 2.2: Critical Decision-Making (CDM) Model. Source: Police Executive Research Forum, 2016.

For example, a detention officer is responding to an inmate who will not get off the phone when told. The detention officer would be asking herself the following types of questions:

- What do I know about this inmate? Has he disobeyed orders in the past? If so, what was the nature of those situations?
- What exactly is happening? How can I communicate with him to get an idea of what is going on in his mind?
- Who is he talking to on the phone? What is the phone call about? Why does he want to stay on the phone?
- Is the inmate threatening me or anyone else? If so, what is the nature of the threat, and how serious is the threat?
- Do I need to take action immediately?
- If I do not need to take action immediately, are there additional resources that could help resolve the situation?
- What are my legal authorities and what are my agency polices governing the situation?
- What am I trying to achieve? What options are open to me?

Even after taking an action, officers continue to ask themselves questions about whether the response had the desired effect and what lessons were learned. If the desired outcome was not achieved, they begin the process again, which is called “spinning the model.”

Source: Police Executive Research Forum, 2016.

Elements of Communication

Attitude

Life is 10% what happens and 90% how we perceive and react to it. Attitude sets people's minds and expectations; it presets reactions. The one thing we have control over is our attitude and interactions with others; do not give others the power to control your attitude and reactions.

As an officer, your job is dependent on good communications. Failure to communicate the right information can lead to an unnecessary encounter—our job is verbal de-escalation in potential conflict situations.

Sgt Travis Reese

South Carolina Department of Corrections

"It [crisis intervention training] helped me be patient with the inmates … Most of the time these inmates just want to be heard and it's the simple things that we can do for them to help get them out of their crisis."

Pace

Pace the contact so that it is appropriate for the individual and the situation.

- A calm, calculated and controlled approach is usually best.
- Sudden aggressive movements on your part can trigger an explosive fight-or-flight response on their part.
- Do not let your tactical guard down.

Patience is priceless and is often key in the interaction.

- Take a deep breath and calm down.
- Model the behavior you want the person to exhibit.
- Allow the person to vent.
- Take your time to properly handle and respond to the individual.

Eye Contact

In the Western culture making eye contact while communicating indicates you are interested, engaged, and confident. There is a difference, however, between making eye contact and staring. You do not want to stare at someone. To avoid staring, make occasional eye breaks.

Eye contact is treated differently in different cultures, however. In Middle Eastern cultures eye contact is less common and considered less appropriate. In Asian cultures, like China and Japan, eye contact is often considered inappropriate. In African and Latin American cultures eye contact is often seen as aggressive and disrespectful.

Command Presence

A uniformed officer's "command presence" is a first level of force and serves as a silent reminder of the authority of the office/position. An officer with command presence projects a professional aura or air of authority, confidence, one who commands respect. An officer without command presence gives off the signals of struggling prey, appears nervous, timid and unsure of himself. Command presence is

important because 75 percent of what we “say” is transmitted through non-verbal means: body language and appearance.

- Confidence: The foundation of command presence is confidence. If you are confident in your abilities it will show. If you are not confident, that will show also. It is important, therefore, to know the law, agency policies, be physically fit, and practice tactics. Know your job!
- Appearance: Most people form an impression of a person within the first 30 seconds. These initial judgments are based on visual cues. Being well-groomed and wearing a clean and pressed uniform contribute to a positive first impression. Good posture and speaking clearly will also contribute to one's first impression of you and your command presence.
- Attitude: Be positive, honorable, confident and respectful.
- Positioning: Involves adequate distance to allow for both safety and seeing/hearing a particular situation/the most effective line of sight. Direct observation with inmates gives a very positive psychological message and allows for closer observation; closer observation provides clues to use in analyzing situations.

Active Listening

An important part of the communication process is active listening as 75% of communication is non-verbal. Most people do not actively listen as it can be more tiring than the act of talking itself. Some of the reasons people do not actively listen are: it takes effort and energy, people want information quickly, people are focused on their agenda not the agenda of the person they are communicating with.

The goals of active listening are to:

- understand and lower a person's emotions behind the words,
- establish rapport and influence,
- gather information, and
- encourage behavioral change.

Active Listening Skills

These skills can be utilized to help buy time, de-escalate the situation and assist the individual with emotion regulation.

- Emotional Labeling: This is trying to determine/identify the emotions the person is experiencing. The following are ways to emotionally label:
  - “You sound angry …”
  - “You seem hurt …”
  - “I hear loneliness …”
  - “I can hear anger in your voice, and it seems like this situation has hurt you.”

  Labeling emotions can build tremendous rapport. Once labeled, talk about why the person is experiencing that emotion. People love to have others understand how they feel.
- Paraphrasing: Put meaning in your own words. Example: “You just got off the phone with your attorney and found out you got a life sentence.” Paraphrasing lets the person know you are paying attention and clarifies your understanding. If your understanding is not correct it gives the person the opportunity to correct your understanding.
- Mirroring/Reflecting: Mirroring or reflecting words or phrases the person tells you. Inmate: “He (other inmate) doesn't pay attention to what I say to him and it makes me angry.” Detention Officer: “It makes you angry.”

- Summarizing: Periodically covering the main points: “Okay, what you've told me so far is this … and as a result, you feel … Do I understand correctly?”
- Open Ended Questions: Ask questions that require more than a “yes” or “no:” Open ended questions convey an interest in gaining an understanding. They give a freedom of response and limit the feelings of an interrogation. Examples:
  - “What happened today?”
  - “How would you like this to work out …?
- Minimal Encouragers: These are brief responses (sounds) that indicate you are paying attention and listening. Examples:
  - “Uh-huh”
  - “Really?”
  - “Yeah”
  - “Okay”
  - “Wow”

  They are best used when the person is talking for an extended time. They let the person know you are paying attention and listening. They are effective in combination with other active listening skills such as paraphrasing or mirroring/reflecting.
- “You” Statements vs. “I” Statements: An “I” statement is an assertion about the feelings, beliefs, values etc. of the person speaking, generally expressed as a sentence beginning with the word “I”, and is contrasted with a “You” statement which often begins with the word “you” and focuses on the person spoken to.

  More often than not, “You” statements sound accusatory and blaming to the individual. “I” statements make the speaker take responsibility for his emotions and they do not sound accusatory or blaming.

  Examples of “You” statements:
  - “You don't listen to me.”
  - “You don't understand me.”
  - “You never help me and I don't appreciate it.”

  Examples of “I” statements:
  - “I feel unheard, can we talk?”
  - “I feel like I am not being understood.”
  - “I feel overworked and would appreciate some help.”

  Table 2.1 provides examples of statements according to different scenarios.

Table 2.1: Sample "You" and "I" Statements

Situation	"You" Statement	"I" Statement
An inmate is on the phone and will not get off when told his time is up.	A detention officer monitoring the phones says "You need to get off the phone, your time is up." The inmate says he needs a few more minutes, he is talking to his mother after just learning from his attorney he received a life sentence. The detention officer responds "You need to get off the phone. I have already told you twice, your time is up. I am not going to tell you again."	A detention officer monitoring the phones says "You need to get off the phone, your time is up." The inmate says he needs a few more minutes, he is talking to his mother after just learning from his attorney he received a life sentence. The detention officer responds "I can see where you would be very distraught after hearing you received a life sentence. I am going to make an exception and let you talk with your mother for a few more minutes. I will need you to get off the phone when that time is up."

Comment: In this scenario, the first detention officer was so focused on the inmate getting off the phone he probably didn't even comprehend what the inmate was telling him. He probably was not actively listening. Hearing you just received a life sentence would be devastating for anyone. What will it hurt to give the inmate a few more minutes to talk with his mother about this? This is a decision for you to make.

Critical Decision-Making Model Questions to Ask Yourself:

- What do I know about this inmate?
- Has he disregarded rules before?
- Is he a problem inmate?
- Have I had disciplinary problems with him in the past?
- What is his name? If known, use it in your conversation with him.
- Who is he talking to on the phone?
- Why does he not want to get off the phone?
- How can I communicate with him to solve this problem?
- Do I need to take action immediately?
- What are my options according to agency policy?
- What am I trying to achieve?
- Is what I am doing working? If not, reassess.

Table 2.1: Sample "You" and "I" Statements (continued)

Situation	"You" Statement	"I" Statement
An inmate has made a noose in a sheet, has put it around his neck, is standing on the railing of a second floor cell block and is threatening to jump off saying "I can't take this anymore."	A detention officer is walking up the stairs and in a loud commanding voice says "You don't want to do this. Get down."	A detention officer is walking up the stairs and in a calm, conversational tone says "I can see you are very upset. Let's talk about this. If you jump you may not kill yourself but you may be paralyzed for the rest of your life. Have you considered this? I would like to talk to you about why you feel you cannot take this anymore. I want to help you."

Comment: In this scenario, telling the inmate "You don't want to do this" is not a good response.

- The inmate does want to do this, at least to a certain extent, or he would not be in this situation. Sometimes people will act out on their threat to commit suicide just to show you they do want to commit suicide when told "You don't want to do this." It is like they are saying "I'll show you."
- Inmates have very little control in jail. This is one situation they do have control over. This inmate might jump just to exert that control if approached the wrong way.
- Saying "Get down" is a command. Commands and orders are issued to inmates all the time. In this situation this command to "Get down" will probably not be received positively. You need to talk with the inmate and get him to want to come down. Just ordering him to get down probably will not work. It needs to be his decision. It will take time to talk about why the inmate wants to commit suicide and provide possible solutions/resources for help. This is where time, patience, empathy, and a caring attitude are so important.

You should not get too close to the inmate for your safety and his. You do not want to crowd his personal space. If the inmate does actually make a move to jump and you try to grab him be very careful. You do not want to go over the railing with him. We recommend not making physical contact unless necessary. Your goal is to try to talk him down; however verbal de-escalation does not always work. There are times you have to physically intervene.

Critical Decision-Making Model Questions to Ask Yourself:

- Do I have to take immediate action and attempt to grab this inmate or is the situation safe for me to try to talk him down?
- What exactly is going on?
- Are other people in danger?
- What is this inmate's name? (If known, use it throughout the conversation)
- Does this inmate have a history of suicide attempts?
- Are there other resources available to help with this situation?
- What are my agency procedures in this situation?
- What are my options in this situation?
- Are there other inmates around him? If so, remove them from the scene if possible.
- What is he saying? (Actively listen)
- What is he doing?
- What does his body language indicate?
- Does he want to kill himself? (Confirm this by asking him "Do you want to jump and kill yourself?"
- What are my legal duties in this situation?

Is what I am doing working? If not, reassess.

Table 2.1: Sample "You" and "I" Statements (continued)

Situation	"You" Statement	"I" Statement
An inmate has just learned his wife is divorcing him and she is going out with his best friend. He is angry and loud saying things like "That motherfucker! I am going to kill him when I get the fuck out of here."	Detention Officer in a loud commanding voice: "You need to calm down! You need to stop talking like that."	Detention Officer in a conversational tone: "You just learned your wife in divorcing you and she is going out with your best friend. I can see you are very angry about hearing this. This is understandable. Let's talk about it. I need you to try to calm down. I am being respectful to you and I need you to be respectful to me. Yelling is not going to help the situation."
Comment: The officer using the "You" statement is telling the inmate to calm down. You cannot order someone to calm down. If done in a loud commanding tone, there is a good chance this interaction will escalate into a shouting match. The officer using the "I" statement started by summarizing what happened (active listening) and then using "I" statements in a conversational tone. He is modeling the calm behavior he wants the inmate to mimic. The chances of the inmate calming down are much higher with the officer actively listening, modeling, and using the "I" statements.		

What Active Listening is Not

It is not advice, judgment or persuasion. Do not express your ideas or values unless asked. It is the feelings, values, statements and opinions of the person that matter, not yours.

Phrases That Damage Rapport

- "Calm Down" This phrase may be perceived as an order which may provoke anger.
- "I understand" Often well-intentioned but many times the person will ask "How can you possibly understand?"
- "Why" Can feel accusatory and may created defensiveness.
- "You should …" A judgmental (advice giving) statement that implies superiority of the advice giver.
- "You shouldn't" Same as above.

Effective Communication

There are eight primary barriers to communication and active listening:

- Arguing
- Criticizing
- Jumping to conclusions
- Pacifying the person
- Derailing
- Moralizing
- Name-calling
- Ordering

Detention Officer Jason Thomas

Lorain County (Ohio) Sheriff's Office

"Inmates remember not what you said to them, but how you made them feel!"

Communication Actions

Table 2.2 shows things you can do to facilitate effective communication and conversely things to avoid in an effort to prevent a situation from escalating.

Table 2.2: Things to Do and Things to Avoid in Communication

Things to Do	Things to Avoid
• Remain calm and avoid overreacting • Indicate a willingness to understand and help • Speak simply and briefly • Move slowly • Remove distractions • Understand a rational discussion may not take place • Be friendly, patient, accepting, and encouraging • Remain firm and professional • Praise cooperative behavior • Be aware a uniform, gun, and handcuffs may frighten the person • Reassure the person that no harm is intended • Recognize a person's delusions and hallucinations are real to him/her • Announce actions before initiating them • Gather information from friends or bystanders • Give space; do not crowd the person • Ask how you can help • Respect the person's emotions • Be empathetic, not sympathetic – Empathy indicates you understand and identify with the person and what he/she is feeling – Sympathy implies pity over involvement; avoid "I feel sorry..."	• Move suddenly • Give rapid orders • Shout • Force discussion • Stare at the person • Touch the person (unless necessary for safety) • Crowd the person • Express anger, impatience, or irritation • Assume a person who does not respond cannot hear • Use inflammatory language (crazy, psycho, mental) • Challenge delusions or hallucinations • Play along with hallucinations or delusions • Make promises you cannot keep • Lie

Other Considerations

Body Language and Facial Expressions

Body language refers to the nonverbal signals that we use to communicate. Understanding body language is important, but it is also essential to pay attention to other cues such as context. In many cases, you should look at signals as a group rather than focusing on a single action.

- Gestures can be some of the most direct and obvious body language signals and commonly include a clenched fist and thumbs up/thumbs down. It is important to be aware that some gestures may be culturally based and may have a different meaning between individuals.

- The arms and legs can also be useful in conveying nonverbal information. Crossing the arms can indicate defensiveness. Crossing legs away from another person may indicate dislike or discomfort with that individual.

Facial expressions are also among the most universal forms of body language. Facial expressions reveal our true feelings about a particular situation; words may convey you are feeling fine in a specific situation, yet the look on your face may contradict the verbal communications. The expression on a person's face can even help determine if we trust or believe what the individual is saying.

- The eyes reveal a great deal about a person's feelings. As you engage with another individual, take note of eye movements. You may notice whether the person is making direct eye contact or averting their gaze, how much they are blinking, or if their pupils are dilated.
- The mouth can indicate subtle indicators of what the person is feeling. Lip signals include pursed lips, lip biting, covering the mouth, and/or turned up or down gestures.

Use of Sarcasm and Jargon

Sarcasm is "a form of ironic speech commonly used to convey implicit criticism with a particular victim as its target." Many people relate sarcasm to irony, but there is a big difference between the two. The following stimuli affect the degree of sarcasm in everyday language: exaggeration, nature of the speaker, relationship of speaker to victim, severity of the criticism, and whether or not the criticism is being made in private or in front of an audience. While sarcasm may be a polite version of criticism, it is a form of criticism that is usually accompanied by particular negative attitudes, such as disapproval, contempt, scorn, and ridicule.

Jargon interferes with the flow of communications in three different ways: by blocking it off, by slowing it down, and by muddying the ideas you are trying to communicate. When you use jargon, knowingly or unknowingly you are signaling that you only want to reach an audience of people who already understand the terms.

Crisis Intervention/De-Escalation Techniques

Crisis intervention/de-escalation techniques include:

- Work toward getting the person to express the emotion he is feeling
- Express personal concern and empathy
- Encourage the person to tell his story
- Bide for time
- Use active listening skills

When dealing with high emotions and energy, we must deal with feelings first before facts.

- Reduce the emotional and energy level if possible.
- If you are unable to reduce emotions and energy safely at that time, then isolate and observe the individual until it is safe to do so.
- If the situation is stable and controlled with no immediate danger, let the individual vent.
- Let them know you recognize their emotions
  - Recognize their anger by saying "You sound angry. What's wrong?"
  - Keep them talking as long as it appears to be letting them blow off steam and calming them down.
  - If blowing off steam works, give encouraging cues to continue such as "Tell me more."

As they start to calm down, paraphrase and summarize what you have heard. Keep it brief. Ask if you heard them correctly. Ask them to clarify.

If the situation is unstable and venting seems to be inciting or exciting them and others:

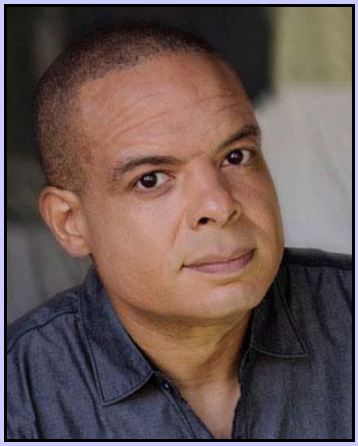
- You must then intervene.
- Breaking in can be dangerous/difficult
- You must consider the prisoner, situation, location, who else is involved or around, your back up.
- Never threaten, set the context and outline the options.
- Sometimes a show of back-up force will calm the situation.

Swann Christopher

Professional Actor

Plays the role of a CIT Inmate

"Anyone who has watched the news in the past few years knows that America has a problem. I feel truly blessed to be a part of the solution to that problem. I know the work we do in CIT training will ultimately save lives. What could be better than that?"



Cultural Competence

The events and conditions each of us experience during our formative years help define who we are and how we view the world. The generation we grow up in is one of the influences on adult behavior while our culture is another influence.

Changing demographics in officers and inmates necessitates our awareness of others and their cultures. When we acknowledge this and gain a better understanding of how age (generations) and culture impacts our interactions and can increase our ability to manage and communicate with inmates of differing generations and cultures.

Remember differences may not always be seen and approximately only 10-15% are apparent (Figure 2.3).

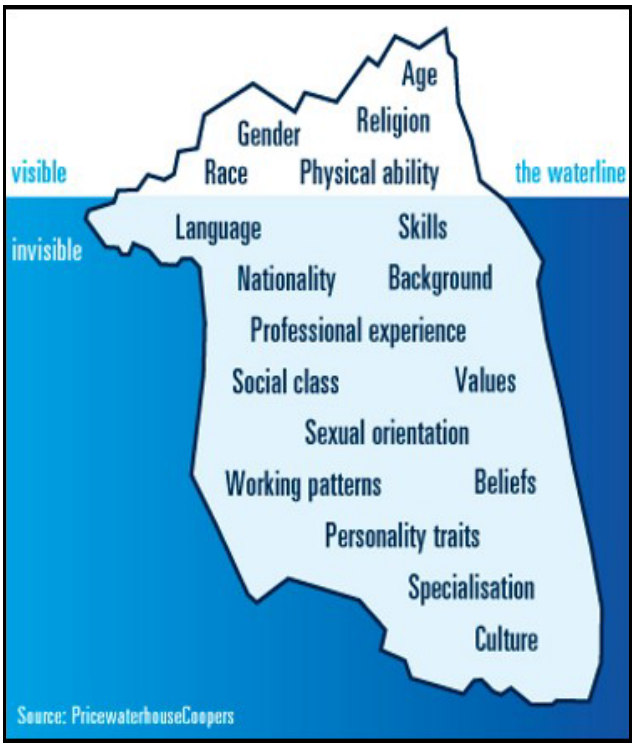


Figure 2.3: Cultural diversity iceberg. Source: Pricewaterhouse Coopers.

Generations

We now have four generations of officers and inmates in our jails and prisons. Within and between generations, there are cultural differences and knowing these differences, will allow us to better manage individuals and the situations we will be presented with.

> **Note:** These are generalizations and not absolutes; individuals may fall outside of these generational breakdowns for a variety of reasons.

Table 2.3 shows the breakdown of the four generations.

Table 2.3: Generations

Characteristics	Traditionalists	Baby Boomers	Generation X	Millennials
Born	1922-1945	1946-1964	1965-1977	1978-2000
Age span	73-96 years	72-54 years	53-41 years	40-18 years
Traits	• Conservative • Believe in discipline • Respect for authority • Loyal • Patriotic	• Idealistic • Break the rules • Time stressed • Politically correct	• Pragmatic • Self-sufficient • Skeptical • Flexible • Media, information, and tech savvy • Entrepreneurial	• Confident • Well-educated • Self-sufficient • Tolerant • Team builders • Socially and politically conscious
Defining events	• Great depression • World War II • Korean War	• Vietnam war • Woodstock • Watergate	• Missing children • Latch Key Kids • Computers in school	• School shootings • Terrorism • Corporate scandals
# in society	35 million	80 million	45 million	75 million
Work purpose	If you want a roof and food	Exciting adventure	Difficult challenge	To make a difference
Work ethic	Loyal/dedicated	Driven	Balanced	Eager but anxious
Employment goals	Retirement	Second career	Work/life balance	Unrealistic
Education	A dream	A birthright	A way to the end	A given
Communication	Face to face	Telephone	Email	Text messaging
Work time defined by	Punch the clock	Visibility	Why does it matter if I get it done today?	Is it the end of the day? I have a life outside of work.
Needs in the workplace	Continued involvement past 65	Recognition	More information	Praise and fun atmosphere

Source: West Midland Family Center, 2008 (adapted).

Generational Communication and Management Strategies

Cultural and generational understanding does not take the place of concern for the individual. Different cultures and different generations care about different things and see the world differently. Utilize the strategies in Table 2.4 when interacting with an individual from the specified generation.

Table 2.4: Communication Strategies

Traditionalists	Baby Boomers
• Allow the traditionalists to set the "rules of engagement" • Ask what has worked for them in the past and fit your approach to that experience • Let them define quality and fit your approach to that definition	• Show them how you can help them use time wisely • Assess their comfort level with technology in advance • Demonstrate how important a strong team is • Emphasize that working with you will be a good experience for them
Generation X	**Millennials**
• Put all the options on the table • Be prepared to answer "why" • Present yourself as an information provider • Use their peers as testimonials when possible	• Offer customization—a plan specific to them • Offer peer-level examples • Spend time providing information and guidance • Be impressed with their decisions and communicate this to them

Module 3

Mood Disorders

Terminal Objective

Upon successful completion of this module, participants will be able to identify mood disorders commonly found in a jail setting.

Enabling Objectives

1. Identify the characteristics of a mood disorder.
2. Identify the forms, signs and symptoms, and risk factors of depression.
3. Identify types, signs and symptoms, and similarities with other illnesses of bipolar disorder.

Mood Disorders

A mood is an emotional state that may last anywhere from a few minutes to several weeks and affects the way people respond to stimuli. A mood disorder is a psychological disorder characterized by the elevation or lowering of a person's mood (also known as affective disorder). Mood disorders are demonstrated by disturbances in emotional reactions and feelings resulting in an individual's emotional experience (mood) being inconsistent with his/her circumstances.

Researchers believe that a complex imbalance in the brain's chemical activity plays a prominent role in mental illness selectivity in the individual (SAMHSA, 2017). Environmental factors can also be a trigger or buffer against the onset. Mood disorders may often have a genetic component, meaning that they tend to run in families.

Depression and bipolar disorder are the two most common mood disorders encountered by officers. Depression is the single most common cause of suicide and bipolar disorder oftentimes involves anger and rage.

Chief Kim Howell

Assistant Chief Deputy-Detention

Lubbock County Sheriff's Office

Past President, Texas Jail Association

Committee Member, Texas Mental Health Training Initiative for Jails

"The development of this program will expand the jailers' abilities to care for the growing numbers of individuals with mental health issues and those in crisis in a professional and humane manner. In addition, the delivery method will provide training and assistance to our rural jails who are often challenged with limited resources."

Depression

Depression is a widespread disorder that is often a natural reaction to trauma, loss, death, or change. Depression is not just a bad mood or feeling. It affects thinking and behaviors not caused by any other physical or mental disorder. The single most common factor in suicidal behavior or death by suicide is that the individual is experiencing depression.

Most people have experienced some form of depression in their lifetime or had repeated bouts with depression. In 2015 an estimated 16.1 million American adults had at least one major depressive episode (NIMH, 2017). Nearly twice as many women as men suffer major depressive episodes and the average age of onset is mid-twenties, but depressive episodes can start much earlier. Possible causes for depressive disorders include genetic factors, biological factors, and environmental factors.

Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.

Forms

Some forms of depression are slightly different, or they may develop under unique circumstances, such as:

- Persistent depressive disorder (also called dysthymia) is a depressed mood that lasts for at least two years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for two years to be considered persistent depressive disorder.
- Postpartum depression is much more serious than the "baby blues" (relatively mild depressive and anxiety symptoms that typically clear within two weeks after delivery) that many women experience after giving birth. Women with postpartum depression experience full-blown major depression during pregnancy or after delivery (postpartum depression). The feelings of extreme sadness, anxiety, and exhaustion that accompany postpartum depression may make it difficult for these new mothers to complete daily care activities for themselves and/or for their babies.
- Psychotic depression occurs when a person has severe depression plus some form of psychosis, such as having disturbing false fixed beliefs (delusions) or hearing or seeing upsetting things that others cannot hear or see (hallucinations). The psychotic symptoms typically have a depressive "theme," such as delusions of guilt, poverty, or illness.
- Seasonal affective disorder is characterized by the onset of depression during the winter months, when there is less natural sunlight. This depression generally lifts during spring and summer. Winter depression, typically accompanied by social withdrawal, increased sleep, and weight gain, predictably returns every year in seasonal affective disorder.

Note: Bipolar Disorder is different from depression, but it is included in the context of this list because someone with bipolar disorder experiences episodes of extremely low moods that meet the criteria for major depression (called "bipolar depression"). A person with bipolar disorder also experiences extreme highs (euphoric or irritable) moods called "mania" or a less severe form called "hypomania."

Source: National Institute of Mental Health, 2018.

Signs and Symptoms

Signs and symptoms of depression include:

- Persistent sad, anxious, or "empty" mood
- Hopelessness or pessimism
- Irritability
- Cognitive changes that interfere with daily life
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies or activities
- Decreased energy or fatigue
- Moving or talking more slowly
- Feeling restless or having difficulty staying still
- Difficulty concentrating, remembering, or making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide, or suicide attempts

- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment

Note: Five or more symptoms are generally present during the same period and are represented by a change from previous functioning for the individual.

Risk Factors

Depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors.

Depression can happen at any age, but often begins in adulthood. Depression is now recognized as occurring in children and adolescents, although it sometimes presents with more prominent irritability than low mood. Many chronic mood and anxiety disorders in adults begin as high levels of anxiety in children.

Depression, especially in midlife or older adults, can co-occur with other serious medical illnesses, such as diabetes, cancer, heart disease, and Parkinson's disease. These conditions are often worse when depression is present. Sometimes medications taken for these physical illnesses may cause side effects that contribute to depression. A doctor experienced in treating these complicated illnesses can help work out the best treatment strategy.

Risk factors include:

- Personal or family history of depression
- Major life changes, trauma, or stress
- Certain physical illnesses and medications

Bipolar Disorder

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

Types

There are four basic types of bipolar disorder; all of them involve clear changes in mood, energy, and activity levels. These moods range from periods of extremely “up,” elated, and energized behavior (known as manic episodes) to very sad, “down,” or hopeless periods (known as depressive episodes). Less severe manic periods are known as hypomanic episodes.

- Bipolar I Disorder is defined by manic episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least two weeks. Episodes of depression with mixed features (having depression and manic symptoms at the same time) are also possible.
- Bipolar II Disorder is defined by a pattern of depressive episodes and hypomanic episodes, but not the full-blown manic episodes described above.
- Cyclothymic Disorder is defined by numerous periods of hypomanic symptoms as well numerous periods of depressive symptoms lasting for at least two years. However, the symptoms do not meet the diagnostic requirements for a hypomanic episode and a depressive episode.
- Other specified and unspecified bipolar and related disorders are defined by bipolar disorder symptoms that do not match the three categories listed above.

Source: National Institute of Mental Health, 2016.

Signs and Symptoms

People with bipolar disorder experience periods of unusually intense emotion, changes in sleep patterns and activity levels, and unusual behaviors. These distinct periods are called “mood episodes.” Mood episodes are drastically different from the moods and behaviors that are typical for the person, lasting at least four days. Extreme changes in energy, activity, and sleep go along with mood episodes.

Table 3.1 shows symptoms that people having either a manic or depressive episode may experience.

Table 3.1: Episode symptoms

Manic episode	Depressive episode
• Feel very “up,” “high,” or elated • Have a lot of energy • Have increased activity levels • Feel “jumpy” or “wired” • Have trouble sleeping • Become more active than usual • Talk really fast about a lot of different things • Be agitated, irritable, or “touchy” • Feel like their thoughts are going very fast • Think they can do a lot of things at once • Do risky things, like spend a lot of money or have reckless sex	• Feel very sad, down, empty, or hopeless • Have very little energy • Have decreased activity levels • Have trouble sleeping, they may sleep too little or too much • Feel like they can't enjoy anything • Feel worried and empty • Have trouble concentrating • Forget things a lot • Eat too much or too little • Feel tired or “slowed down” • Think about death or suicide

An individual may quickly swing from the manic phase to depressed state and can experience periods of normal mood in between. This is due to the fact that an individual cannot maintain the level of activity normally associated with mania for a long period of time. Changes may be subtle or dramatic and vary greatly over a person’s life and often occur without an obvious trigger. People usually only seek professional assistance during the depressive phase, as the manic phase is reportedly very pleasant, energetic, and creative.

Sometimes a mood episode includes symptoms of both manic and depressive symptoms. This is called an episode with mixed features. People experiencing an episode with mixed features may feel very sad, empty, or hopeless, while at the same time feeling extremely energized.

Bipolar disorder can be present even when mood swings are less extreme. For example, some people with bipolar disorder experience hypomania, a less severe form of mania. During a hypomanic episode, an individual may feel very good, be highly productive, and function well. The person may not feel that anything is wrong, but family and friends may recognize the mood swings and/or changes in activity levels as possible bipolar disorder. Without proper treatment, people with hypomania may develop severe mania or depression.

Other Illnesses

Some bipolar disorder symptoms are similar to other illnesses, which can make it hard for a doctor to make a diagnosis. In addition, many people have bipolar disorder along with another illness such as anxiety disorder, substance abuse, or an eating disorder. People with bipolar disorder are also at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses.

- Psychosis. Sometimes, a person with severe episodes of mania or depression also has psychotic symptoms, such as hallucinations or delusions. The psychotic symptoms tend to match the person's extreme mood. For example:
  - Someone having psychotic symptoms during a manic episode may believe she is famous, has a lot of money, or has special powers.
  - Someone having psychotic symptoms during a depressive episode may believe he is ruined and penniless, or that he has committed a crime.

  Note: As a result, people with bipolar disorder who also have psychotic symptoms are sometimes misdiagnosed with schizophrenia.
- Anxiety and ADHD. Anxiety disorders and attention-deficit hyperactivity disorder (ADHD) are often diagnosed among people with bipolar disorder.
- Substance Abuse. People with bipolar disorder may also misuse alcohol or drugs, have relationship problems, or perform poorly in school or at work. Family, friends and people experiencing symptoms may not recognize these problems as signs of a major mental illness such as bipolar disorder.

Module 4

Thought Disorders

Terminal Objective

Upon successful completion of this module, participants will be able to outline how thought disorders are inter-related and proper response techniques.

Enabling Objectives

1. Identify the characteristics and terminology of thought disorders.
2. Discuss the causes and characteristics of psychosis.
3. Discuss the characteristics, symptoms, and types of schizophrenia.
4. Discuss response techniques for dealing with a person experiencing psychosis.

Thought Disorders

A thought disorder is a disorder of cognitive organization, characteristic of psychotic mental illness, in which thoughts and conversation appear illogical and lacking in sequence and may be delusional or bizarre in content.

Thought disorders are usually diagnosed when a person's behavior or speech patterns indicates problematic, illogical, or incoherent patterns of thinking. Thinking normally involves three parts:

- thinking about something,
- stringing thoughts together on what you are thinking about, and,
- finally, the delivery or flow of a thought pattern.

A thought disorder disrupts one or more aspects of the thought process.

Characteristics

As no one can see the thoughts of others, thought disorders are often diagnosed based on how people talk and act. General characteristics of thought disorders include:

- Disorganized thinking: difficult to follow; cannot organize/connect thoughts logically
- Tangentiality: thoughts go off in odd direction; usually experienced during high anxiety
- Circumstantiality: thoughts seem to go around in circles (non-lineal thought pattern)
- Thought blocking: can't get thoughts out; often occurs suddenly without explanation
- Neologisms: meaningless words or phrases not accepted in common use (also known as word salad)
- Disinhibited speech: lack of restraint manifested in disregard for social conventions, impulsivity, and poor risk assessment
- Clang Associations: a shift in a conversation or flow of ideas based on the sound of the words being used, not the content

Terminology

There are two terms that are fairly universal among thought disorders: hallucinations and delusions.

Hallucinations

Hallucinations are distortions in sensory input, causing an individual to experience hearing, seeing, feeling, or smelling something that is not apparent to others. These sensory perceptions can be distinguished from 'illusions' when an actual, external stimulus is misperceived or misinterpreted.

Types of Hallucinations

Hallucinations can make it very difficult for someone to focus on a conversation, hear, understand, or respond to what is being said. The three groupings of hallucinations include:

- Visual
- Auditory
- Olfactory, Taste, and Tactile

Auditory hallucinations are the most common (50-75% percent hear voices), followed by visual hallucinations. Tactile hallucinations are less frequent and usually associated with brain damage. A person may experience more than one auditory hallucination at a time.

Behavioral Signs of Hallucinations

Hallucinations can manifest with the following behaviors:

- Talking to self, laughing alone (out of context), crying without cause
- Covering ears with hands, clothing or earphones
- May “duck” or fend off something/make gestures
- Sitting/standing motionless or rocking motion
- Looking around/staring towards voices

Delusions

Delusions are fixed false beliefs that cannot be accounted for by cultural background nor altered by rational arguments and are maintained despite overwhelming evidence to the contrary. Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences.

- Bizarre delusions are things that could not occur in real life. An example is the belief that aliens removed all the person's organs and they continue to function without any internal organs.
- Non-bizarre delusions are events that could occur in real life. An example is the belief that the phone is tapped by the FBI (people are out to get me).

Types of Delusions

Delusions can make it very difficult for someone to connect with others. There are several types of delusions but we will focus on the two primary types, to include:

- Persecutory: Experiencing the feeling of being attacked, harassed, cheated, stalked, and/or conspired against.
- Grandeur: Believing that you have special powers, are much greater or more influential than you really are, believing you are famous, or have a special relationship with deity.
  - Ideas of reference: Experiencing innocuous events or mere coincidences and believing these events are of strong personal significance
  - Thought Broadcasting: Belief that thoughts can be heard by others

Behavioral Signs of Delusions

The delusion, if acted out, often leads to behaviors which are abnormal and/or out of character, although perhaps understandable in the light of the delusional beliefs. Delusions can manifest with the following behaviors:

- Expressing an idea or belief with unusual persistence or force
- Maintaining a quality of secretiveness or suspicion when the questioned about the belief
- Tending to be humorless and oversensitive, especially about the belief
- Persistently checking on items/locations out of fear of being watched
- Becoming irritable and hostile when the belief is challenged by others

Psychosis

Broadly speaking, psychosis is an illness involving a distortion of reality that may be accompanied by delusions and/or hallucinations. The individual may have sensory experiences that are not real (seeing or hearing things that others cannot see or hear) or they may believe things that have no factual basis

(that he or she is Jesus Christ). To the affected person, these hallucinations and delusions are absolutely real.

Causes

Psychosis is a symptom of a number of mental illnesses rather than a medical condition in its own right and can be present with other diagnoses, such as substance intoxication, bipolar disorder, and even major depressive disorder. Physical circumstances can also induce a psychotic state. Potential conditions include trauma, organic brain disorders (brain injury or infections to the brain), biochemical impairment, and drug or alcohol withdrawal.

Depending on the cause, psychosis can come on quickly or slowly. Experiencing a psychotic episode can be incredibly frightening for the individual and, sometimes, the event can cause the individual to lash out and hurt themselves and/or others.

Characteristics

Physical characteristics of a person in psychosis includes:

- Inappropriate or bizarre attire
- Body movements are lethargic or sluggish
- Impulsive or repetitious body movements
- Responding to hallucinations
- Causing injury to self

Early or first-episode psychosis refers to when an individual first shows signs of beginning to lose contact with reality. It is important to act quickly to connect the person with the right treatment during early psychosis.

Schizophrenia

Schizophrenia is a brain disorder that impacts the way a person thinks and is characterized by a range of cognitive, behavioral, and emotional experiences that can include: delusions, hallucinations, disorganized thinking, and grossly disorganized or abnormal motor behavior.

Schizophrenia is the most serious and debilitating mental illness affecting approximately 2.2 million adults age 18 and older. Scientists believe many different genes may increase the risk of schizophrenia, but that no single gene causes the disorder by itself. Scientists also think that interactions between genes and aspects of the individual's environment are necessary for schizophrenia to develop. Environmental factors may include exposure to viruses, prenatal nutrition, problems during birth, or psychosocial factors (NIMH, 2016).

Characteristics

To an individual dealing with schizophrenia, the experiences are extremely real and result in poor processing of information and disorganized and rambling speech and/or delusions. When an individual is dealing with a schizophrenic episode, they often respond very emotionally (not rationally) and can be very aggressive as they feel their life is being threatened. This results in a ‘flight-or-fight response’ whereby an already emotionally charged individual may take actions they would not normally take.

Characteristics of schizophrenia include:

- Delusions
- Hallucinations
- Disorganized thinking
- Grossly disorganized or abnormal motor behavior
- Negative symptoms

With schizophrenia, substantial functional deterioration generally occurs during the first 5-10 years followed by clinical deterioration which generally plateaus.

Symptoms

Schizophrenia can manifest as a broad range of symptoms with variations in severity and patterns between individuals and can change over time. Symptoms are commonly divided into two categories: positive and negative.

Positive

A positive symptom is one that adds a behavior, thought, or feeling that most people do not experience. Positive symptoms include:

- Illogical and confusing thoughts
- Hallucinations
- Delusions
- Bizarre, disorganized behavior (may be self-destructive)

Negative

A negative symptom is when a normal behavior, thought pattern, or emotion is missing. Negative symptoms include:

- Disillusionment with daily life
- Apathetic appearance
- Diminished facial expression
- Decreased emotional expressiveness
- Isolating behavior
- Lack of motivation
- Lack of significant cognitive activity
- Infrequent or monotone speaking

Types

Although the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) 5th edition changed the method of classification for schizophrenia to bring all previously existing categories under a single heading, we will briefly mention the most prevalent previously existing types here as a point of reference.

Paranoid Schizophrenia

Paranoid schizophrenia is the most commonly experienced type of schizophrenia and is characterized by very prominent hallucinations and delusions. Individuals often have an extensive network of paranoid

thoughts and ideas which results in a disproportionate amount of time spent thinking up ways to protect themselves from their perceived persecutors.

Catatonic Schizophrenia

Catatonia is a disturbance in motor movements that has either a psychological or physiological basis. The most common state includes periods where the individual:

- moves very little and
- does not respond to instructions (in a stupor).

Symptoms can flip between underactivity to hyperactivity (catatonic excitement) where the individual demonstrates motor activity that is considered excessive and peculiar such as:

- Echolalia (mimicking sounds)
- Echopraxia (mimicking movements)

Individuals suffering from catatonia will experience a pattern of worsened symptoms alternating with remissions instead of a cure.

Responding to a Person in Psychosis

A person experiencing a psychotic episode may not wish to get help or even realize that they are unwell. It is important to recognize that reactions such as fear, anxiety, anger, loss, sadness, blame and confusion are common for these individuals. When responding to a person experiencing psychosis, do the following:

- Stay calm
- Be aware
- Maintain professionalism
- Listen non-judgmentally
- Don’t laugh/make fun
- Give simple, evenly paced answers
- Prepare to repeat
- Don’t confirm/deny the person’s beliefs
- Don’t make medication, treatment, or diagnosis the focus
- Don’t threaten
- Stay positive and ask questions
- Don’t play into the person’s hallucinations

Psychotic individuals are at a greater risk of harming themselves. Any threats of violence, self-harm, or suicide should be taken seriously.

Module 5

Personality Disorders

Terminal Objective

Upon successful completion of this module, participants will be able to group personality disorders according to cluster and how they may be inter-related.

Enabling Objectives

1. Discuss the causes, characteristics, and three clusters of personality disorders.
2. Discuss the characteristics and behaviors of the three cluster a personality disorders.
3. Discuss the characteristics and behaviors of the four cluster b personality disorders.
4. Discuss the characteristics and behaviors of the three cluster c personality disorders.

Personality Disorders

Personality is the way of thinking, feeling and behaving that makes a person different from other people. An individual's personality is influenced by:

- experiences,
- environment (surroundings and life situations), and
- inherited characteristics.

A personality disorder is a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning, and lasts over time. This deviation in thinking and behaving may affect one's perceptions of themselves and others; emotional reactions; the ability to maintain healthy interpersonal relationships; and/or ability to manage impulses.

The defining features of a personality disorder can be summarized as:

- Distorted thinking patterns
- Problematic emotional responses
- Over or under-regulated impulse control
- Interpersonal difficulties

  Note: Before a diagnosis is made, a person must demonstrate significant and enduring difficulties in at least two of those four areas.

Causes

Common to all personality disorders is a long-term pattern of behavior and inner experience that differs significantly from what is expected. The pattern of experience and behavior begins by late adolescence or early adulthood, and causes distress or problems in functioning. Without treatment, the behavior and experience is inflexible and usually long-lasting.

Most personality disorders are caused by a combination of environmental and genetic factors. Environmental factors often include childhood history of instability, verbal/physical abuse, neglect, and poor peer relationships. One does not have to exhibit all the example behaviors in order to meet the criteria for a diagnosable personality disorder.

Individuals dealing with a personality disorder usually have very little insight that they have a problem and tend to believe the “problems” are caused by other people or the “system.” Personality disorders are not treated like other mental illnesses (not amenable to medications) and most are thought to be caused by family history.

Characteristics

Characteristics of personality disorders include:

- Difficulty dealing with other people
- Inflexible and rigid
- Unable to respond to the changes and demands of life
- Narrow view of the world
- Difficult to participate in social events
- Usually do not seek treatment, don't think they have a problem
- Breaks the laws

- Use alcohol and illegal substances as a form of self-medication
- Often need treatment for chemical dependency or depression

Types

According to the DSM-V, there are 10 distinct types of personality disorders which can be grouped into three clusters according to similarities:

- Cluster A: appear odd/eccentric
  - Paranoid, Schizoid, Schizotypal
- Cluster B: appear dramatic/erratic
  - Antisocial, Borderline, Histrionic, Narcissistic
- Cluster C: appear anxious/fearful
  - Avoidant, Dependent, Obsessive-compulsive

A person can be diagnosed with more than just one personality disorder. Research has shown that there is a tendency for personality disorders within the same cluster to co-occur (Skodol, 2005).

Cluster A Personality Disorders

Cluster A personality disorders have the descriptive similarities of “odd and eccentric.” The common features of the personality disorders in this cluster are social awkwardness and social withdrawal. These disorders are dominated by distorted thinking.

Paranoid Personality Disorder

Individuals with paranoid personality disorder often exhibit the following:

- Pervasive distrust and suspiciousness of others such that motives are interpreted as malevolent, deliberately threatening, or demeaning
- Assume that others are out to harm them, take advantage of them, or humiliate them; perceives other individual’s behavior as dismissive
- May build up and harbor unfounded resentment for an unreasonable length of time
- May preemptively attack others whom they feel threatened

The disorder, surfacing by early adulthood, is manifested by an omnipresent sense of distrust and unjustified suspicion that yields persistent misinterpretation of others' intentions as being malicious.

People with paranoid personality disorder are usually unable to acknowledge their own negative feelings toward others but do not generally lose touch with reality. They will not confide in people, even if they prove trustworthy, for fear of being exploited or betrayed. This avoidance and strong need for self-sufficiency make the individual appear as rigid and often litigious. Due to their avoidance of closeness with others, they may appear calculating and cold.

Schizoid Personality Disorder

Individuals with schizoid personality disorder often exhibit the following:

- Detachment from social relationships; tend to be socially isolated
- Do not seek out or enjoy close relationships; typically seek out solitary activities

- Restricted range of emotional expression in interpersonal settings; may seem aloof, detached, or cold

Schizotypal Personality Disorder

Individuals with schizoid personality disorder often exhibit the following:

- Pervasive pattern of social and interpersonal limitations; appearing socially isolated, reserved, and distant
- Acute discomfort in social settings and a reduced capacity for close relationships
- Perceptual and cognitive distortions and/or eccentric behavior (unlike the Schizoid Personality Disorder)
- Often have odd or superstitious beliefs and fantasies inconsistent with cultural norms

Cluster B Personality Disorders

Cluster B personality disorders have the descriptive similarities of “dramatic, emotional, and erratic.” The common features of the personality disorders in this cluster are problems with impulse control and emotional self-regulation.

Antisocial Personality Disorder

Individuals with antisocial personality disorder often exhibit the following:

- Pervasive patterns of disregard for and violation of the rights of others; often manifests as hostility, blaming others, and/or aggression
- Individuals often exhibit superficial charm, grandiosity, pathological lying, manipulation, and deceitfulness
- Express callousness, lack of remorse, shallowness and failure to accept responsibility; have a blatant disregard for society’s laws
- Often place themselves in dangerous or risky situations; impulsive, sensation seeking, and irresponsible

The diagnosis of antisocial personality disorder is generally not given to individuals under the age of 18 but is given only if there is a history of some symptoms of conduct disorder before age 15. The symptoms of antisocial personality disorder can vary in severity. The more egregious, harmful, or dangerous behavior patterns are referred to as sociopathic or psychopathic. Although there has been much debate as to the distinction between these descriptions, they are primarily defined as follows:

- Sociopathy is chiefly characterized as something severely wrong with one's conscience.
- Psychopathy is characterized as a complete lack of conscience regarding others.

Note: Some professionals describe people with this constellation of symptoms as “stone cold” to the rights of others.

People with this illness may seem charming on the surface, but they are likely to be irritable and aggressive as well as irresponsible. They may have numerous somatic complaints and perhaps attempt suicide. Due to their manipulative tendencies, it is difficult to tell whether they are lying or telling the truth. Complications of this disorder include imprisonment, drug abuse, and alcoholism.

Borderline Personality Disorder

Individuals with borderline personality disorder often exhibit the following:

- Tend to experience intense and unstable emotions and moods that can shift fairly quickly between “all good” and “all bad”
- See the world in polarized, all-or-nothing terminology; causes an unstable sense of self
- Pattern of radical changes that occur without warning or advanced preparations; pattern of unstable relationships, including employment; Feelings of emptiness or abandonment
- Engage in impulsive behaviors such as substance abuse, risky sexual encounters, self-injury, overspending, and/or binge eating

Borderline personality disorder is one of the most studied personality disorders and often occurs in women and/or victims of sexual abuse or disrupted early development. The disorder occurs in the context of relationships: sometimes all relationships are affected, sometimes only one. It usually begins during adolescence or early adulthood. These individuals frequently view themselves as victims of their circumstances and take little responsibility. These individuals may engage in deliberate self-harming behaviors (e.g. cutting, burning, hitting, head banging) as the pain of the injury may generate a sense of release/relief of the emotional pain.

The overlap of this disorder with other disorders is widely studied and includes the following:

- 24-74% also diagnosed with Major Depression
- 4-20% also diagnosed with Bipolar Disorder
- 25% are also bulimic
- 67% are diagnosed with substance use/abuse disorders

Histrionic Personality Disorder

Individuals with histronic personality disorder often exhibit the following:

- Pattern of excessive emotions and attention seeking; seek the thrill of drama
- Self-centered behaviors and conversations when around others; uncomfortable when they are not the center of attention
- Flamboyant and theatrical expressions; exhibit an exaggerated degree of emotional expression yet the expression is vague and shallow
- Often quite flirtatious and seductive to draw attention to self; easily influenced by other’s suggestions and opinions

Narcissistic Personality Disorder

Individuals with narcissistic personality disorder often exhibit the following:

- Gradiose; need admiration to bolster self esteem; and lack empathy for others
- Believe they deserve special treatment; assume they have special powers/uniquely talented; believe they are especially brilliant or attractive
- Act in ways that fundamentally disregard and disrespect the worth of others due to their sense of self entitlement
- Often feel devastated when they realize that they have normal, average human limitations

Cluster C Personality Disorders

Cluster C personality disorders have the descriptive similarities of “anxious and fearful.” The common feature of the personality disorders in this cluster are high levels of anxiety.

Avoidant Personality Disorder

Individuals with avoidant personality disorder often exhibit the following:

- Believe they are not good enough; that others don't like them
- Think of themselves as unappealing and socially inept
- Feel intense anxiety in social situations; intense fear of being ridiculed, criticized, and rejected
- Hypersensitivity to negative comments

Dependent Personality Disorder

Individuals with dependent personality disorder often exhibit the following:

- Excessive need to be taken care of; submissive, clinging behavior; fear of separation
- Intense fear of losing a relationship makes them vulnerable to manipulation and abuse
- Find it difficult to express disagreement or make independent decisions; have difficulty beginning a task on their own
- When a relationship ends, they will immediately seek another source of support; being alone is extremely hard

Obsessive-Compulsive Personality Disorder

Individuals with obsessive-compulsive personality disorder often exhibit the following:

- Preoccupation with orderliness, perfectionism, and mental and inter-personal control, often at the expense of flexibility, openness, and efficiency
- Often devoted to work; neglect social relationships
- Perfectionist tendencies; so driven in their work to “get it right” they become unable to complete projects
- Get lost in the details, and fail to see the “forest for the trees”

Module 6

Cognitive Disorders

Terminal Objective

Upon successful completion of this module, participants will be able to identify the categories and associated symptoms of cognitive disorders.

Enabling Objectives

1. Identify the characteristics, symptoms, and categories of a cognitive disorder.
2. Discuss the characteristics of delirium.
3. List the symptoms and forms of dementia.
4. Outline the impacts and symptoms of traumatic brain injury.
5. List the symptoms, response techniques, and documentation expectations for excited delirium.

Cognitive Disorders

Cognitive disorders are a category of mental health disorders that primarily affect learning, memory, perception, and problem solving, and defined as any disorder that significantly impairs the cognitive function of an individual to the point where normal functioning in society is impossible without treatment.

Characteristics

Cognitive disorders consist of significant cognitive decline in one or more areas:

- *Attention:* ability to sustain attention to a task; ability to pay attention to something despite other distractions; ability to do two things at once.
- *Executive function (judgment/decision making):* impaired ability to plan, make decisions, hold information briefly in one's mind (a telephone number), ability to learn from mistakes.
- *Learning and memory:* ability to repeat words or digits; ability to recall recent information; ability to apply information.
- *Language:* ability to find the correct labels or words for an object or situation; misuse of names, verbs, or other word choices; comprehension.
- *Perceptual-motor:* eye-hand/body coordination.
- *Social awareness:* identification in changes in others' facial expression; emotional intelligence

Symptoms

Symptoms related to cognitive disorders are:

- A major loss of contact with reality
- A gross interference with the ability to meet life's demands
- Possible delusions and hallucinations
- Alteration of mood
- Defects in perception, language, memory and cognition

Categories

There were previously four major categories of cognitive disorders.

- Delirium: A change in consciousness that develops over a short period of time where the individual has a reduced awareness of their environment.
- Dementia: A progressive deterioration of brain function that is marked by impairment of memory, confusion, and inability to concentrate.
- Amnesia: A significant loss of the memory despite no loss of other cognitive functions.
- Cognitive disorders not otherwise specified: Cognitive impairment presumed to be due to a general medical condition or substance use that does not fit into the other categories.

Under the previous classification system, cognitive impairments not meeting the criteria for dementia were labeled cognitive disorder not otherwise specified (NOS), or perhaps age-related cognitive decline.

When the DSM-V was revised, the cognitive disorders categories were changed to:

- Delirium
- Mild Neurocognitive Disorder

- Major Neurocognitive Disorder

Delirium remains the same. In the new continuum-based system, cognitive impairments that do not reach the threshold for a diagnosis of dementia are termed mild neurocognitive disorders, whereas the different types of dementias constitute nearly all of the major neurocognitive disorders.

> **Note:** For the purposes of this course, we will focus on defining the key terms so that you can better understand where these items may fall on the continuum.

Delirium

Delirium is a condition of severe confusion and rapid changes in brain function. In and of itself, it is not a disease, but rather a cluster of symptoms that may result from a disease or other clinical process. Delirium can be drug induced, medication induced, or due to a medical condition and usually develops over a short period (hours or days).

Delirium is characterized by attentional deficits (reduced ability to direct, focus, sustain, or shift attention), memory deficit, and disorientation. Individuals experiencing delirium often experience an inability to comprehend speech or follow instructions.

Dementia

Dementia is an umbrella term used to describe a decline in memory or brain function that impacts an individual's daily life. This is different from the normal decrease in short-term memory most people experience as they age.

Dementia is caused by changes in the brain which impact cognitive function, including vascular disease, brain damage, stroke, as well as other conditions.

Symptoms

Dementia is a degeneration of mental functioning involving thinking, memory, and reasoning. Dementia severity can range from mild (some impairment in day to day living) to severe (completely reliant upon others for basic needs). Although memory loss is a common sign of dementia, memory loss alone does not mean someone has dementia (NIH, 2017).

Symptoms of dementia include:

- Memory problems
- Confabulation (confusing fact with fiction)
- Impaired thinking
- Impaired judgment
- Impaired problem solving

Especially in later stages, subjects may be disoriented:

- in time (not knowing the day, week, or even year),
- in place (not knowing where they are), and
- in person (not knowing who they and/or others around them are).

Dementia can be classified as either reversible or irreversible.

Forms

There are seven forms of dementia, with the two primary forms discussed here. Although dementia mainly affects older people, it is not a normal part of aging. Worldwide, 47.5 million people have dementia and there are 7.7 million new cases every year. Alzheimer's disease is the most common cause of dementia and may contribute to 60-70% of cases.

Distinguishing between different types of neurodegenerative conditions is important as it helps in determining the best treatment approach. Medications suitable for one of these conditions, for example, might create problems when given to a patient with the other condition.

Alzheimer’s Disease

Every 66 seconds someone in the United States develops Alzheimer's, a progressive disease, where dementia symptoms gradually worsen over a number of years. In its early stages, memory loss is mild, but with late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment.

Parkinson’s Disease

Parkinson's disease is a chronic and progressive movement disorder, meaning that symptoms continue and worsen over time. Nearly one million people in the US are living with Parkinson's disease. The cause is unknown, and although there is presently no cure, there are treatment options such as medication and surgery to manage the symptoms.

Parkinson's involves the malfunction and death of vital nerve cells in the brain, called neurons. Parkinson's primarily affects neurons in an area of the brain called the substantia nigra. Some of these dying neurons produce dopamine, a chemical that sends messages to the part of the brain that controls movement and coordination. As this disease progresses, the amount of dopamine produced in the brain decreases, leaving a person unable to control movement normally.

Traumatic Brain Injury

Traumatic brain injury, often referred to as TBI, is most often an acute event similar to other injuries. That is where the similarity between traumatic brain injury and other injuries ends. One moment the person is normal and the next moment life has abruptly changed.

Traumatic brain injuries are “caused by impact to the head, or other mechanisms of rapid movement or displacement of the brain within the skull, as can happen with blast injuries” (Meaney, D.F., Morrison, B., and Bass, D., 2014).

In most other aspects, a traumatic brain injury is very different. Since our brain defines who we are, the consequences of a brain injury can affect all aspects of our lives, including our personality. A brain injury is different from a broken limb or punctured lung. An injury in these areas limit the use of a specific part of your body, but your personality and mental abilities remain unchanged. Most often, these body structures heal and regain their previous function.

These injuries can occur from proximity to a blast, blunt force trauma, and penetrating injuries. Brain injuries do not heal like other injuries. Recovery is a functional recovery, based on mechanisms that remain uncertain. No two brain injuries are alike and the consequence of two similar injuries may be very different. Symptoms may appear right away or may not be present for days or weeks after the injury. One of the consequences of brain injury is that the person often does not realize that a brain injury has occurred.

Impacts of Traumatic Brain Injuries

Impacts of a traumatic brain injury include:

- Difficulty in taking initiative
- Inability to problem solve
- Narrowed judgment
- Inhibition of behavior
- Lack of planning/anticipation
- Difficulty self-monitoring
- Errors with motor planning
- Changed personality/emotional responses
- Lack of awareness of abilities/limitations
- Difficulty with organization
- Limited attention/concentration
- Decreased mental flexibility
- Speaking (expressive language)

Following a moderate to severe TBI, individuals experience a decline in life satisfaction. Life satisfaction is associated with factors including ability to maintain employment and thus earn sufficient income, quality of social relationships, ability to engage in leisure activities, and level of acquired disability.

Symptoms of Traumatic Brain Injuries

The presentation of symptoms varies between individuals and with the severity of the injury. Behavioral symptoms of traumatic brain injury include:

- Irritability
- Aggression
- Paranoia
- Lack of restraint
- Anxiety
- Apathy/depression
- Insensitivity
- Egocentricity
- Lack of concentration
- Difficulty with memory
- Reckless decision-making
- Agitation
- Anger
- Lack of empathy
- Increased verbal and physical altercations
- Inappropriate or impulsive behavior/aggression or abusive language

- May appear to be resistance to authority
- Difficulty remaining focused
- May present as early dementia
- Subject may not remember, or respond well to, instructions or questions

Excited Delirium

Excited delirium syndrome is a serious and potentially deadly medical condition/emergency involving psychotic behavior, elevated temperature, and an extreme fight-or-flight response by the nervous system. Failure to recognize the symptoms and involve emergency medical services (EMS) to provide appropriate medical treatment and stabilization may lead to death.

Excited delirium syndrome subjects typically are males around the ages of 30 and 40. Most have a history of psychostimulant use or mental illness or a combination of both.

- Subjects are usually violent, aggressive, and combative with hallucinations, paranoia, or fear.
- Subjects may demonstrate profound levels of strength, resist painful stimuli or physical restraint, and seem impervious to self-inflicted injuries.
- Severe sweating is a clue that the subject has an elevated temperature and when combined with hallucinations excited delirium syndrome should always be promptly considered as a possibility.

  Note: Differentiating excited delirium syndrome from other medical causes or uncomplicated intoxication can prove difficult, but a prudent course of action is to assume the worst and obtain medical help for the subject.

In cases where death occurs, the following series of events almost always occurs:

- The subject shows signs of excited delirium syndrome and is under the influence of drugs or has a history of mental illness.
- There is a struggle with law enforcement/detention personnel.
- Some sort of force is used (physical, chemical, or electronic).
- The subject is restrained.
- The subject stops struggling, his or her breathing becomes shallow, and within minutes he or she is dead.

  Note: Only those restraints necessary to control the situation should be used, and the subject should be positioned in a way that assists breathing, such as on his or her side or sitting up. As soon as the subject is controlled, EMS personnel should examine the subject and provide medical aid as necessary.

Symptoms

Symptoms of excited delirium include:

- Aggressive, threatening, or combative behavior which escalates when challenged or injured
- Superhuman strength
- Insensitivity to pain
- Pressure or loud or incoherent speech
- Sweating (or continuing to sweat) after physical exertion has ceased
- Dilated pupils; individual is less reactive to light

- Rapid breathing
- High body temperature (105-113ºF); subject will often disrobe due to profuse sweating and high body temperature
- Constant or near constant physical activity
- Nakedness/shedding of clothing that might indicate “self-cooling” attempts
- Making unintelligible, animal-like noises
- Lack of fatigue
- Paranoid or panicked demeanor
- Attraction to bright lights, loud sounds, glass, or shiny objects

Appropriate Response to Excited Delirium

Appropriate response to excited delirium is as follows:

- Notify medical staff (rapid chemical sedation can be lifesaving)
- Remove physical restraints when feasible
- When using restraints monitor the subject for positional asphyxiation If reasonably possible, wait for adequate backup before making physical contact with the subject.
- When the subject is responsive to verbal commands, only one officer should approach the subject and employ verbal techniques to help reduce his or her agitation before resorting to force. The officer should:
  - not rush toward, become confrontational, verbally challenge, or attempt to intimidate the subject, as he or she may not comprehend or respond positively to these actions and may become more agitated and combative;
  - remain calm and avoid overacting;
  - introduce yourself;
  - indicate a willingness to understand and help;
  - actively listen;
  - if there is no apparent threat of immediate injury to the subject or others, keep your distance and do not make physical contact with the subject;
  - use the inmate's name throughout the conversation/interaction;
  - speak simply and briefly and move slowly;
  - if possible, remove distractions, upsetting influences, and disruptive inmates;
  - be friendly, patient, accepting, and encouraging;
  - remain firm and professional;
  - reassure the subject that no harm is intended;
  - recognize that a subject's delusions or hallucinations are real to him or her.
- If it is necessary to get the subject under physical control, the Swarm/Star technique is recommended as long as an adequate number of deputies/officers are available. A coordinated restraint plan should be devised before implementing this approach.
- Use only those approved restraints that appear necessary to control the situation and only for the period of time required.

- When restrained, position the subject in a manner that will assist breathing, such as placement on his or her side, and avoid pressure to the chest, neck or head.
- Do not attempt to control continued resistance or exertion by pinning the subject to the ground or against a solid object, using their body weight.
- If possible, do not kneel or sit on the subject's back or neck while the subject is in a prone position on his or her stomach. This can cause positional asphyxia.
- Check the subject's pulse and respiration on a continuous basis until transferred to EMS/medical personnel.
- Following a struggle, the subject should be showing normal signs of physical exertion such as heavy breathing.

Note: If the subject becomes calm and breathing is not labored during or after the application of restraints, it might be an indication that he or she is in jeopardy and requires immediate medical attention.

Less Lethal Options

Corrections officers should be aware that pepper spray, impact weapons, and electronic control weapons (ECSs) used in “contact” mode may not always be effective with these subjects due to their elevated threshold of pain. However, these options should be utilized as part of the use-of-force continuum when it is reasonable to do so.

Emergency Medical Response

As soon as control is obtained, pre-staged EMS/medical personnel should examine the subject and provide emergency medical aid as necessary.

Swarm/Star Technique

A coordinated technique to gain physical control of an individual. This technique requires five personnel. Each officer is responsible for immobilizing an extremity: head, right arm, left arm, right leg, and left leg. Personnel swarm the subject at the same time immobilizing their assigned extremity.

Note: This technique should be used if available staff are available and according to the facility policy.

Documentation

Documentation of excited delirium syndrome incidents is critical for purposes of:

- Post-incident personnel review and debriefing
- Training
- The creation of a historical record to respond effectively to any civil litigation that might arise
- To respond effectively to inquiries concerning the incident from the community and media

Personnel should follow standard incident documentation procedures for your agency.

Module 7

Psychopharmacology

Terminal Objective

Upon successful completion of this module, participants will be able to state the importance of psychopharmacology to mental health stability.

Enabling Objectives

1. Review the history, mode of action, and usage of psychoptropic medications for mental illness.
2. Identify the five classes of psychotropic medications.
3. Discuss how each class of psychotropic medications functions and is utilized in controlling the symptoms of mental illness.
4. List at least two side effects of each class of psychotropic medications.

Psychoptropic Medications

One of the primary reasons people go into mental health crisis is because they do not take their prescribed psychotropic medications. The main therapy today for individuals with serious and persistent mental illness is drug therapy and thus learning about psychotropic medications is integral to understanding this issue.

Definition

Psychotropic refers to any chemical prescribed and administered primarily to change behavior, mood, consciousness, cognition, perception or anxiety level. These medications are used in the treatment of Mental Illness to:

- Control dysfunctional symptoms
- Improve functioning
- Enhance quality of life
- Aid in restoration of “normalcy” or recovery

Psychopharmacology is the study of the way treatment with chemicals alters and affects brain and body functioning. Today, we have a wide array of medications that have been developed to address depression, anxiety, and psychosis.

History

The widespread use of drugs for treatment among persons with a mental illness is a relatively new development. Treatment with medications began during the 1950's, and continues to be an effective option for individuals with a mental illness.

While it is not a cure, they are used to control symptoms and improve coping skills, which can then help reduce the severity of the mental illness. Most individuals who are on psychotherapeutic medications for mental illness will continue taking them for the rest of their lives.

Mode of Action

Psychotropic medications act on the brain and central nervous system. They change the way chemicals in the brain called neurotransmitters send messages between brain cells through a synapse (Figure 7.1) or crossing. Each psychotropic medication is used to treat certain “target” symptoms.

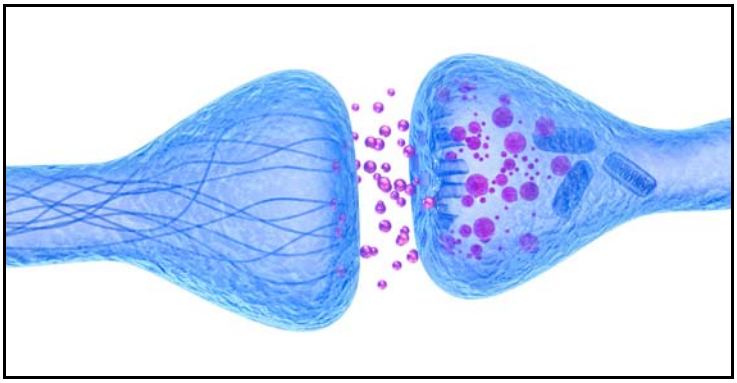


Figure 7.1: Synapse

The main neurotransmitters in the brain are dopamine, serotonin, norepinephrine and GABA. Medications can increase or decrease the neurotransmitters and consequently they affect changes in brain activity.

Usage

The question “Is mental illness a biological or psychological problem?” is too simplistic. Most practitioners now adopt the “bio-psychosocial” position of causality; disease cannot be understood without reference to the person’s psychological and social environment.

Mental Illness is considered an interplay of environmental and psychological factors coupled with biochemical dysfunction.

- Most “purely” psychological problems are not primarily treated with medication, except possibly for symptom reduction.
- Most biologically-based mental illnesses require medication as a central part of treatment.

Medications, even when the person is compliant, are not usually sufficient and require different types of therapy:

- Individual
- Group
- Day Treatment

Persons with mental illness often lack insight into their condition and this appears as the most common reason for relapse (i.e., discontinuation of medications). In the community, persons with mental illness also need:

- Case management and wrap-around services
- Safe, affordable housing
- Therapeutic employment
- Clubhouse services

Once the right medication regimen is identified for the properly diagnosed disorder, there is a high probability of an efficacious response. Persons with mental illness who stick to their medications as prescribed do experience symptom relief and improvements in their quality of life.

Classes of Psychotropic Medications

Classes of medication are covered here to provide an overview to officers. They are not intended to be a comprehensive diagnostic tool nor are they intended to be a comprehensive list as new medications continue to come on the market.

Antipsychotics

Antipsychotics are used mainly for schizophrenia and bipolar disorder but can also be used to help with severe anxiety or depression.They can help with hallucinations, delusions, difficulty thinking clearly, extreme mood swings, and severe depression. These medications reduce dopamine however in excess they can cause Parkinson-like side effects.

- Older drugs are called “Typical”
  - First appeared in the mid-1950s
  - Block the action of dopamine

- New drugs are called “Atypical”
  - Over the last 10 years
  - Still block dopamine but much less so than the older drugs

Note: Tardive dyskinesia is a side effect of antipsychotic medications that causes stiff, jerky movements of the face and body that can't be controlled. An individual might blink their eyes, stick out their tongue, or wave their arms without meaning to do so.Not everyone who takes an antipsychotic drug will get it but it can sometimes become permanent. If you observe this behavior in an inmate, notify the medical staff so that they can adequately observe and adjust medications.

Table 7.1 shows the different side effects for the different types of antipsychotic medications.

Table 7.1: Side Effects

Older Antipsychotics Side Effects	Newer Antipsychotics Side Effects
• Stiffness and shakiness (like Parkinson's disease) • Feeling sluggish and slow in your thinking • Uncomfortable restlessness (akathisia) • Some can effect your blood pressure and make you feel dizzy • Problems with sex life/changes in libido	• Sleepiness and slowness • Weight gain • Interference with sex life/changes in libido • Increased chance of developing diabetes • Some can effect blood pressure and make you feel dizzy • Long-term use can produce movements of face (tardive dyskinesia)

Mood Stabilizers

Mood stabilizers are used primarily to treat bipolar disorder, mood swings associated with other mental disorders, and in some cases, to augment the effect of other medications used to treat depression. Lithium, which is an effective mood stabilizer, is approved for the treatment of mania and the maintenance treatment of bipolar disorder.

A number of cohort studies describe anti-suicide benefits of lithium for individuals on long-term maintenance. Mood stabilizers work by decreasing abnormal activity in the brain and are also sometimes used to treat:

- Depression (usually along with an antidepressant)
- Schizoaffective Disorder
- Disorders of impulse control
- Certain mental illnesses in children

Anticonvulsant medications are also used as mood stabilizers. They were originally developed to treat seizures, but they were found to help control unstable moods as well.

Side effects include:

- Itching, rash
- Excessive thirst
- Frequent urination
- Tremor (shakiness) of the hands
- Nausea and vomiting

- Slurred speech
- Fast, slow, irregular, or pounding heartbeat
- Blackouts
- Changes in vision
- Seizures
- Hallucinations (seeing things or hearing voices that do not exist)
- Loss of coordination
- Swelling of the eyes, face, lips, tongue, throat, hands, feet, ankles, or lower legs.

Antidepressants

Antidepressants are medications commonly used to treat depression and other health conditions, such as anxiety, pain and insomnia. Although antidepressants are not FDA-approved specifically to treat ADHD, antidepressants are sometimes used to treat ADHD in adults.

Antidepressants control the feelings of sadness, hopelessness, and suicidal thoughts. These medications are considered effective, non-addictive, and non-tolerance forming and are most commonly prescribed for severe and/or long-standing depression, The type of anti-depressant prescribed will determine if there is an increase of either/both serotonin and norepinephrine and generally takes 4-6 weeks for total medication effect.

Some antidepressants may cause more side effects than others. You may need to try several different antidepressant medications before finding the one that improves your symptoms and that causes side effects that you can manage. The most common side effects listed by the FDA include:

- Nausea and vomiting
- Weight gain
- Diarrhea
- Sleepiness
- Sexual problems

Anti-Anxiety Agents

Anxiety is a normal reaction to stress. It helps a person deal with a tense situation by helping one cope. But when anxiety becomes excessive and irrational it becomes a disorder. Anxiety disorders can take on many forms.

- You may feel a “free-floating” anxiety which translates into not knowing what you are anxious about.
- You could suffer panic attacks which are sudden, intense, and strike without warning.
- Your anxiety could display itself as extreme social inhibition, a phobia, or an unwanted obsession or compulsion.

These anxieties however, have one thing in common. They are persistent and often overwhelming and can lead to the following characteristics:

- Constant, unrelenting, and all-consuming
- Causing self-imposed isolation or emotional withdrawal
- Interference with normal activities like going outside or interacting with other people.

Anti-anxiety medications help reduce the symptoms of anxiety, such as panic attacks, or extreme fear and worry. They generally have a muscle-relaxing, tension-relieving, fear-reducing effect with a quick onset of 30 minutes or less. Alertness and reactions may be slowed or impaired and addiction and withdrawal symptoms are significant.

The most common anti-anxiety medications are called benzodiazepines. Benzodiazepines can treat generalized anxiety disorder. In the case of panic disorder or social phobia (social anxiety disorder), benzodiazepines are usually second-line treatments, behind SSRIs or other antidepressants.

Side effects include:

- Nausea
- Blurred vision
- Headache
- Confusion
- Tiredness
- Nightmares

Stimulants

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. Stimulant medications are often prescribed to treat individuals diagnosed with ADHD. Prescription stimulants have a calming and “focusing” effect on individuals with ADHD. Stimulant medications are safe when given under a doctor's supervision; however some individuals may feel slightly different or “funny.”

Side effects include:

- Difficulty falling asleep or staying asleep
- Loss of appetite
- Stomach pain
- Headache

Less common side effects include:

- Motor tics or verbal tics (sudden, repetitive movements or sounds)
- Personality changes, such as appearing “flat” or without emotion

Module

8

Substance Abuse and Co-Occurring Disorders

Terminal Objective

Upon successful completion of this module, participants will be able to outline how substance abuse is a factor in mental illness and other co-occurring disorders.

Enabling Objectives

1. Discuss substance abuse risk factors, the stages of alcohol or drug involvement, and the five substance categories.
2. Define co-occurring disorders.
3. Define substance-induced psychosis.

Substance Abuse

According to the World Health Organization (WHO), substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome (a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use) and typically includes:

- a strong desire to take the drug,
- difficulties in controlling its use,
- persisting in its use despite harmful consequences,
- a higher priority given to drug use than to other activities and obligations,
- increased tolerance, and
- sometimes a physical withdrawal state.

Addiction is defined as both a physical dependence and a psychological dependence upon a drug or multiple drugs, including alcohol.

- Physical dependence is characterized by a tolerance to the drug of choice (e.g., needing an increasingly larger dose in order to experience the desired effect).
- Psychological dependence is defined by cravings for the drug or obsessing over the thrill of getting and staying high.

According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Risk Factors

Individuals often begin abusing substances as a form of self-medication to treat symptoms such as depression, insomnia, or anxiety. Combining drugs or alcohol with medications may result inconsistent medication absorption, dangerous chemical combinations, and a lack of medical monitoring. Factors can affect the likelihood and speed of developing an addiction, to include:

- Family history of addiction
- Mental health disorder
- Peer pressure
- Lack of family involvement
- Early use
- Taking a highly addictive drug

There appears to be a cause and effect relationship between mental illness and substance abuse disorders.

- Individuals with mental illness have an increased risk for substance abuse disorders; conversely individuals with substance abuse disorders have an increased risk for mental illness.
- 1/3 of mental illness patients experience substance abuse disorders at some point; twice the rate among people without mental illness.
- More than 50% of people who use or abuse alcohol and other drugs have experienced psychiatric symptoms significant enough to fulfill diagnostic criteria for a mental illness.

Prolonged abuse of any drug whether it is alcohol, prescription medications, or ‘street drugs’ can cause chemical dependency or addiction. If these substances are used for extended periods of time and/or in

large dosages, they may also cause permanent damage to the central nervous system. This damage can cause a wide range of psychological reactions that are classified as disorders. Examples of such psychological reactions are:

- Smoking a stimulant like crack cocaine can cause paranoid symptoms
- Prolonged alcohol use can produce depressive symptoms
- Taking drugs such as Bath Salts, Kush, Cocaine, PCP and Methamphetamine can result in Excited Delirium Syndrome, a serious and potentially deadly medical condition involving psychotic behavior

Stages of Alcohol or Drug Involvement

There are four different stages of alcohol or drug involvement. All stages present problematic behaviors that may have some mental health involvement.

- Use can prompt development and provoke mental illness emergence.
- Use can worsen the severity of mental illness.
- Use can temporarily mask mental health symptoms and syndromes.

Stage 1: Intoxication

Intoxication is a reversible, substance-specific syndrome due to recent ingestion of/or exposure to a substance. While intoxicated, individuals may experience exhilaration, excitement, and/or euphoria.

Symptoms are not due to a general medical condition and are not accounted for by another mental disorder. The symptoms of drug use or intoxication vary, depending on the type of drug. Intoxication can mimic mental illness symptoms and syndromes with the type, duration, and severity of the symptoms related to the type, dose and chronicity of the substance used.

Stage 2: Abuse

Abuse is the continuous pattern of use leading to clinically significant impairment or distress. In this stage, an individual's overindulgence in an addictive substance is often a result of a lack of self-control and can result in:

- failure to fulfill personal/social obligations,
- seemingly senseless decision making,
- legal problems, and
- places the person in physically hazardous situations.

Long-term exposure and the use of Illicit substances have been found to permanently alter brain chemistry and functioning.

Stage 3: Dependence

Dependence refers to a physical condition in which the body has adapted to the presence of a drug. An individual may develop a tolerance which is defined as a person's diminished response to a drug that is the result of repeated use. This usually manifests as:

- the need for markedly increased amounts of the substance to achieve effect, or
- a markedly diminished effect with continued use of the same amount of the substance.

This physical effect of repeated use of a drug is not necessarily a sign of addiction and does not develop equally to all effects. The three main types of tolerances are:

- Acute: caused by repeated exposure to a drug over a relatively short period of time
- Chronic: develops when an individual's body adapts to constant exposure to a drug over weeks or months
- Learned: results from frequent exposure to certain drugs

Note: Dependence is often a part of addiction; however non-addictive drugs can also produce dependence in individuals.

Stage 4: Withdrawal

If an individual with drug dependence stops taking that drug suddenly, that person will experience predictable and measurable symptoms (withdrawals). The symptoms of withdrawal, and the length of that withdrawal, vary depending on the drug of abuse and the length of the addiction. Once a dependence on a substance has formed, withdrawal symptoms will manifest when the substance is removed. The severity and duration of withdrawal is influenced by the level of dependency on the substance and the following factors:

- Length of time abusing the substance
- Type of substance abused
- Method of abuse (e.g., snorting, smoking, injecting, or swallowing)
- Amount taken each time
- Family history and genetic makeup
- Medical and mental health factors

Symptoms often appear in either an emotional or physical form (Table 8.1).

Table 8.1: Emotional vs. Physical Withdrawal Symptoms

Emotional Withdrawal Symptoms	Physical Withdrawal Symptoms
• Anxiety • Restlessness • Irritability • Insomnia • Headaches • Poor concentration • Depression • Social isolation	• Sweating • Racing heart • Palpitations • Muscle tension • Tightness in the chest • Difficulty breathing • Tremor • Nausea, vomiting, and diarrhea

Note: If you see these symptoms seek medical help. Just as some drugs that cause dependence are not addictive, there are also highly addictive drugs that do not produce physical withdrawal symptoms. Withdrawal is the most volatile stage of alcohol and drug involvement as individuals may become suicidal.

Substance Categories

Substances are defined by category and familiar types in the category. The descriptions used in this course are from the International Drug Evaluation and Classification Program (2017). The behavioral or physical manifestations of intoxication, and signs of overdose are provided from the Drug Recognition

Expert (DRE) Matrix (MN DPS, 2017), and is the legally accepted standard for categorizing drugs and their effects.

> **Note:** This is not a comprehensive listing and should be used as a point of reference when encountering individuals suspected of substance abuse. Always consult a medical professional or other certified mental health professional for further assistance and guidance.

Central Nervous System Depressants

Central nervous system depressants slow down the operations of the brain and the body. Methods of administration include oral ingestion and occasionally injection. The most commonly encountered central nervous system depressant is alcohol.

Central Nervous System Stimulants

Central nervous system stimulants accelerate the heart rate, elevate the blood pressure, and sharply increase the 'feel good' chemicals (e.g. dopamine, serotonin; the chemical impacted is determined by the drug) in the brain causing an over-stimulation of the body. Methods of administration include insufflation, smoking, injection, and oral ingestion. The two most commonly encountered central nervous system stimulants are methamphetamine and cocaine.

Hallucinogens

Hallucinogens cause the user to perceive things differently than they appear to others. Methods of administration include ingestion, insufflation, smoking, injection, and eye drops. There is no known threshold for hallucinogen overdose. The two most commonly encountered hallucinogens are LSD and MDMA/Ecstasy.

Dissociative Anesthetics

Dissociative anesthetics includes drugs that inhibit pain by cutting off or dissociating the brain's perception of the pain. Methods of administration include smoking, ingestion, injection, or eye drops. The most commonly encountered dissociative anesthetic is PCP and its analog ketamine.

Narcotics Analgesics

Narcotic analgesics relieve pain, induce euphoria, and create mood changes in the user (an analgesic effect). Methods of administration include injection, ingestion, smoking, and insufflation.

Co-Occurring Disorders

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) *2014 National Survey on Drug Use and Health*, approximately 7.9 million adults in the United States had co-occurring disorders in 2014. The coexistence of two (or more) independent medical/psychiatric disorders is referred to as a co-occurring disorder. Alternatively, a co-occurring disorder has been used to describe the co-existence of a mental health disorder and an alcohol or drug (AOD) problem that causes clinically and functionally significant impairment.

> **Note:** Any combination of mental health disorders and substance abuse or addiction qualifies for this diagnosis. There is no single combination of disorders that comprises this disorder.

People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components.

The consequences of undiagnosed, untreated, or under treated co-occurring disorders can lead to a higher likelihood of the following:

- Homelessness
- Involvement with law enforcement
- Incarceration
- Medical illnesses
- Suicide
- Early death

Substance-Induced Psychosis

Substance-induced psychosis is any psychotic episode that is related to the abuse of a drug. These episodes can occur as a result of taking too much of a certain drug, having an adverse reaction after mixing substances, during withdrawal from a drug, and/or if the individual has an underlying mental health issue. Onset occurs most commonly during periods of intoxication (symptoms and their intensity vary between substances) and can be difficult to distinguish from true psychosis.

Symptoms include:

- Auditory, visual, and tactile hallucinations
- Delusional thought processes (e.g. grandiosity)
- Muscle rigidity
- Extreme paranoia and persecutory thoughts
- Superhuman strength
- Excited delirium

Withdrawal during substance-induced psychosis can cause:

- Grand mal seizures
- Heart attacks
- Strokes
- Hallucinations
- Delirium tremens

Module

9

Intellectual and Developmental Disorders

Terminal Objective

Upon successful completion of this module, participants will be able to identify individuals with intellectual and developmental disorders as well as proper communication techniques for interacting with these individuals.

Enabling Objectives

1. List the signs and symptoms, assessment strategies, and communication considerations for intellectual disabilities.
2. Review developmental disabilities.
3. Describe the signs and symptoms and communication considerations associated with autism spectrum disorder.

Intellectual Disability

Intellectual disability is a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This is a fixed mental condition that, unlike many mental illnesses, cannot be "cured" and originates and is detectable before the age of 18.

The term intellectual disability covers the same population of individuals who were diagnosed previously with mental retardation in number, kind, level, type, duration of disability, and the need of people with this disability for individualized services and supports. Every individual who is or was eligible for a diagnosis of mental retardation is eligible for a diagnosis of intellectual disability.

> **Note:** While intellectual disability is the preferred term, it takes time for language that is used in legislation, regulation, and even for the names of organizations, to change.

Lee Johnson

Deputy Director

Texas Council of Community Centers

"Correctional professionals across Texas fulfill an essential role on the frontline of public safety and often face circumstances involving people with mental illness, substance use disorders, and intellectual disabilities. The new Jail Mental Health course provides correctional professionals the tools they need to respond safely. On behalf of the Texas Council of Community Mental Health and Intellectual Disability Centers, we commend Chief Howell and members of the team whose leadership was instrumental in creating of this outstanding training program."

Table 9.1 shows the primary characteristics of mental illness and intellectual disabilities so that you can see how the two are different.

Table 9.1: Mental Illness vs. Intellectual Disability

Mental Illness	Intellectual Disability
• Unrelated to intelligence • Develops any point in life • No cure • Medications control symptoms • Behavior is unpredictable	• Below average intellectual function • Occurs before age of 18 • Permanent impairment • Medications cannot help • Behavior is consistent to a very specific functional level

Signs and Symptoms

- Persistence in childlike behavior, possibly demonstrated in speaking style
- Trouble understanding social rules and customs such as taking turns, waiting in line, or fitting into a housing unit
- Failure to appreciate and avoid dangerous situations such as associating with the wrong people in jail, entering the wrong cell

- Difficulty solving ordinary, simple problems
- Trouble remembering things and require a single task order at a time
- Difficulty meeting educational demands (usually identified at initial booking)
- Excessive behavioral problems such as impulsivity and poor frustration tolerance

Assessment Strategies

Strategies to use when determining possible intellectual disability are shown in Table 9.2.

Table 9.2: Assessment Strategies

Strategy	Observations/Task
Inmate Activity	• Apparent the subject is a follower rather than leader of criminal activity • May readily confess, due to lack of full understanding of the circumstances • Behavior at the scene of the incident (remained at the scene while others left) • May have been used as a pawn by more sophisticated offenders (easily swayed
Speech/Language	• Obvious speech defects • Limited ability to speak or comprehend at age-normative level • Marked difficulty maintaining attention or conversation • Difficulty describing facts in detail
Social Behavior	• Associating with significantly older or younger individuals • Ignorance of personal space in the cell • Non-age appropriate behavior
Performance Tasks (to help determine if an intellectual disability exists)	• Ask the individual to read or write a simple statement • Give directions to their home • Tell time • Count to 100 by multiples of five • Define abstract terms (such as emotions or feeling terms) • Explain how to make change from a dollar **Note:** An inability to read or write (illiteracy), in and of itself, does not indicate intellectual disability.

Communication Considerations

- Allow additional time to exchange information (where possible).
- Assess the language skills to help choose the level of language you use.
- Many people have stronger receptive (understanding) communication skills than expressive skills. A person's expressive speech may sometimes give an impression of better comprehension than is actually the case.
- Some people may be delayed in responding to questions; so much so that answers may seem to "come out of nowhere."

- Some people with severe disabilities may also have difficulty giving you an accurate picture of their feelings and symptoms because of limitations in interpreting internal cues (e.g., need to urinate, anxiety).

Developmental Disability

Developmental disabilities are severe chronic disabilities that can be cognitive (e.g. learning disorders) or physical (e.g. blindness) or both (e.g. Downs Syndrome). The disabilities appear before the age of 22 and are likely to be lifelong. Some developmental disabilities are largely physical issues, such as cerebral palsy or epilepsy. Some individuals may have a condition that includes a physical and intellectual disability, for example Down syndrome or fetal alcohol syndrome.

> **Note:** Intellectual disability encompasses the “cognitive” part of this definition, that is, a disability that is broadly related to thought processes. Because intellectual and other developmental disabilities often co-occur, intellectual disability professionals often work with people who have both types of disabilities.

Developmental disabilities occur among all racial, ethnic, and socioeconomic groups. Recent estimates in the United States show that about one in six, or about 15%, of children aged 3 through 17 years have a one or more developmental disabilities, such as:

- ADHD
- Autism spectrum disorder
- Cerebral palsy
- Hearing loss
- Intellectual disability
- Learning disability
- Vision impairment,
- Other developmental delays

Autism Spectrum Disorder

Autism is the fastest-growing American developmental disability, with an annual growth rate of between 10-17%. The prevalence is estimated at 1 in 88 births, and is 4X more prevalent in boys than in girls. By way of comparison, this is more children than are affected by diabetes, AIDS, cancer, cerebral palsy, cystic fibrosis, muscular dystrophy or Down syndrome, combined.

Autism spectrum disorder (ASD) is a developmental disorder that affects communication and behavior. Although autism can be diagnosed at any age, it is said to be a “developmental disorder” because symptoms generally appear in the first two years of life. People with ASD have:

- Difficulty with communication and interaction with other people
- Restricted interests and repetitive behaviors
- Symptoms that hurt the person's ability to function properly in school, work, and other areas of life

No two people with autism are alike. Autism is known as a “spectrum disorder” because there is wide variation in the type and severity of symptoms people experience. ASD occurs in all ethnic, racial, and economic groups. Although ASD can be a lifelong disorder, treatments and services can improve a person's symptoms and ability to function.

Signs and Symptoms

People with ASD have difficulty with social communication and interaction, restricted interests, and repetitive behaviors. The list below gives some examples of the types of behaviors that are seen in people diagnosed with ASD. Not all people with ASD will show all behaviors, but most will show several.

Interaction Behaviors

Social communication/interaction behaviors may include:

- Making little or inconsistent eye contact
- Tending not to look at or listen to people
- Rarely sharing enjoyment of objects or activities by pointing or showing things to others
- Failing to, or being slow to, respond to someone calling their name or to other verbal attempts to gain attention
- Having difficulties with the back and forth of conversation
- Often talking at length about a favorite subject without noticing that others are not interested or without giving others a chance to respond
- Facial expressions, movements, and gestures that do not match what is being said
- Unusual tone of voice that may sound sing-song or flat and robot-like
- Difficulty understanding another person's point of view or being unable to predict or understand other people's actions

Repetitive Behaviors

Restrictive/repetitive behaviors may include:

- Repeating certain behaviors or having unusual behaviors. For example, repeating words or phrases, a behavior called echolalia
- Having a lasting intense interest in certain topics, such as numbers, details, or facts
- Having overly focused interests, such as with moving objects or parts of objects
- Getting upset by slight changes in a routine
- Being more or less sensitive than other people to sensory input, such as light, noise, clothing, or temperature

People with ASD may also experience sleep problems and irritability. Although people with ASD experience many challenges, they may also have many strengths, including:

- Being able to learn things in detail and remember information for long periods of time
- Being strong visual and auditory learners
- Excelling in math, science, music, or art

Observable Physical Manifestations

A person with autism might:

- Have an impaired sense of danger.
- Wander to bodies of water, traffic or other dangers.
- Be overwhelmed by criminal justice presence.

- Fear a person in uniform (e.g. fire turnout gear) or exhibit curiosity and reach for objects/equipment (e.g. shiny badge or handcuffs).
- React with “fight” or “flight.”
- Not respond to “stop” or other commands.
- Have delayed speech and language skills.
- Not respond to his/her name or verbal commands.
- Avoid eye contact.
- Engage in repetitive behavior (ex. rocking, stimming, hand flapping, spinning).
- Sensory perception issues.
- Epilepsy or seizure disorder.

Communication Considerations

When interacting with a person with autism:

- Be patient and give the person space.
- Use simple and concrete sentences.
- Give plenty of time for person to process and respond.
- Be alert to signs of increased frustration (often act out by striking) and try to eliminate the source if possible as behavior may escalate.
- Avoid quick movements and loud noises.
- Do not touch the person unless absolutely necessary.
- Use information from caregiver, if available, on how to best respond.

Module

10

Post-Traumatic Stress Disorder

Terminal Objective

Upon successful completion of this module, participants will be able to list the signs and symptoms of Post-Traumatic Stress Disorder (PTSD) and associated on-set and duration timeframes.

Enabling Objectives

1. Define Post Traumatic Stress Disorder (PTSD).
2. List the behavioral, emotional, and social symptoms of PTSD.
3. Discuss the diagnostic criteria of PTSD.
4. Discuss the variables that factor into the onset and duration of PTSD.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event. A person may have experienced the traumatic event(s) directly, or may have witnessed them occur to someone else. According to the DSM-V, the disorder is included in the new category of “Trauma and Stressor-Related Disorders.”

Examples of events that can result in PTSD include but are not limited to:

- Physical violence
  - Abuse
  - Assault
  - Physical attack
  - Robbery
  - Domestic violence
- Sexual violence
  - Rape
  - Sexual abuse
  - Sex trafficking
  - Non-contact sexual abuse
- Combat (civilian or military)

Approximately 70% of adults in the United States have experienced a traumatic event at least once in their lifetime. Up to 20% of these people will go on to develop PTSD as a result of the event. Women are twice as likely to develop PTSD resulting in approximately 10% of all women developing PTSD, during a lifetime, compared to only 4% of men (Veteran's Affairs, 2017).

Symptoms of PTSD

An individual experiencing PTSD may experience a myriad of symptoms which can generally be classified into behavioral, emotional, or social symptoms.

Behavioral

- Intrusive memories
- Avoids reminders
- Concentrating
- Emotional outbursts
- Hypervigilance/hyperarousal
- Flashbacks
- Loss of interest in hobbies
- Withdrawal from others
- Reckless or self-destructive behavior

- Increased self-medication

Emotional

- Anger
- Irritability
- Sadness
- Anxiety
- Hopelessness
- Inappropriate guilt
- Emotional numbing/depersonalization
- Control issues

Social

- Becoming withdrawn, detached, or disconnected
- Loss of desire for intimacy, closeness
- Mistrust
- Over-controlling/over-bearing behavior
- Argumentative
- Family violence may result

Diagnostic Criterion of PTSD

Types

Although the DSM-V eliminated the distinction of the types of PTSD, we will include them here as a point of reference.

- Acute PTSD: Symptoms have a duration of less than three months
- Chronic PTSD: Symptoms have a duration of more than three months

Note: Although symptoms usually begin within 3 months of exposure, a delayed onset is possible months or even years after the event has occurred.

Diagnostic Criteria

According to the DSM-V, the exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental);
- or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.

There are four distinct diagnostic clusters associated with PTSD which can be are described as re-experiencing, avoidance, negative cognitions and mood, and arousal.

> **Note:** The number of symptoms that must be identified depends on the cluster. DSM-V would only require that a disturbance continue for more than a month and would eliminate the distinction between acute and chronic phases of PTSD.

Re-Experiencing

Re-experiencing covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress. Individuals can experience a sudden acting or feeling as if the traumatic event were recurring. There is often intense psychological distress at exposure to things that symbolizes or resembles an aspect of the trauma, including anniversaries of the event. Physiological reactivity when exposed to internal or external cues of the event.

Avoidance

Avoidance refers to distressing memories, thoughts, feelings or external reminders of the event. Individuals will undergo great efforts to avoid the thought or feelings associated with the trauma along with activities, places, people or situations that arouse recollection of the trauma. Individuals may experience the Inability to recall an important aspect of the trauma (psychological amnesia).

Avoidance can have a significant negative impact on a person's life and the lives of those around him/her. Avoidance can manifest as:

- not wanting to be placed in a specific cell because of an individual's presence or memory tied to the cell
- not wanting to associate with former acquaintances who trigger the memories
- not wanting to go to communal areas because of the crowds

Negative Thoughts and Mood/Feelings

Negative thoughts and mood/feelings represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

Individuals have a markedly diminished interest in significant activities or association with those family members who are most interested in their well-being. Feelings of detachment or estrangement from others frequently occur as well as being unable to have loving feelings.

Arousal

Arousal is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance or related problems.

Individuals may have great difficulty falling asleep or staying asleep accompanied by difficulty concentrating or an exaggerated startled response. Irritability or outbursts of anger frequently occur seemingly uncontrollably and this persistent irritability can progress to rage.

On-Set and Duration

PTSD can occur at any age, including childhood, and can affect anyone. Individuals who have recently immigrated from areas of considerable social unrest and civil conflict may have elevated rates of PTSD.

No clear evidence that members of different ethnic or minority groups are more or less susceptible than others.

High levels of stress may cause a breakdown in information processing, leading memories to be stored as physical or sensory cues. Experiences associated with the original event(s) (e.g. emotions, smells, sounds, humidity, visual images, taste, people/objects that were present, etc.) may have the power to evoke seemingly realistic memories of the event.

Figure 10.1 shows the duration of symptoms for individuals who receive treatment versus those that do not receive treatment. Over a period of time, it shows some element of truth to the “time heals wounds” saying, but it also illustrates the importance and value of seeking early interventions to overall mental health.

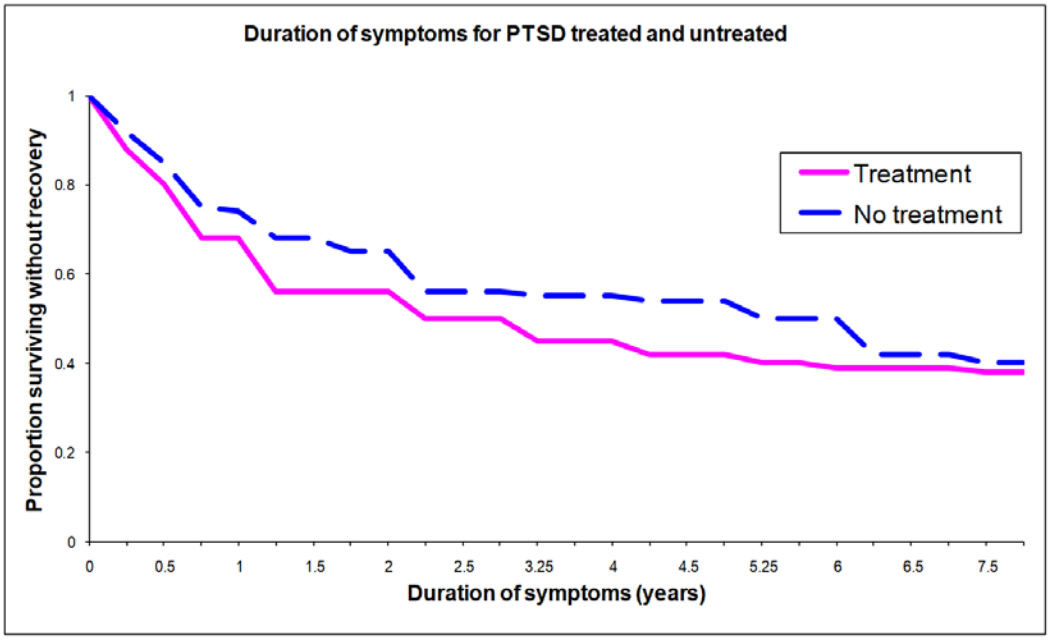


Figure 10.1: Duration for PTSD Treated and Untreated. Source: CIT Partnership Training: Crisis Intervention Teams, 2016.

Variables that Factor into the Development of PTSD

A number of variables factor into why an individual may develop PTSD from a trauma exposure, while others will not. Some of those variables include (SAMSA, 2017):

- The intensity of duration of the trauma
- Frequency of exposure
- Lasting injury or impairment from the trauma
- How much control the person felt during the traumatic event
- Intensity of emotional reaction during the event
- Level and quality of support received (or perceived access to support) following the event

Frequency in Veterans

The lifetime prevalence of PTSD among American Vietnam theater veterans

- 30.9% men
- 26.9% women.
- 22.5% men and 21.2% of women have had partial PTSD at some point in their lives.

More than half of all male Vietnam veterans and almost half of all female Vietnam veterans, have experienced “clinically serious stress reaction symptoms.”

For Gulf War veterans, the incidence rate of PTSD is 10.1% among those who had experienced combat. It is still unclear if prevalence of PTSD among those returning from Operation Iraqi Freedom or Operation Enduring Freedom will increase or decrease.

Module 11

Suicide

Terminal Objective

Upon successful completion of this module, participants will be able to determine how to identify a suicidal inmate and properly communicate and respond to the individual.

Enabling Objectives

1. Review suicide statistics.
2. Discuss the general profile and warning signs of a suicidal inmate.
3. Identify the six pre-disposing and risk factors.
4. Discuss the four major predictors of suicide.
5. List factors that reduce the likelihood of suicide.
6. List the four communication techniques for interacting with a suicidal inmate.
7. Summarize watch considerations when observing or interacting with a suicidal inmate.
8. Summarize response considerations for the five primary suicidal situations.
9. Outline reporting and notification considerations for suicidal situations.

Suicide Statistics

Suicide in the United States has surged to the highest levels in nearly 30 years, a federal data analysis has found, with increases in every age group except older adults. The rise was particularly steep for women. It was also substantial among middle-aged Americans, sending a signal of deep anguish from a group whose suicide rates had been stable or falling since the 1950s.

The suicide rate for middle-aged women, ages 45 to 64, jumped by 63 percent over the period of the study, while it rose by 43 percent for men in that age range, the sharpest increase for males of any age. The overall suicide rate rose by 24 percent from 1999 to 2014, according to the National Center for Health Statistics.

Officers are also categorized as high-risk for suicide due to their occupational conditions. They are more prone to the risk of divorce, alcoholism, emotional/physical problems and PTSD, which are all contributing factors in the risk of suicidal behaviors. Another reason experts believe officers are a high risk of suicide is the innate nature of the culture. Control command presence is an essential component of the job itself. It is often seen by peers and superiors as weak if help for emotional issues is requested. This misconception can affect an officer's sense of self confidence and personal expectations and their relationship/trust level with their team.

National Statistics

- Average of 83 suicides per day
- 8th leading cause of death for males, 19th leading cause for females
- 4 times more men than women die by suicide
- Highest suicide rates (73%) in the US is white men over age 85
- 3 times more women than men report a history of attempted suicide
- Leading method of suicide is via firearms
- Estimated 8-25 attempted suicides for each suicide death

  Source: National Institute of Mental Health Suicide Prevention Resource Center

Jail Statistics

More than 90% of people who kill themselves have a diagnosable mental illness with depression and/or substance abuse being the most common.

The September 2006 Bureau of Justice Study found that more than half of all prison and jail inmates reported mental health symptoms

- 56% of state prisoners
- 45% of federal prisoners
- 64% of local jail inmates
- Female inmates had higher rates than male inmates

National Jail Statistics

- The suicide rate in local jails in 2014 was 46 per 100,000 local jail inmates. This is the highest suicide rate observed in local jails since 2000.
- More than a third (425 of 1,053 deaths, or 40%) of inmate deaths occurred within the first 7 days of admission.

- Almost half (47%) of suicides occurred in general housing within jails between 2000 and 2014.
- Suicide is the leading cause of death in US jails.
- From three national studies conducted from 1994-1996, suicide rates in jail can be up to 9 times greater than general population.
- The highest suicide rates occur with jail inmates under the age of 18 (101 per 100,000).
- Per the Department of Justice Statistics Special Report, in 2002, the nation's smaller jails (< 50 inmates) had suicide rate 5x higher than largest jails (> 2,000 inmates).

Texas Jail Statistics

- 24% of suicides in Texas jails occur within the first 24 hours of incarceration
- 27% of suicides in Texas jails occur between 2-14 days of incarceration
- 20% of the suicides occurring in Texas jails involve victims who are intoxicated at the time of suicide
- 31% of victims are found after more than one hour of observation
- 93% of suicide victims in Texas jails use the hanging method for suicide

The number of suicides by year are shown in Figure 11.1.

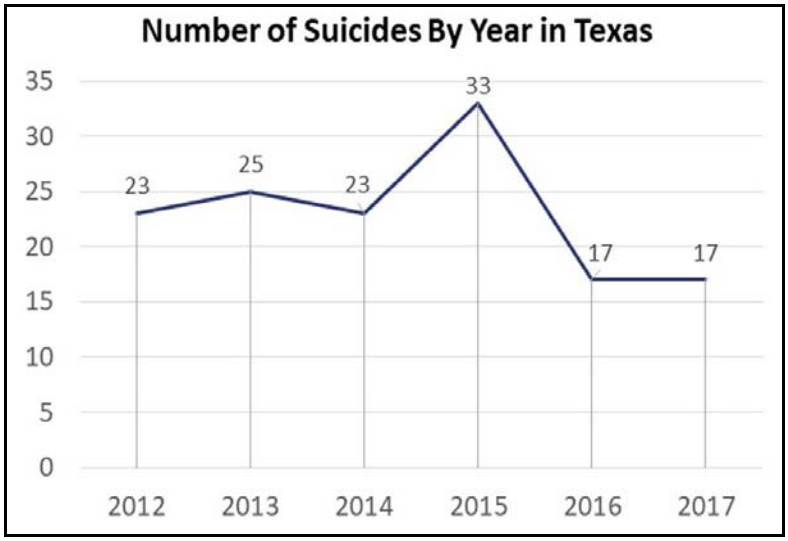


Figure 11.1: Number of Suicides by Year in Texas

Greg Hansch, LMSW

Public Policy Director

National Alliance on Mental Illness (NAMI) Texas

"The new 40-Hour Jail Mental Health Class will improve circumstances for Texans experiencing mental illness in jail. Jailers who complete the training will be much better equipped to intervene in crisis situations and support the mental health of incarcerated individuals. As an organization that represents individuals with mental illness and their families, NAMI Texas is grateful to have been consulted in the development of this class."

General Profile and Warning Signs of Texas Jail Inmates

An individual thinks seriously about suicide when they experience the 3 I's in their life situation:

- Intolerable. Their life situation is so painful that it seems unbearable.
- Interminable. It seems like it's going to go on like this forever.
- Inescapable. It seems like nothing they've tried has changed or will change their experience.

An individual who is suicidal has a deep feeling of hopelessness and helplessness so keep these points in mind:

- The person is facing an untenable obstacle.
- Their life is significantly disrupted and/or changed.
- They have no response/resource(s) to deal with the situation.
- All the resources, skills, and problem solving ideas that they can think of will not help.

The suicidal person often has the following feelings.

- Suicide is all about the pain of the situation with only one way out.
- It's common to hear "everyone will be better off without me." The only way to end the pain.
- The is no ability to plan the future. There is no future.
- The past is often unknown. There is only now.

General Profile

A general profile of a suicidal Texas inmate is as follows:

- 52% were single
- 75% had non-violent charges
- 27% detained on alcohol/drug charges
- 78% had prior charges
- 10% were held on violent charges
- 60% under influence of alcohol/drugs when incarcerated
- 30% occurred between midnight and 6 am
- 94% by hanging
- 33% were in isolation
- 51% occurred within first 24 hours of incarceration
- 29% occurred within first three hours

Note: The numbers are not as important as the strata of the data.

Signs/Symptoms

- Depression or paranoia
- Expresses guilt/shame over offense
- Statements about suicide or death
- Self-harm attempts

- Severe agitation or aggression
- Agitation often precedes suicide
- Suicide can be a possible means to relieve agitation
- Hopeless/pessimistic about future
- Extreme concern or anxiety over what will happen to them
- Appetite and sleep changes
- Mood/behavior changes
- May refuse treatment
- Withdraws from others, may demand to be celled alone
- Neglects personal hygiene or appearance
- Preoccupied with past; doesn't deal well with present
- Packing/giving away belongings (especially with a jovial attitude)
- Writes a will
- Hallucinations and delusions; may hear voices or see visions that tell inmate to harm self
- Vulnerable offender at facility with recent suicide or attempt (i.e. "Copycat" phenomenon)

Note: Each attempt should be taken seriously and handled as if it was a first attempt! Act fully on protocol every time. Do not take ownership and waive seriousness of the situation.

Pre-Disposing Factors and Risk Factors

Most people who commit suicide have made direct or indirect statements about their suicidal intentions and the acts represent a carefully thought out strategy for coping with their problems. Most suicidal people have mixed feelings about killing themselves; they are doubtful about living, not intent on dying. Most individuals want to be saved and utilize the act as a means for gaining attention of others.

Correctional facilities seem like an unlikely place to commit suicide, however, the incarcerated individual has limited control, few options, and their future is more unpredictable. As a result, the individual may experience feelings of hopelessness which may lead the offender to see suicide as the only way to deal with his/her problems

Corrections Environment

Corrections environment factors increasing suicide risk include:

- Authoritarian environment is unfamiliar and possibly traumatic for the individual
- Loss of control over future resulting in feelings of helplessness and hopelessness
- Isolation from family, friends, community with support seeming to be unavailable or restricted
- Shame of incarceration, often inversely disproportionate to the offense
- Dehumanizing aspects of confinement (lack of privacy, controlled actions, unknown environment)
- Fears due to media and self-imposed stereotypes which results in heighten anxiety
- Staff insensitivity to inmate's situation, especially for first-time arrestee

Offender

Offender factors increasing suicide risk include:

- History of self-harm acts-especially suicide attempt while confined
- Intoxication and/or withdrawal and/or substance abuse history
- Recent loss of stabilizing resources (loved one, job, home, and/or finances)
- Juvenile
- Sex offender
- Segregation and/or isolation from others
- Family history of suicide
- Mental Illness (especially depression or delusions/hallucinations)
- First offense
- Long sentence
- Violent history
- Shame or stigma associated with crime
- Publicity
- Public figure or “pillar of society”
- Fear of same-sex rape or threat of it
- Poor physical health or terminal illness
- Difficulties with staff or other inmates
- Gambling debts, drugs
- Ending of close relationship with another offender
- Working the system to be celled alone, i.e., requesting protective custody, threatening cellmate, etc.

Note: Consider that offenders requesting protective custody or demanding to be celled alone may be contemplating suicide.

Personal Illness

- Chronic and debilitating illnesses can increase the risk for suicide in some people
- Examples of illnesses are:
  - HIV/AIDS
  - Cancer
  - Chronic Pain
  - Long-term dialysis for kidney failure

High Risk Periods

- First 24 hours
- Withdrawal from alcohol or drugs
- Awaiting Trial
- Sentencing
  - Additional Charges

  - Longer/More Severe Sentence than expected
  - Repeat Offender - knows what to expect in prison
- Impending release
- Holidays
- Darkness
- Decreased staff supervision (weekends, nights, holidays, shift change)
- Bad News (breakup, home foreclosure, death notice, no-show visitor, etc.)
- Receipt of Disciplinary Report

At Risk Groups

Inmates which are considered the highest at risk groups include:

- In pre-trial status
- Experiencing a mental illness
- In restrictive housing units
- Convicted of a sex offense

Triggering Events

- Break up of relationships
- Receiving bad news
- Visit does not happen
- Perceived rejection
- Threats, bullying, debts
- Sleeplessness
- Disciplinary sanctions
- Transfers
- Unexpected sentence
- Peer suicides or attempts
- Increase in any prison stress

Major Predictors

Any individual with one or more prior suicide attempts is at much greater risk than those who have never attempted suicide. First attempts may be designed to scare, manipulate, or make another feel guilty. First attempts are usually most fearful for the individual and repeated attempts are easier to undertake. As an individual increases attempts there is an increase the probability of success of the attempt as 4 out of 5 who actually commit suicide have tried to do so at least once previously.

When evaluating the major predictors of suicide, consider the following:

- S = How specific is the plan?
- A = How available are the means?

- L = How lethal is the potential?

Presence of Specific Plans

Plans are usually well thought out and utilize a highly lethal method, resulting in the highest risk of being undertaken. Specificity has generally proven to be less of factor in adolescents and young adults as they tend to be more impulsive.

Availability of Means

Availability of means is the degree to which the person has the method, the knowledge, and skill to commit suicide. This includes that the individuals already has the means in possession and knows or is trained on how to use the weapon.

Lethality of Means

Manipulative goals as a motive for self-injury are not useful in distinguishing more lethal attempts from less lethal attempts. Lethality of means refers to how capable something is of causing death.

- High: hanging, jumping, guns, car crash, drowning
- Medium: sleeping pills/barbiturates
- Low: wrist cutting, non-prescription drugs; any means in which there is time to change mind or be found

Factors that Reduce the Likelihood of Suicide

Factors that reduce the likelihood of an individual becoming suicidal include:

- Healthy support system
- Not using drugs or alcohol
- Connection to a spiritual faith
- Employment
- Financial stability
- Access to local health services
- Effective mental health care
- Connectedness to individuals, family, community, and social institutions
- Problem-solving skills
- Contacts with caregivers
- Cognitive flexibility
- Positive coping skills
- Physical and mental health

Communication Techniques

The primary obstacle when dealing with the issue of suicide is negative attitudes or stigmas on the topic. It is through the perpetuation of these attitudes that the hurdle often remains in seeking assistance or treatment.

Most suicides can be prevented. You cannot make someone suicidal when you show an interest in their welfare by discussing the possibilities of suicide. Concerned, non-judgmental questions encouraging the person to discuss his/her ideas may help relieve the psychological pressure. Never ignore the risk or threat as offenders can become suicidal at any point during incarceration.

- Listen patiently.
  - Treat the offender as a person and encourage them to talk.
  - Ask direct questions about suicidal ideation, including details about their suicide plan.
  - Do not act sarcastic, make jokes, or challenge the inmate to follow through with the threat.
- Trust your own judgment.
  - If you believe the offender is in danger of suicide, implement suicide prevention protocols and keep the offender in a safe place where they are monitored.
  - Do not accept the inmate's denial of suicidal ideation too quickly.
- Maintain contact.
  - Address the offender by their name.
  - Don't be reluctant to express your concerns about the offender.
  - Use appropriate eye contact; show concern, not disapproval, disgust, anger, or judgment.
- Try to keep the offender's sense of the future positive.
  - Focus on programs available to offender (i.e., school, vocational training, and substance abuse programs).
  - Talk about support from family and friends that care.
  - Provide a feeling of control refraining from making promises that you cannot keep.
  - Find something in their past to give them hope in the future.
  - Help them discover a reason to live yet.

Arlys Alford

Voice teacher and performance coach

Plays the role of a CIT Inmate

"It is a sincere honor to work amidst the dedicated individuals who coordinated, coached, trained, and participated in the Texas program, with the intent to protect and serve a population that is generally forgotten and ignored. Thank you for your mental health initiatives and commitment to crisis intervention training for safer de-escalation. It was humbling to work with people who care so deeply."

Watch Considerations

When dealing with a "close watch" situation, communicate every day with mental health staff during daily suicide watch rounds. Mental health staff want to know: the following information when you communicate regarding an inmate:

- Is the offender eating meals?

- Is the offender sleeping normally?
- What is the offender's behavior when awake?
- Is the offender attentive to personal hygiene?
- Does the offender communicate appropriately with detention officers and/or other offenders?

Note: Remember, suicide watch is discontinued only by a mental health professional. Successful suicide prevention must be a team effort between healthcare and correctional staff.

Risk Assessments

Assessing for suicide using a low/med/high scale was done away with many years ago by crisis helplines. It is easy to get in to a place where you are lulled in to a sort of complacency if you see a low, or panic when you see a high and forget about all the other buffers that serve as protective factors. Crisis helplines do not have scales or point systems. They rely on training, clinical judgment, and consultation.

Telemedicine Consultations

The use of telephone and telemedicine consultations improves health care access to inmates across the state. This approach allows doctors to examine inmates at a safe distance not only for physical health conditions but for mental health as well. Video-connected care may not solve the mental health care provider shortage, but it may ease the problem in jails, where barriers to care stem from the physical constraints of the facilities themselves. Most of the telepsychiatry offered to Texas inmates is aimed less at therapy and more at making diagnoses and managing medications. This approach improves access to care, continuity of care, and gives mental health services many efficiencies to see patients in a more timely manner.

This technology can assist detention staff with the ability to identify and flag inmates if the inmate should be placed on suicide precautions or if special housing should be assigned. Through the use of a clinician's interview, the mental health provider can provide real-time evaluations and assessments instead of having to wait for the inmate to be scheduled, and possibly transferred, to mental health program care.

Response Considerations

Ensure that you take all threats seriously. Don't ignore threat because you think the offender is simply acting out. It is not the officer's responsibility to decide whether the threat is genuine or "fake." Diagnosis is the duty of the mental health professional.

Always refer potential suicide threats immediately to the mental health professional for evaluation and determination of level of suicide risk. Place the offender in a safe environment where he/she is not left alone until a mental health professional can assess level of suicide risk Remember, accidental deaths do occur with offenders who were allegedly "acting out" by threatening suicide.

Note: Know your facility procedure for placement and correctional officer monitoring of offenders awaiting evaluation by mental health professionals.

Responsive but Suicidal

When approaching a responsive but suicidal inmate, keep in mind the following:

- Remember that the inmate may attempt to have others kill them
- Remain calm
- Call for assistance

- Develop a plan and follow it: rushing to rescue increases the risk to all those who are involved
- Be alert
- Check out the situation
- Ask the inmate to remove the means if time permits. This allows them to take action for their own safety

Active Suicides

1. All active suicides will be called in as an emergency.
   – 10/33
   – Suicide
   – Location
   – Type of assistance needed
2. Check scene for the safety of self and others.
   – Check for a set up
   – Look for items that could be used as weapon (i.e. razor blade)
   – Move all persons that are not actively giving life saving actions away from scene.
   – Use universal precautions (gloves, goggles, CPR mask)
3. Administer immediate life saving actions.
4. Secure site as soon as possible. It is important to preserve the site for any follow -up investigations however life safety should be the first priority.
5. Debrief staff and gather all reports, observations, and logs.

Hanging

Note: When responding to a hanging, always follow your department's policy.

1. First staff person on scene will conduct visual assessment of offender from outside cell to determine if offender has article around neck and is attempting to hang self and observe offender's hands for possible weapons.
2. First staff person on scene shall stay at cell front to observe and summon another officers via radio for assistance and request a medical response.
3. Immediately upon arrival of at least three (3) correctional officers, staff will enter the cell or according to your policy.
4. Staff will lift the offender up and one (1) staff member will cut the offender down with the designated cutting device. Always cut well above the knot, investigations may need this as evidence.
5. The first responders will be responsible to ensure the cutting device is ready for use at incident area.
6. The offender will be laid on the floor (hard surface if possible) and the article around his/her neck removed.
7. Officers/staff will begin basic life-saving techniques.
8. When medical assistance arrives, health care staff will assume the lead role in life-saving techniques assisted by officers/staff if necessary.

Unresponsive

Note: When responding to an unresponsive individual, always follow your department's policy.

1. First staff person on scene will conduct a visual assessment from outside cell to determine if offender is not responding to any questions about his/her condition and appears to be either unconscious or experiencing a medical emergency.
2. First staff person on scene shall stay at cell front to observe and summon another officers via radio for assistance and request a medical response.
3. First staff on scene will observe offender's hands for any objects that may be weapons.
4. Once a minimum of three (3) staff persons (at least two [2] correctional officers) have arrived at cell, the door will be opened and staff shall enter the cell.
5. Staff will enter the cell with caution and be prepared to use O/C, but move quickly to secure the offender's arms.
6. Officers may need to wear a vest, helmet and gloves, depending on your department's policy.

Uncooperative or Actively Assaultive

In both of these situations you might have to wait until you have enough staff or the right equipment so you can give care. Safety of self, other staff, the community, and other offenders must all be considered.

Reporting and Notification Considerations

Staff must take all reports of a possible suicide seriously. Even an individual that is using self-mutilation in an attempt to manipulate staff can often go too far and kill themselves. Staff is required to report any suicidal behavior through their chain of command. Only mental healthcare providers can formally determine whether an individual is suicidal. Correctional officers are responsible for the safety of the inmates in their care. All appropriate notifications should be made as soon as possible and noted in the report. All appropriate reports should be completed prior to staff leaving the facility at the end of the shift.

Local Mental Health Authority and Documentation for Release

Local resources and partnerships exist to assist with individuals in crisis and in need of supportive services. A list of mental health services, veteran resources, and peer support can be found at the following locations:

- Texas Health and Human Services Local Mental Health Authorities <https://dshs.texas.gov/mhsa/lmha-list/>
- Texas Health and Human Services Mental Health Crisis Hotlines <http://www.dshs.texas.gov/mhsa-crisishotline/>
- Texas Veteran's Commission Directory <http://tvc.texas.gov/Find-Your-Local-Office.aspx>
- Military Veteran Peer Network Peer Service Coordinators <http://milvetpeer.site-ym.com/page/MVPN_PSC>

Follow-Up Post Suicide Attempt

Assessing inmates for suicide risk is an on-going process, from when the inmate is brought in for processing by the arresting officer/deputy until they are released from jail. Inmates may become suicidal at any point in their incarceration. Particular attention should be paid to inmates around high risk periods (first 24 hours, in close proximity to court hearings, sentencing, holiday, etc.), when triggering events are present (break up of relationships, receiving bad news, threats, etc.), and for certain crimes (murder,

domestic violence, child molestation). Brief mental health status screening assessments may be conducted during these times/events. Suicide risk should be continually assessed by medical and behavioral health staff as well as by detention officers throughout the inmates' incarceration. Oftentimes the best source of information regarding an inmate's state of mind is other inmates.

Module

12

Care Considerations for Officers

Terminal Objective

Upon successful completion of this module, participants will be able to summarize key care considerations related to mental health officers and their profession.

Enabling Objectives

1. Identify the importance and role of self-care for a corrections officer.
2. List the five pillars of self care.
3. Identify strategies to invest in yourself and the benefits of healthy detention officers.
4. Identify resources and programs available for officer wellness.

Officer Self Care

Detention officer wellness is an important issue for all correctional organizations. One of the greatest threats to the wellness of a detentions officer is the stress they encounter as a result of their occupation. Detention officers face a wide spectrum of stressors that, in many cases, are unique to their profession. Stress can have significant negative consequences as it affects their health and well-being, work performance, the inmates they supervise, their co-workers and their families.

Ronny Taylor

Captain

Harris County Sheriff's Office

DOJ Certified PREA Auditor

Committee Member, Texas Mental Health Training Initiative for Jails

"Jail systems are often cited as the largest provider of mental health services. Unfortunately, this designation is not by design and is simply the byproduct of a mental health system which, Slate, Buffington-Vollum, & Johnson (2013) refer to as, "a fragmented, complicated mess" (p. 61). It is my hope this training and certification process will serve to not only build better bridges between the criminal justice system and the mentally ill, but also serve as another step in enhancing our current mental health practices."

Although there are parallels between the work of detention officers and police officers, in many ways the job of the detention officer is more stressful than that of the police officer. The threat of violence is constant for the detention officer while it is periodic for police officers. Most detention officers are not armed and police officers are encouraged to develop positive relationships with the community (known as community policing). Detention officers rarely have the opportunity for this positive feedback.

Detentions personnel, as well as other persons in emergency service fields are a population highly prone to suffering from PTSD, as a direct result of their work. They are involved in traumatic events through direct or indirect involvement on a daily basis. PTSD affects both men and women. Its effects lie not only with "frontline" personnel but support staff. By virtue of their job, these individuals experience or are exposed to traumatic experiences on a recurrent basis throughout their careers. Over time, they become accustomed to "numbing" their feelings or reactions to traumatic occurrences. They may not even realize this is happening. Many of their daily activities may seem routine to them when in fact they are quite stressful; seeing the events of criminal activity regularly creates a hyper-vigilance on and off the job.

The realities of the job can be quite staggering.

- Correctional officers have the second highest mortality rate of any occupation.
- 33.5% of all assaults in prisons and jails are committed by inmates against staff.
- A corrections officer's 58th birthday, on average, is their last.
- A corrections officer will be seriously assaulted at least twice in a 20 year career.
- On average, individuals will live only 18 months after retirement.
- Corrections officers have a 39% higher suicide rate than any other occupation.
- Individuals have a higher divorce and substance abuse rates then the general population.

Source: "Stress Management for the Professional Correctional Officer", Donald Steele, Ph.D., Steele Publishing 2001 "Corrections Yearbook 2000, 2002", Criminal Justice Institute, Middletown, CT

"Sourcebook of Criminal Justice Statistics 2003", Bureau of Justice Statistics, 31st edition, NCJ 208756
"Suicide Risk Among Correctional Officers", Archives of Suicide Research, Stack, S.J., & Tsoudis, O.
1997 Metropolitan Life Actuarial Statistics, 1998 Society of Actuaries.

Cycle of Life

While on duty, an individual typically experiences hyper-vigilance, which is the biological process an individual undergoes while on duty. This heightens their awareness, thinking abilities, and quick response to anything that comes up. Once the shift is over, the body needs to recover, which means off-duty, the body goes into a depression-like state to offset the effects of the body while in hyper-vigilance.

One must be aware of the stress levels at both home and at work and recognize the impact and carry over that can occur. We are often hard-wired to focus on the negative as we are always in threat assessment mode. This can be a good defense for officer safety but it is not so good for personal relationships.

Stress

There are two different types of stress:

- Acute stress: stress resulting from specific events or situations that involve novelty, unpredictability, a threat to the ego, and leave us with a poor sense of control.
- Chronic stress: stress resulting from repeated exposure to situations that lead to the release of stress hormones.

Correctional facilities are very stressful environments and Figure 12.1 shows different shift inputs that impact stress levels. Additional areas of stress include understaffing, overtime, shift work, and supervisor demands. The following are some of the stressful situations detention officers have to deal with regarding the care of inmates:

- Suicide attempts and completions
- Manipulation
- Anger
- Serious mental illnesses
- Gang activity
- Seclusion
- Sexual assault of other inmates
- Physical assault of other inmates and fellow detention officers
- Communicable diseases
- Depression

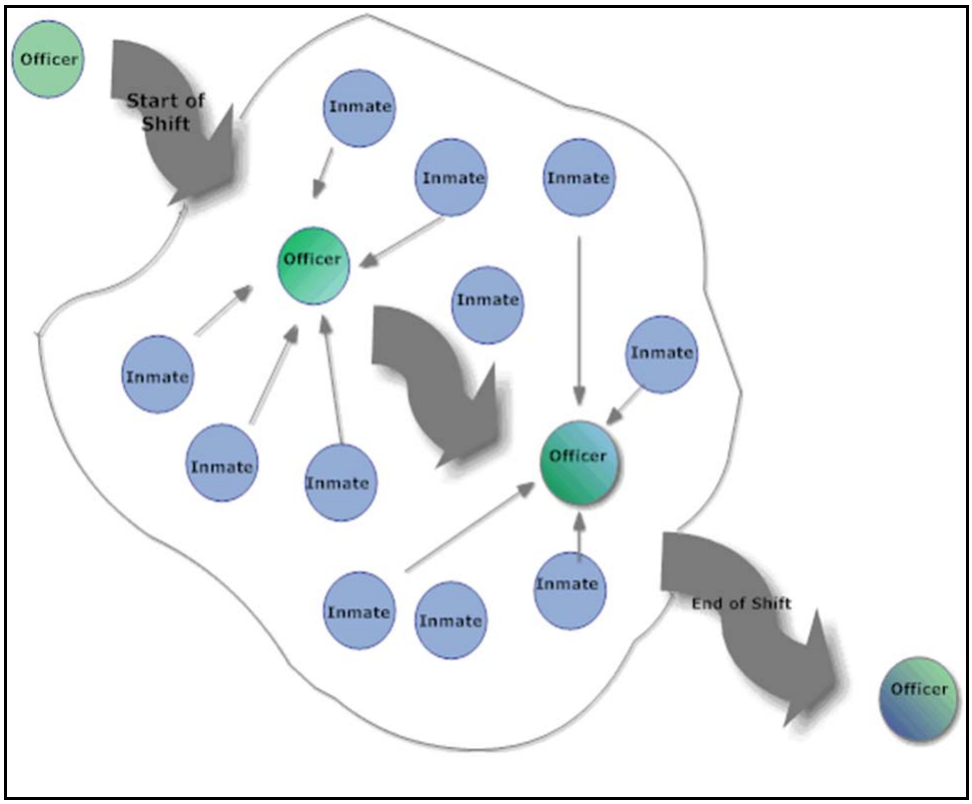


Figure 12.1: Shift inputs. Source: Desert Waters Correctional Outreach

Consequences of Stress

The consequences of stress pose a serious threat.

- Stress is mental or emotional strain or tension resulting from adverse or very demanding circumstances.
- Burnout is the cumulative process marked by emotional exhaustion or withdrawal associated with increased workload or institutional stress.
- Compassion fatigue is the emotional residue/strain of exposure to working with those suffering traumatic events. It can encompass physical symptoms, such as difficulty sleeping, and emotional symptoms, such as loss of self-worth or anger.

Manifestation of Stress

Signs and symptoms of stress can often be traced back to depletion of energy and resources and may manifest as:

- Isolation and withdrawal
- Being disengaged or unmotivated
- Physical exhaustion
- Nightmares and flashbacks
- Poor hygiene or apathy about one's physical appearance
- Loss of empathy or compassion
- Relationship issues, including divorce
- Substance misuse and abuse

- Recurrent sadness or depression
- Resistance to feedback
- Resistance to change
- Reduced job satisfaction
- Increase in citizen complaints

Pillars of Self Care

The preventative measure to combat this stress is self care to improve mental health. Self care is a conscious process of considering our needs and seeking out activities and habits that replenish our energy.

Exercise

Work itself is stressful and can release many hormones that keep us on alert, such as adrenaline and cortisol and activate parts of the brain, such as the amygdala, that generate feelings of anxiety, hyper-alertness and fear. Exercise flushes out toxins, releases good hormones, such as endorphins, stimulates sleep, and has many physiological benefits to allow us to think and perform more effectively.

Mindfulness

Mindfulness as a self-care strategy whereby a person intentionally tries to build an awareness of themselves, through some form of practice, where there is a greater ability to be present in the moment and to not be aversive or clinging towards particular thoughts, feelings and bodily sensations. When people learn to be present, they are better able to be engaged with others and often find meaning in what they are doing.

Relationships

Relationships are a key component of maintaining a self of reality and resilience. Strong social networks can lead to better health, greater emotional well-being and higher levels of self-esteem and a sense of meaning. Close friends and family within our circle and cultivating a life outside of our officer mentality can lead us towards being more or less trusting and patient with others. We should aim to cultivate our relationships with coworkers, family, and other potential positive influences.

Fun and Pleasure

When entrenched in the suffering and mistakes of others it can create an undue burden on an individual that can cause you to not experience fun and pleasure due to the “numbing” sensation that you might experience. It is important to be able to balance these emotions so that you can withstand the strains and rigors of correctional work. Encourage yourself to seek out ways for enjoying yourself and finding satisfaction and contentment in your activities. These experiences can generate positive emotions which help you become more stress resistant.

Self-Awareness

Self awareness can give us greater insight about our reactions, which in turn can offer more self-control and autonomy, which can result in a greater sense of efficacy and ability to be effective in our relationships and work with others.

Healthy Detention Officers

Strategies to Invest in Yourself

It is important to maintain a sense of community, joy, and fun in your life even while working with the challenging population so that you do not experience burnout. Ways to invest in yourself include:

- Building and bonding with family and friends
- Taking care of your health
- Fulfilling spiritual and life meaning needs
- Creating a healthy view of life

Benefits of Healthy Detention Officers

The following are some of the benefits of healthy detention officers:

- Reduced need to pay overtime to cover for officers on sick leave or quit because of work-related stress
- Reductions in the time officers need off after a critical incident before returning to work
- Reduced fees paid into the retirement fund because of fewer stress-related retirements
- Improved officer performance through higher staff morale
- Increased safety by having fewer inexperienced officers

  Source: Addressing correctional officer stress: programs and strategies, 2000.

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“Jails have been tasked with caring for the most vulnerable populations in our country. CIT training will give officers skills they can confidently use when working with those with mental illness so everyone has a better outcome. This training will not only improve the lives of those incarcerated, but the lives of corrections officers who are entrusted with their care.”

Resources and Programs

Peer Support Programs

Some agencies, like the California Department of Corrections and Rehabilitation (CDCR) and Multomah County (Portland, Oregon), have implemented Peer Support Programs (PSP). The goal of the PSP is to support employees who are involved in work-related critical incidents and/or facing a mental health crisis. Examples of support include: an employee who is depressed as he/she is going through a divorce, an employee who is having difficulty after witnessing a traumatic event at work (riot, assaults, sexual assaults, assaults on staff), an employee who is having difficulty dealing with the death of a co-worker, an employee having issues with a supervisor, an employee having difficulty dealing with the death of a loved one, etc.

The Peers are not behavioral health counselors, but other detention officers who the officer needing assistance can relate to. Peers typically go through a peer counseling training to prepare them for this position. A PSP team member is someone who will listen, answer questions, and offer resources to help the employee deal with his/her situation in a confidential environment. These programs are voluntary.

Employee Assistance Programs

In general, an Employee Assistance Program (EAP) is designed to offer professional services to assist 1) work organizations in addressing productivity issues and 2) clients in identifying and resolving personal concerns such as health, marital, family, financial, substance use, legal, emotional or other issues that may affect job performance.

Law enforcement (and some correctional) agencies generally offer two different types of Employee Assistance programs: internal and external.

- Internal EAPs, which are housed within the agency, can be quickly and easily accessed. Internal EAP providers likely have a thorough understanding of the host agency and the current issues impacting the officers. Alternatively, internal EAPs can be seen as an extension of the agency and therefore, may not be as readily used if the employee is dissatisfied with the agency or is concerned about confidentiality (e.g., the social stigma described earlier).
- External EAPs may be viewed as independent from the officer's agency and may be deemed as more confidential. However, external EAPS have drawbacks including: required travel to an outside location, scheduling problems (e.g., working around different shifts and mandatory overtime) and the external provider's lack of knowledge of current agency issues.

  Source: Correctional Officer Wellness and Safety Literature Review, 2013.

Jail Mental Health Officer

A Texas Mental Health Training Initiative for Jails

Participant Guide

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CORRECTIONAL MANAGEMENT INSTITUTE OF TEXAS

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