

Module 5

Mental Health, De-escalation Techniques, and Suicide Detection and Prevention

INSTRUCTOR NOTE: This curriculum has been created as a minimum standard of training to be provided for jail staff. The instructor may supplement this curriculum as they desire; however, course material being removed is not authorized.

MENTAL HEALTH

5.1.0 Unit Goal: Summarize mental impairments and effective responses and the impact of individuals with mental impairments within the jail system.

- A. An increasing number of incarcerated persons today have a documented diagnosis associated with a mental impairment. Jails have become homes to thousands of inmates who have mental impairments resulting in more severe symptoms and more disruptive behavior. Incarcerated persons, even those that do not have a mental illness, experience significant stress in the jail environment to include: separation from family and friends, lack of privacy, fear of assault, and boredom. These stressors are compounded for a person with a mental illness, often overwhelming the limited coping skills they do have, resulting in functional deterioration.
- B. With the decrease in inpatient psychiatric beds and decline in the availability of community mental health services, people with serious mental illnesses frequently go without the treatment and services. When someone experiences a psychiatric crisis, or acts out as a result of symptoms of their illness, often police are the first-line responders, and jails and prisons are increasingly used to house and treat these individuals.

5.1.1 Define the term “Mental Health.”

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

Source: <https://www.mentalhealth.gov/basics/what-is-mental-health/>

5.1.2 Define the term “Mental Illness.”

- A. 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.
- B. Mental illness means an illness, disease, or condition, other than epilepsy, dementia, substance abuse, or intellectual disability, that:
 - 1. Substantially impairs a person's thought, perception of reality, emotional process, or judgment; or

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2. Grossly impairs behavior as demonstrated by recent disturbed behavior.

Source: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.571.htm#571.003>

5.1.3 List five prominent categories of mental illness.

- A. Mood Disorders
- B. Schizophrenia/Psychotic Disorders
- C. Dementias
- D. Anxiety Disorders
- E. Eating Disorders

5.1.4 Define a mood disorder.

A psychological disorder characterized by the elevation or lowering of a person's mood, such as depression or bipolar disorder.

5.1.5 Identify prevalent behaviors associated with the two most common mood disorders encountered by jailers.

- A. The two most common mood disorders encountered by jailers are:
 1. Depression
 2. Bi-Polar Disorder
- B. Depression:
 1. Depression is a common, widespread disorder.
 2. Depression is a natural reaction to trauma, loss, death, or change.
 3. Major depression is not just a bad mood or feeling “blue,” but a disorder that affects thinking and behavior not caused by any other physical or mental disorder.
 4. A major depressive syndrome is defined as a depressed mood or loss of interest of at least two weeks duration accompanied by symptoms such as weight loss/gain and difficulty concentrating. Five or more symptoms are generally present during the same two-week period and are represented by a change from previous functioning. Depressed mood or loss of interest must also be included as a symptom.
 5. Other symptoms of depression:
 - a. Prolonged feelings of hopelessness or excessive guilt
 - b. Loss of interest in usual activities
 - c. Difficulty concentrating or making decisions
 - d. Low energy/fatigue
 - e. Changes in activity level

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- f. An inability to enjoy usual activities
 - g. Changes in eating habits leading to weight gain or loss
 - h. Changes in sleeping habits (sleeping more or less; an inability to fall asleep, or waking up early in the morning and not being able to go back to sleep).
6. Depressive Disorders (Including Major Depressive Disorder):
- a. Depressive disorders are among the most common mental health disorders in the United States. They are characterized by a sad, hopeless, empty, or irritable mood, and somatic and cognitive changes that significantly interfere with daily life. Major Depressive Disorder (MDD) is defined as having a depressed mood for most of the day and a marked loss of interest or pleasure, among other symptoms present nearly every day for at least a two-week period. Suicidal thoughts or plans can occur during an episode of major depression, which can require immediate attention.
 - b. MDD is thought to have many possible causes, including genetic, biological, and environmental factors. Adverse childhood experiences and stressful life experiences are known to contribute to risk for MDD. In addition, those with closely related family members (for example, parents or siblings) who are diagnosed with the disorder are at increased risk.
7. Statistics:
- 8.2% of adults aged 18 or older had a major depressive episode (MDE) in 2024.

INSTRUCTOR NOTE: It is the instructor's responsibility to update statistics using the following source before presenting course material:

- <https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf>

C. Bipolar Disorder:

- 1. A mental illness involving mania (an intense enthusiasm) and depression
- 2. Mania Phase may include:
 - a. Abnormally high, expansive or irritated mood
 - b. Inflated self-esteem
 - c. Decreased need for sleep
 - d. More talkative than usual
 - e. Flight of ideas or feeling of thoughts racing
 - f. Excessive risk-taking
- 3. Depressive Phase may include:
 - a. Prolonged feelings of sadness or hopelessness
 - b. Feelings of guilt and worthlessness
 - c. Difficulty concentrating or deciding

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- d. Lack of interest
 - e. Low energy
 - f. Changes in activity level
 - g. Inability to enjoy usual activities
 - h. Fatigue
- 4. An individual may quickly swing from the manic phase to the depressed stage.
 - 5. An individual cannot maintain the level of activity normally associated with mania for a long period of time.

Correctional considerations for Veterans with mood disorders:

Military conditioning may affect behavior in correctional settings: Mental health issues are often stigmatized in the military. Therefore, seeking help in a correctional setting may be viewed as weakness, leading to veterans refusing services, denying mental health needs, or downplaying symptoms.

5.1.6 Define schizophrenia.

Schizophrenia is a brain disorder that impacts the way a person thinks (often described as a “thought disorder”), 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.

5.1.7 Identify the characteristics of schizophrenia.

- A. The defining characteristic of schizophrenia and other psychotic disorders is abnormalities in one or more of five domains: delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms, which include diminished emotional expression and a decrease in the ability to engage in self-initiated activities.
 - 1. These symptoms are chronic and severe, significantly impairing occupational and social functioning.
 - 2. The lifetime prevalence of schizophrenia is estimated to be about 1% of the population. Childhood-onset schizophrenia (defined as onset before age 13) is much rarer, affecting approximately 0.01% of children. Symptoms of schizophrenia typically manifest between the ages of 16 and 30.
 - 3. People with schizophrenia can experience what are termed positive or negative symptoms.
 - a. Positive symptoms are psychotic behaviors including:
 - 1) Delusions of false and persistent beliefs that are not part of the individual’s culture;

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- 2) For example, people with schizophrenia may believe that their thoughts are being broadcast on the radio.
 - 3) Hallucinations that include hearing, seeing, smelling, or feeling things that others cannot;
 - 4) Most commonly, people with the disorder hear voices that talk to them or order them to do things.
 - 5) Disorganized speech that involves difficulty organizing thoughts, thought blocking, and making up nonsensical words; and
 - 6) Disorganized or catatonic behavior.
- b. Negative symptoms may include:
- 1) Flat affect:
 - a) Decreased emotional expressiveness
 - b) Diminished facial expression
 - c) Apathetic appearance
 - 2) Disillusionment with daily life;
 - 3) Isolating behavior
 - 4) Lack of motivation
 - 5) Infrequent speaking, even when forced to interact
4. As with other forms of serious mental illness, schizophrenia is related to homelessness, involvement with the criminal justice system, and other negative outcomes.

5.1.8 Define 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, and it can be associated with a number of types of dementia many of us are familiar with such as Alzheimer's, Parkinson's, and Huntington's disease.

Source: <https://www.alz.org/alzheimers-dementia/what-is-dementia>

5.1.9 Identify the symptoms of dementia.

A. Symptoms

1. Memory Problems – Memory problems can relate to recent memory or memories of the past.
2. Confabulation – Some people, who do not remember, make up facts to cover lack of memory. “Lying” is not done on purpose but is a part of the mental illness.
3. Impaired Thinking – The person may be unable to complete simple tasks like dialing a phone or reading simple signs.

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4. Impaired Judgment – The person cannot properly evaluate the propriety of actions, and so, may act in socially inappropriate ways such as grabbing people, making off-color comments, urinating in the corner of a room.
- B. When addressing symptoms in jail treat the individual as you would with any disability. Their inability to remember or follow directions is not intentional.

Source: Kentucky Department for Behavioral Health

5.1.10 Define anxiety disorders.

Anxiety disorders are a group of mental disturbances characterized by anxiety as a central or core symptom. Although anxiety is a commonplace experience, not everyone who experiences it has an anxiety disorder. Anxiety is associated with a wide range of physical illnesses, medication side effects, and other psychiatric disorders.

Source: <http://medical-dictionary.thefreedictionary.com/Anxiety+Disorders>

5.1.11 Identify the characteristics of anxiety disorders.

- A. Anxiety disorders are characterized by excessive fear or anxiety that is difficult to control and negatively and substantially impacts daily functioning. Fear refers to the emotional response to a real or perceived threat while anxiety is the anticipation of a future threat. These disorders can range from specific fears (called phobias), such as the fear of flying or public speaking, to more generalized feelings of worry and tension. Anxiety disorders typically develop in childhood and persist to adulthood. Specific anxiety disorders include generalized anxiety disorder (GAD), panic disorder, separation anxiety disorder, and social anxiety disorder (social phobia).
- B. Evidence suggests that many anxiety disorders may be caused by a combination of genetics, biology, and environmental factors. Adverse childhood experiences may also contribute to risk for developing anxiety disorders.

Source: <https://www.samhsa.gov/mental-health/what-is-mental-health/conditions/anxiety>

5.1.12 Define eating disorders.

Eating disorders are serious conditions related to persistent eating behaviors that negatively impact your health, your emotions, and your ability to function in important areas of life.

5.1.13 Identify common eating disorders.

- A. The most common eating disorders are:
 1. Anorexia nervosa
 2. Bulimia nervosa
 3. Binge-eating disorder

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- B. Although eating disorders are classified under the five prominent categories of mental illness this form of mental illness has not significantly impacted jail populations as severely as the other four have.

5.1.14 Define the term substance use disorders /co-occurring disorders.

Substance Use Disorders - Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. 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.

Source: <https://www.samhsa.gov/disorders/substance-use>

- A. Co-occurring Disorders - The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. Co-occurring disorders were previously referred to as dual diagnoses.
- B. According to SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH), approximately 7.9 million adults in the United States had co-occurring disorders in 2014.
 - 1. People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated.
 - 2. The consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.

INSTRUCTOR NOTE: It is the instructor's responsibility to update statistics using the following source before presenting course material:

- <https://www.samhsa.gov/substance-use/treatment/co-occurring-disorders>

5.1.15 List the symptoms of substance withdrawal.

- A. Emotional Withdrawal Symptoms
 - 1. Anxiety
 - 2. Restlessness
 - 3. Irritability
 - 4. Insomnia
 - 5. Headaches
 - 6. Poor concentration
 - 7. Depression
 - 8. Social isolation

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B. Physical Withdrawal Symptoms

1. Sweating
2. Racing Heart
3. Palpitations
4. Muscle Tension
5. Tightness in the Chest
6. Difficulty Breathing
7. Tremor
8. Nausea, Vomiting, diarrhea

5.1.16 List the symptoms of substance withdrawal and associated risk factors related to substance withdrawal.

Alcohol and tranquilizers produce the most dangerous physical withdrawal. Suddenly stopping alcohol or tranquilizers can lead to seizures, strokes, or heart attacks in high-risk patients. Medically supervised detoxification can minimize withdrawal symptoms and reduce the risk of dangerous complications. Some of the dangerous symptoms of alcohol and tranquilizer withdrawal are:

1. Grand mal seizures
2. Heart attacks
3. Strokes
4. Hallucinations
5. Delirium tremens (DTs)

Source: <https://www.addictionsandrecovery.org/withdrawal.htm>

5.1.17 Define psychosis.

Psychosis is an illness involving a distortion of reality that may be accompanied by delusions and/or hallucinations. These are most commonly seen in persons with schizophrenia, bipolar disorder, severe depression, or drug induced disorders. Physical circumstances can also induce a psychotic state. Potential conditions include: organic brain disorders (brain injury or infections to the brain), electrolyte disorder, pain syndromes, drug withdrawal, and closed head injuries.

Source: <https://medical-dictionary.thefreedictionary.com/psychosis>

5.1.18 Identify the two most common experiences related to psychosis.

- A. Hallucinations are seeing, hearing, or feeling things that aren't there, such as the following:
1. Hearing voices (auditory hallucinations)
 2. Strange sensations or unexplainable feelings
 3. Seeing glimpses of objects or people that are not there, or distortions

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- B. Delusions are strong beliefs that are not consistent with the person's culture, are unlikely to be true and may seem irrational to others, such as the following:
1. Believing external forces are controlling thoughts, feelings and behaviors
 2. Believing that trivial remarks, events, or objects have personal meaning or significance
 3. Thinking you have special powers, are on a special mission, or even that you are God.
 4. They are not being uncooperative; they are simply disconnected and unable to focus because of the noise in their heads. Coercive directives will not work and will only increase confusion and distress. Simple directions, reassurance that they are in a safe place and compassion will always work better than coercion.

For individuals experiencing delusions and hallucinations, these experiences are real. There is poor processing of information and illogical thinking that can result in disorganized and rambling speech and/or delusions. It is not uncommon for a person hearing voices to hear two or more at a time. If you approach the person and start yelling at him, you are only adding to his confusion. Imagine having two or three people shouting at you all at once while an officer is trying to give you directions. This could cause the person to experience the fight or flight sensation.

INSTRUCTOR NOTE: Discuss the issue of "fight or flight"

Source: <https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis/>

5.1.19 Identify characteristics of a person in psychosis.

A. Behavioral characteristics of persons in psychosis:

1. Inappropriate or bizarre attire
2. Body movements are lethargic or sluggish
3. Impulsive or repetitious body movements
4. Responding to hallucinations
5. Causing injury to self
6. Home environment:
 - a. Strange decorations (e.g., aluminum on windows)
 - b. Pictures turned over
 - c. Waste matter/trash on floors and walls (hoarding)
7. Unusual attachment to childish objects or toys

B. Emotional characteristics of persons in psychosis:

1. Lack of emotional response
2. Extreme or inappropriate sadness
3. Inappropriate emotional reactions

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5.1.20 Define excited delirium.

A serious and potentially deadly medical condition involving psychotic behavior, elevated temperature, and an extreme fight-or-flight response by the nervous system.

Source: <https://leb.fbi.gov/2014/july/excited-delirium-and-the-dual-response-preventing-in-custody-deaths>

5.1.21 Identify the symptoms of excited delirium.

- A. Aggressive, threatening, or combative behavior which gets worse when challenged or injured
- B. Superhuman strength
- C. Insensitivity to pain
- D. Pressured, loud, or incoherent speech
- E. Sweating or continuing to sweat after physical exertion has ceased
- F. Dilated pupils / less reactive to light
- G. Rapid breathing
- H. High body temperature (105–113 degrees F.) - Subject will often disrobe due to profuse sweating and high body temperature.

5.1.22 Identify appropriate responses to excited delirium.

- A. Notify Medical Staff - rapid chemical sedation can be lifesaving.
- B. Remove physical restraints when feasible.
- C. When using restraints, monitor the subject for positional asphyxiation.

Source: <http://mentalhealthdaily.com/2015/04/22/excited-delirium-syndrome-causes-symptoms-treatment/>

5.1.23 Define personality disorder.

A deeply ingrained, inflexible pattern of relating, perceiving, and thinking serious enough to cause distress or impaired functioning is a personality disorder. Personality disorders are usually recognizable by adolescence or earlier, continuing throughout adulthood, and become less obvious throughout middle age.

Source: <https://mhanational.org/conditions/personality-disorder/>

5.1.24 Identify the three most common personality disorders.

- A. Paranoid:
 - 1. Tendency to interpret the actions of others as deliberately threatening or demeaning

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2. Foresee being in position to be used or harmed by others
 3. Perceive dismissive behavior from other people
- B. Antisocial:
1. Most commonly recognized in males
 2. A pattern of irresponsible and antisocial behavior diagnosed at or after age 18
 3. May have one or more of the following:
 - a. History of truancy as a child or adolescent
 - b. Starting fights
 - c. Using weapons
 - d. Physically abusing animals or other people
 - e. Deliberately destroying others' property
 - f. Lying
 - g. Stealing
 - h. Other illegal behavior
 - i. Unwilling to conform to society's expectations of family and work
- C. Borderline:
1. Most commonly recognized in females
 2. May have one or more of the following:
 - a. Unstable and intense personal relationships
 - b. Impulsiveness with relationships, spending, food, drugs, and sex
 - c. Intense anger or lack of control of anger
 - d. Recurrent suicidal threats
 - e. Chronic feelings of emptiness or boredom
 - f. Feelings of abandonment

5.1.25 Identify the characteristics of personality disorders.

- A. Those who struggle with a personality disorder have great difficulty dealing with other people.
1. Tendencies may include being:
 - a. Inflexible
 - b. Rigid
 - c. Unable to respond to the changes and demands of life
 2. Although they feel their behavior patterns are "normal" or "right," people with personality disorders tend to have a narrow view of the world and find it difficult to participate in social activities.
 3. People with personality disorders usually will not seek treatment because they don't think they have a problem.
 4. They may end up in the criminal justice system because their disorder may lead them to break laws and come to the attention of law enforcement (i.e., by theft, hot-check writing, fraud, etc.).

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5. They may use alcohol and illegal substances as a form of self-medication, due to the stress and the consequences of their behaviors. They often need treatment for chemical dependency or depression.

5.1.26 Define intellectual and developmental disorders and distinguish major differences between mental illness and intellectual and developmental disabilities.

- A. Intellectual disability means significantly sub-average general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.
- B. Developmental disability means a severe, chronic disability that:
 1. Is attributable to a mental or physical impairment or a combination of physical and mental impairments;
 2. Is manifested before the person reaches 22 years of age;
 3. Is likely to continue indefinitely; and
 4. Results in substantial functional limitations to areas of major life activities such as a lack of capacity for independent living.

Source: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm>

Source: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.591.htm#591.003>

5.1.27 Identify the characteristics associated with intellectual and developmental disorders.

A. Speech / Language

1. Obvious speech defects
2. Limited response or understanding
3. Inattentiveness
4. Vocabulary or grammatical skills lacking
5. Difficulty describing facts in detail

B. Social Behavior

1. Adult associating with children or early adolescents
2. Eager to please
3. Ignorance of personal space
4. Non-age appropriate behavior
5. Easily influenced by others
6. Easily frustrated or aggressive in response to direct questioning

5.1.28 Identify the differences between mental illness and intellectual and developmental disabilities.

- A. Mental illness is unrelated to intelligence, while intellectual disabilities are associated with below-average intellectual functioning.

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- B. Mental illness develops at any point in one's life, while developmental disability occurs before the age of 22.
- C. There is no cure for mental illness, but medications can control symptoms. Intellectual disability involves permanent intellectual impairment. No medications can help.
- D. Behavior is less predictable with individual with mental illness, while a person with intellectual and/or developmental disability behavior is consistent to a very specific functional level.

5.1.29 Define trauma.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Source: [Trauma and Violence - What Is Trauma and Its Effects? | SAMHSA](#)

Responses to trauma are automatic and adaptive during the traumatic event but may persist in ways that are maladaptive in non-threatening environments, contributing to incarceration risk.

- A. Common mental health conditions associated with trauma
 - 1. Post-Traumatic Stress Disorder (PTSD) – See 5.1.30-5.1.33
 - 2. Depression – See 5.1.4-5.1.5
 - 3. Anxiety disorders – See 5.1.10-5.1.11
 - 4. Substance use disorders – See 5.1.14-5.1.16
 - 5. Personality disorders – See 5.1.23-5.1.25

Source: U.S. Department of Veterans Affairs: National Center for PTSD

Suggested activity: Corrections personnel will likely encounter individuals whose behaviors, reactions, and needs have been shaped by trauma. Trauma doesn't discriminate, but certain populations face higher rates of traumatic experiences due to systemic factors, life circumstances, or environmental conditions. Recognizing which populations are disproportionately affected helps personnel approach their work with informed awareness and appropriate response strategies.

Use the following discussion prompts to assess current knowledge and identify gaps in understanding of trauma's reach across different communities—including the incarcerated population.

- Name specific populations of people who are known to be disproportionately affected by trauma.

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- Explain how recognizing these groups is critical to effective communication and safe interactions within a correctional setting.
- How can a lack of awareness regarding trauma-affected populations lead to misinterpretation of inmate behavior, unintended escalation, and compromise facility safety?
- Many inmates with a history of trauma are resistant to accessing mental health services while incarcerated. What are some barriers that prevent inmates from seeking help?

5.1.30 Define Post-Traumatic Stress Disorder (PTSD).

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault.

Source: <https://psychiatry.org/patients-families/ptsd/what-is-ptsd>

5.1.31 Identify causes of Post-Traumatic Stress Disorder (PTSD).

PTSD can occur after a traumatic event. A traumatic event is something terrible and scary that is seen, heard, and/or experienced, like:

- A. Child sexual or physical abuse
- B. Terrorist attack
- C. Sexual or physical assault
- D. Serious accidents, like a car wreck
- E. Natural disasters, like a fire, tornado, hurricane, flood, or earthquake
- F. Veterans with PTSD may have experienced trauma from various sources:
 - 1. In-service traumatic events:
 - a. Combat exposure
 - b. Accidents and injuries
 - c. Military sexual trauma
 - 2. Moral injury: emotional distress from violating deeply held moral beliefs.
 - 3. Pre- and post-military service factors: traumatic experiences that occurred before entering the military or after discharge.

5.1.32 Identify symptoms of Post-Traumatic Stress Disorder (PTSD).

- A. Behavioral symptoms:
 - 1. Intrusive memories (Example: Being reminded of traumatic event by an everyday experience which may change how an individual reacts to the situation.)
 - 2. Avoiding reminders

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3. Trouble concentrating
 4. Emotional outbursts
 5. Hypervigilance
 6. Flashbacks
 7. Loss of interest in hobbies
 8. Withdrawal from others
 9. Reckless or self-destructive behavior
 10. Increased self-medication
- B. Emotional Symptoms:
1. Anger
 2. Irritability
 3. Sadness
 4. Anxiety
 5. Hopelessness
 6. Guilt
- C. Social Symptoms:
1. Becoming withdrawn, detached, or disconnected
 2. Loss of desire for intimacy, closeness
 3. Mistrust
 4. Over-controlling/overprotective behavior
 5. Argumentative
 6. Family violence may result
- D. Physical Symptoms:
1. Digestion problems/stomachaches
 2. Sleep disruptions, fatigue
 3. Headaches
 4. Increased heart rate, rapid breathing
 5. Shakiness/weakness
 6. Worsening of ongoing medical problems

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Correctional considerations for Veterans with PTSD:

Post-Traumatic Stress Disorder (PTSD) is a prolonged response to trauma that veterans may continue to experience long after their military service has ended. In a correctional setting, misinterpretation of PTSD symptoms can lead to dangerous escalation, unnecessary use of force, or inappropriate disciplinary action.

While persons with PTSD may display any of the behavioral, emotional, social or physical symptoms listed above, PTSD symptoms seen in veterans are organized into four core categories, which often manifest as the following observable behaviors among veterans in custody:

- A. Intrusion symptoms
 - 1. Re-experiencing or reliving memories through flashbacks, nightmares, or intrusive memories in reaction to specific triggers.
 - 2. Observable behaviors:
 - a. Appearing distracted or inattentive
 - b. Overly reactive to staff presence or commands
 - c. Jerking away or cowering when approached or lightly touched
- B. Avoidance symptoms
 - 1. Avoiding people, situations, conversations, places, or internal thoughts/feelings that trigger memories of past trauma.
 - 2. Observable behaviors:
 - a. Physical resistance
 - b. Refusing to make eye contact or turning away from staff
 - c. Being agitated when encountering unexpected situations
- C. Negative alterations in cognitions and mood
 - 1. Emotional numbing, negative beliefs about oneself or the world, and difficulty experiencing connection.
 - 2. Observable behaviors:
 - a. Appearing emotionally detached
 - b. Non-compliance in response to commands
 - c. Appearing unresponsive to questions
- D. Alterations in arousal and reactivity
 - 1. Hypervigilance, an exaggerated startle response, irritability and outbursts of anger. This heightened state of alertness is often mistaken for defiance, paranoia or suspicion.
 - 2. Observable behaviors:
 - a. Constantly screening their environment
 - b. Body positioning (sitting with back to the wall, facing the door)
 - c. Appearing jumpy or overreacting to sudden noises or movements

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- d. Anger or aggressiveness in response to feeling threatened, controlled or surprised
- e. Difficulty relaxing and sleep disturbances

Recognizing PTSD symptoms as trauma responses rather than behavioral problems can transform correctional interactions, reduce escalation, and support safer and more positive outcomes for veterans in custody.

Source: U.S. Department of Veterans Affairs: National Center for PTSD

5.1.33 Identify triggers of Post-Traumatic Stress Disorder (PTSD).

- A. High levels of stress may cause a breakdown in information processing, leading memories to be stored as physical or sensory cues.
- B. 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 memories of the event.

Correctional considerations for Veterans with PTSD:

The jail environment—with its controlled spaces, loud noises, hierarchical structure, and high stress—can mirror military settings and activate post-traumatic stress responses that affect behavior, compliance, and mental health.

Identifying common PTSD triggers and understanding how these triggers manifest in jail settings prepares corrections personnel to de-escalate situations, provide appropriate support, and create a safer environment for both staff and inmates.

A. Common PTSD triggers for veterans

- 1. Sensory cues
 - a. Sounds – yelling, alarms, sirens, slamming doors
 - b. Sights – uniforms, authoritative postures, weapons
 - c. Smells – smoke, burnt materials, fuel, certain foods or cleaning products
- 2. Anniversaries and dates
 - a. Anniversary of a traumatic event or loss
 - b. Holidays associated with military service or deployment
- 3. Places and environments
 - a. Locations resembling where trauma occurred
 - b. Crowded or confined areas
 - c. Unfamiliar surroundings

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4. People and behaviors

- a. Individuals who resemble someone involved in the traumatic event
- b. Aggressive postures, raised voices, or confrontational behavior
- c. Authority figures or chain-of-command interactions

5. Emotional states

- a. Strong emotions like anger, fear, panic, or sadness
- b. Feelings of helplessness or loss of control

6. Specific words or phrases

- a. Military terminology or commands
- b. Language associated with combat or threat

Source: [Traumatic Events and Post-Traumatic Stress Disorder \(PTSD\) - National Institute of Mental Health \(NIMH\)](#)

5.1.34 Define Traumatic Brain Injury (TBI).

TBI is a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

- A. The severity of injury may range from a mild concussion to severe closed or open head injury.
- B. The injury may not be reported or diagnosed.
- C. TBI symptoms may not appear for months or years.

INSTRUCTOR NOTE: A TBI can result in short- or long-term problems with functioning (e.g., daily activities, social functioning, work/school, etc.).

5.1.35 Recognize and identify signs of Traumatic Brain Injury (TBI).

- A. The most common Traumatic Brain Injury is a frontal lobe (front of head) injury, which may impact:
 - 1. Initiation
 - 2. Problem solving
 - 3. Judgment
 - 4. Inhibition of behavior
 - 5. Planning/anticipation
 - 6. Self-monitoring
 - 7. Motor planning
 - 8. Personality/emotions
 - 9. Awareness of abilities/limitations
 - 10. Organization

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11. Attention/concentration
12. Mental flexibility
13. Speaking (expressive language)
- B. Behavioral symptoms that may accompany a Traumatic Brain Injury:
 1. Symptoms
 - a. Irritability
 - b. Aggression
 - c. Paranoia
 - d. Lack of restraint
 - e. Anxiety
 - f. Apathy/depression
 - g. Insensitivity
 - h. Egocentricity
 - i. Lack of concentration
 - j. Difficulty with memory
 - k. Reckless decision-making
 - l. Agitation
 - m. Anger
 - n. Lack of empathy
 - o. Increased verbal and physical altercations
 - p. Inappropriate or impulsive behavior/aggression or abusive language
 - q. May appear to be resistant to authority
 - r. Difficulty remaining focused
 - s. May present as early dementia
 - t. Subject may not remember, or respond well to, instructions or questions
 2. These symptoms can be de-escalated with skilled use of de-escalation strategies.
 3. Jail personnel may mistake individuals with brain injury for individuals under the influence of alcohol or other substance.

INSTRUCTOR NOTE: What can staff do to de-escalate situations where subjects exhibit these symptoms? What would escalate the situation?

Correctional considerations for Veterans with a Traumatic Brain Injury:

According to the Traumatic Brain Injury Center of Excellence (TRICoE), over 518,000 TBIs were diagnosed among U.S. service members worldwide between 2000 and early 2025. The majority (over 81%) are classified as mild TBIs/concussions, while the rest are classified as moderate, severe, penetrating or not classifiable. While combat-related incidents, such as explosions or direct projectile impacts, are major causes of TBIs, particularly the severe types, accidents during training and routine active duty also contribute significantly to the overall risk. The severity of these injuries ranges from mild to severe, resulting in long-term effects on a veteran's health and well-being.

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Functional impacts of TBIs, including impaired memory, reasoning, communication, and emotional regulation, can manifest as behavioral issues, including irritability, impulsivity, or poor judgment.

Sources:

<https://www.ninds.nih.gov/health-information/disorders/traumatic-brain-injury-tbi>

<https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence>

5.1.36 Define delirium.

Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of your environment. The start of delirium is usually rapid — within hours or a few days.

Source:

<https://www.mayoclinic.org/diseases-conditions/delirium/symptoms-causes/syc-20371386>

5.1.37 Recognize medical conditions in which delirium may present itself.

Delirium can often be traced to one or more contributing factors:

- A. Severe or chronic medical illness
- B. Changes in your metabolic balance, such as low sodium
- C. Medication
- D. Infection
- E. Surgery
- F. Diabetes
- G. Water intoxication
- H. High ammonia levels
- I. Alcohol or drug withdrawal

5.1.38 Identify symptoms of delirium.

A. Primary symptoms include:

1. Reduced awareness of the environment may result in:
 - a. An inability to stay focused on a topic or to switch topics
 - b. Getting stuck on an idea rather than responding to questions or conversation
 - c. Being easily distracted by unimportant things
 - d. Being withdrawn, with little or no activity or little response to the environment

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2. Poor thinking skills (cognitive impairment) which may appear as:
 - a. Poor memory, particularly of recent events
 - b. Disorientation, for example, not knowing where you are or who you are
 - c. Difficulty speaking or recalling words
 - d. Rambling or nonsense speech
 - e. Trouble understanding speech
 - f. Difficulty reading or writing
3. Behavior changes which may include:
 - a. Seeing things that don't exist (hallucinations)
 - b. Restlessness, agitation, or combative behavior
 - c. Calling out, moaning, or making other sounds
 - d. Being quiet and withdrawn — especially in older adults
 - e. Slow movement or lethargy
 - f. Disturbed sleep habits
 - g. Reversal of night-day sleep-wake cycle
4. Emotional disturbances which may appear as:
 - a. Anxiety, fear, or paranoia
 - b. Depression
 - c. Irritability or anger
 - d. Sense of feeling elated (euphoria)
 - e. Apathy
 - f. Rapid and unpredictable mood shifts
 - g. Personality changes

Source: <http://www.mayoclinic.org/diseases-conditions/delirium/basics/symptoms/con-20033982>

- B. Refer to departmental policy concerning detoxification protocols.

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DE-ESCALATION TECHNIQUES

5.2.0 Unit Goal: Summarize barriers to de-escalation and techniques to overcome those barriers.

5.2.1 Define crisis as related to mental health.

A. Crisis: A situation in which:

1. The individual presents an immediate danger to self or others;
2. The individual's mental or physical health is at risk of serious deterioration; or
3. An individual believes that they present an immediate danger to self or others, or that their mental or physical health is at risk of serious deterioration.

Source: [26 TAC, Part 1, Chapter 301, Subchapter G, Division 1, Rule 301.303](#)

5.2.2 Identify principles of trauma-informed care.

- A. A trauma-informed approach begins with understanding the physical, social, psychological, and emotional impact of trauma.
- B. Individuals, groups, organizations, and systems can all be trauma informed.
- C. The approach incorporates four (4) key assumptions, the “4 Rs”
 1. Realize the widespread impact of trauma and understand potential paths to recovery.
 2. Recognize the signs and symptoms of trauma in others.
 3. Respond by fully integrating knowledge of trauma into policies, procedures, and practices.
 4. Resist re-traumatization actively through trauma-informed and compassionate responses.

5.2.3 Illustrate the key principles of trauma-informed approach.

- A. Incorporating a trauma-informed approach takes into consideration the following key principles:
 1. Safety
 - a. Ensure immediate safety and address any medical concerns.
 - b. Reduce unpredictability.
 2. Trustworthiness and transparency
 - a. Clear communication
 - 1) Rules
 - 2) Procedures
 - 3) Consequences

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- b. Staff consistency
 - 1) Keep promises
 - 2) Explain why things happen
- 3. Peer support
 - a. Facilitate access to assistance support
 - b. Allow for support groups
 - c. Peer-led programs
- 4. Empowerment
 - a. Providing small choices helps restore a sense of control
- 5. Cultural, historical, and gender issues
 - a. Recognize and address cultural, historical, and gender-related factors that can influence trauma and their process of healing.
 - b. Understand how trauma can influence behavior and trust.

5.2.4 Recognize trauma triggers in a jail environment.

- A. A trauma trigger is anything – a sound, smell, visual cue, or interaction that reminds someone of a traumatic experience and causes a stress response.
- B. Loud noises
 - 1. Slamming doors
 - 2. Yelling
 - 3. Radios squawking
 - 4. Sudden alarms
- C. Aggressive posture or tone
 - 1. Shouting
 - 2. Pointing
 - 3. Physical intimidation
- D. Isolation or Confinement
 - 1. Solitary cells
 - 2. Time in segregation

5.2.5 Recall how traditional correctional practices may unintentionally retraumatize veterans.

- A. While correctional settings have necessary security protocols, some traditional practices can unintentionally trigger trauma responses, especially in veteran populations.
- B. Authoritarian structures
 - 1. Command style orders may mimic military command.
 - 2. In a corrections setting, this may be triggering if a veteran experienced abuse by an authority figure.

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C. Use of force

1. Being restrained can mimic combat experiences.
2. In a corrections setting, sudden physical contact can provoke panic or flashbacks.

D. Noise and sensory overload

1. Loud alarms and crowded spaces may mimic combat experiences.
2. In a corrections setting, this may lead to emotional shutdown or aggression as a survival response.

5.2.6 Discuss practices for de-escalation/communication techniques for the management of individuals in crisis.

A. Keys to Communication

1. You will need to build trust and rapport to obtain information quickly and accurately. Use these three helping skills:
 - a. Empathy is the ability to accurately describe the emotional state of another. Do not confuse this with sympathy.
 - b. Sensitivity comes from your understanding and commitment to staying with the person until the present crisis is resolved.
 - c. Utilize objectivity and subjectivity in your communications.
 - 1) Use objectivity to make accurate evaluations.
 - 2) Use subjectivity to understand the pain the person in crisis is going through.
 - a) Trauma informed practices promote safety and trust, essential for effective interactions and de-escalation in correctional settings.
 - 3) Utilize active listening techniques.

2. Promoting Communication

a. Listening

- 1) Listening is one of the most important skills used during a crisis de-escalation. Listening effectively establishes trust and allows you to understand information more thoroughly.
- 2) To be an effective listener remember to:
 - a) Recognize verbal and nonverbal cues.
 - b) Avoid distractions.
 - c) Note extra emphasis the person in crisis places on words or phrases.
 - d) Notice speech patterns and recurring themes.

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- b. Clarification: It is important to remember that any statement not understood needs to be clarified. Nothing should ever be assumed. Some techniques to aid in clarifying:
 - 1) Rephrase the person's statement in a way that encourages the person to clarify.
 - 2) Repeat key words. This focuses attention on particular thoughts and feelings.
 - 3) Admit confusion or misunderstanding of a statement and ask for clarification.
 - 4) Ask "open ended" questions to obtain better understanding.
 - c. Dealing with silence: if faced with silence during a crisis situation, do not let the silence become discomforting, use it as a time to observe the person's behavior.
 - 3. Respond Effectively
 - a. Handle the feelings of the person in crisis with care and concern and treat the person's feelings as legitimate.
 - 1) Trauma can influence behavior and trust
 - 2) Speak calmly and evenly, using clear, respectful, neutral phrasing.
 - b. It is essential not to judge, give advice, or belittle the person during a crisis.
 - 1) Avoid slang, confrontational questions.
 - a) Example: Replace "What's your problem?" with "Can you help me understand what's going on?"
 - 4. Maintain Personal Space
 - a. This is a crucial element for effective communication and is different for every individual in crisis.
 - b. Observe the person's reaction to proximity to create a comfortable space for effective communication.
 - c. Maintain an appropriate distance to ensure individual safety.
- B. Basic Communication Guidelines
 - 1. Use short, clear direct sentences.
 - a. Direct communication reduces misunderstandings.
 - b. Long, involved explanations are difficult for people with mental illness to handle.
 - c. They will tune you out.

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2. Keep the content of communications simple.
 - a. Cover only one topic at a time.
 - b. Give only one direction at a time.
 - c. Be as concrete as possible.
 - 1) Clear communication of rules, procedures and consequences promotes trustworthiness and transparency
 - 2) Use structured, predictable responses
3. Keep the “stimulation level” as low as possible.
 - a. High stimulation levels are painfully defeating for anyone who has suffered a mental breakdown.
4. If the person appears withdrawn and uncommunicative, allow time for them to acclimate to the situation and re-approach.
 - a. Offer limited choices when possible
 - 1) Example: “You can return to your cell now, or we can talk in the office first.”
 - 2) Small choices help restore a person’s sense of control
5. Instructions and directions will often have to be repeated. Be patient.
6. Be pleasant and firm. Make sure your boundaries are specific and clear.
 - a. Be assertive, not aggressive
 - 1) Use “I” statements
 - 2) Key distinction:
 - a) Assertive is respectful boundary setting
 - i. Example: “I need you to return to your cell now. I understand you’re upset, and we can talk more once things are settled.”
 - b) Aggressiveness is intimidation or hostility
 - i. Example: “Get back in your cell now or you’ll regret it.”
7. To increase the desired results, praise all cooperative behavior.
8. Practice active listening.
 - a. Avoid interruptions and allow the speaker to finish their thoughts.
 - b. Listen to understand, not just to respond.
 - c. Use phrases like:
 - 1) Sounds like you’re feeling (angry, upset, and sad) - Is that right?
 - 2) You’re pretty (angry, upset, and sad) right now, aren’t you?
 - 3) I want to make sure that I understand what you are saying - are you telling me that you are...?

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9. Remember a person in crisis may be further agitated by intervention, even when they are necessary.
 - a. Promoting safety and trust is essential for effective interactions
10. Nonverbal communication speaks volumes. A cooperative and open stance may be more effective.
 - a. Maintain open, relaxed body language.
 - b. Avoid pointing or clenched fists.
 - c. Keep hands visible and respect personal space.

INSTRUCTOR NOTE: Analyze the phrases below comparing what not to say with what to say to individuals in crisis. How do these phrases demonstrate communication and de-escalation strategies outlined in this section?

What not to say	What to say
"Calm down."	"I see you're struggling right now. I need you to control your breathing so we can talk. Take a slow, deep breath."
"What's wrong with you?"	"Can you help me understand what's going on?"
"You're overreacting."	"I see you are frustrated. We need to focus on resolving this safely. What is the main issue right now?"
"You're being difficult."	
"You're making things worse for yourself."	"I want to help you get through this without additional consequences. What can we do differently right now?"
"That's not my problem."	"I understand this is critical. I will relay this information to the appropriate staff member who handles that."
"You're not making any sense."	"I see you're upset. We will address this when you can speak calmly. I will check back with you in five minutes."
"You need to get it together."	"I can see you're going through something difficult. Let's figure out what would help right now."
"I don't have time for this."	"I hear you. Give me a moment to address this properly with you."

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5.2.7 Recognize the concepts of the de-escalation paradox.

- A. The difference between traditional inmate encounters and an encounter with an inmate who has mental illness is the need to be non-confrontational.
 - 1. Such a requirement to, in effect, shift gears is completely opposed to the way officers are routinely expected to control conflict.
 - 2. When responding to an emergency, officers are forced to make split second decisions about their safety and the safety of others.
 - 3. Those decisions are often based upon command and control tactics.
 - 4. The same command techniques used to gain control of a traditional inmate can escalate an encounter with an inmate with a mental illness into violence.
 - 5. An inmate with compromised coping capacity who is experiencing a crisis may have unpredictable behavior which can be mistaken for non-compliance with your commands.
- B. Safety is compromised any time a jailer goes “hands-on” with a person. Jailers should use non-confrontational, verbal de-escalation skills to talk them down versus take them down.
 - 1. A non-confrontational approach gives you time to think, act, and understand the situation immediately in front of you.
 - 2. Reasons why command and control approaches can escalate a situation due to mental impairments:
 - a. Disorganized thinking causes difficulty in reasoning and following simple requests.
 - b. Hallucinations, where a subject is hearing or seeing things that are not there, can make the subject’s compliance to your commands difficult.
 - c. Paranoid thoughts cause mistrust of others, including officers.
 - 3. Reasons for non-compliance are less about a power struggle and more about the brain disorder (i.e., condition and stressful life event).
- C. Fostering a de-escalation mindset.
 - 1. Taking a less physical, less authoritative, less controlling approach to an individual with mental impairments may increase the probability of a safe resolution.
 - 2. Remaining alert and using empathy and patience will help frame your communication skills and increase the chance of a voluntary, peaceful resolution.
 - 3. It is important you appear calm, interested, confident, and resourceful.
- D. Refer to your departmental policies for mental health evaluations.

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5.2.8 Identify local resources and partnerships to assist with individuals in crisis and in need of supportive services.

The following resource guide has been developed to provide resources for the students. Mental health services, veteran resources, and peer support can be found on these websites:

- A. [Texas Health and Human Services: Mental Health Crisis Services](#)
- B. [Texas Veterans Commission: Health Care Advocates](#)
- C. [Texas Veterans Commission: Military Veteran Peer Network](#)

INSTRUCTOR NOTE: The instructor shall provide a list of resources for your geographic area using the above-mentioned links.

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SUICIDE DETECTION AND PREVENTION

5.3.0 Unit Goal: Be able to screen for suicide risk and follow up with questions and actions necessary when an individual is identified as a suicide risk.

INSTRUCTOR NOTE: Introduce the lesson with national and state statistics for suicide rates in jail settings. Include information on the correctional population such as rates of mental health conditions or disorders and substance use or abuse prior to incarceration.

- Discuss the statistics with students to give a clearer understanding of suicide prevalence in correctional settings, how likely inmates are to be at risk of suicide/suicidal tendencies, and the extent to which these issues are present within the populations the students serve.
- Resources for statistics for Unit 5.3.0 can be found here:
 - <https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statistical-tables>
(Bureau of Justice Statistics – Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables)
- It is the responsibility of the instructor or training provider to ensure the data used for statistics is current.

5.3.1 Define suicidal ideation.

- A. Suicidal ideation refers to thinking about or formulating plans for suicide.
- B. The ideation exists on a spectrum of intensity.
 1. Begins with a general desire to die that lacks any concrete method, plan, intention, or action.
 2. Progresses to active suicidal ideation, which involves a detailed plan and a determined intent to act on the ideas.

5.3.2 Explain common myths and accompanying facts about suicide.

- A. **Myth:** People who make suicidal statements or threaten suicide do not commit suicide.
Fact: Most people who commit suicide have made either direct or indirect statements indicating their suicidal intentions.
- B. **Myth:** Suicide happens suddenly and without warning.
Fact: Most suicidal acts represent a carefully thought-out strategy for coping with various personal problems.
- C. **Myth:** People who attempt suicide have gotten it out of their systems and will not attempt it again.
Fact: Any individual with a history of one or more prior suicide attempts is at much greater risk than those who have never made an attempt.

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D. **Myth:** Suicidal people are intent on dying.

Fact: Most suicidal people have mixed feelings about killing themselves. They are ambivalent about living, not intent on dying, and most suicidal people want to be saved.

E. **Myth:** Asking about and probing the inmate about suicidal thoughts or actions will cause them to kill themselves.

Fact: You cannot make someone suicidal when you show your interest in their welfare by discussing the possibility of suicide.

F. **Myth:** All suicidal individuals are mentally ill.

Fact: Although the suicidal person is extremely unhappy, they are not necessarily mentally ill.

G. **Myth:** The rate of suicide is lower in a jail setting.

Fact: Jail suicides occur several times more often than in the general population.

H. **Myth:** Inmates who are suicidal can be easily distinguished from those who hurt themselves but are just being manipulative.

Fact: Manipulative goals as a motive for self-injury are not useful in distinguishing more lethal attempts from less lethal attempts.

I. **Myth:** You cannot stop someone who is intent on committing suicide.

Fact: Most suicides can be prevented.

5.3.3 List potential risk factors, signs, and symptoms of suicide.

A. Situational factors:

1. First-time arrestee or insignificant arrest
2. Young inmate i.e anyone under 18, regardless of whether in adult court
3. Prior suicide by close family member or loved one
4. Previously imprisoned/facing new, serious charges and long prison term
5. Prior jail suicide or recent attempt by another inmate
6. Harsh, condemning, rejecting attitudes of jailer or an authoritarian environment-regimentation
7. Loss of community stability, ex: loss of loved ones, loss of home, loss of employment etc.

B. Personal factors:

1. Current mental illness, poor health, or terminal illness
2. The shame of incarceration or over the offense
3. Consistent or long-term mental or physical pain and suffering

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4. Recent, excessive drinking and/or use of drugs, or withdrawals
 5. No apparent control over future, including fear and uncertainty over legal process
 6. Fear of sexual assault, or the threat of it
- C. Segregation increases risk of psychological difficulties, especially in the mentally ill and juveniles.
- D. Emotional warning signs:
1. Expresses feelings of hopelessness, helplessness, or being trapped
 2. Expresses thoughts of self-harm or death
 3. Expresses strong guilt and/or shame over offenses
 4. Signs and symptoms of depression
 5. Signs of intense emotional pain or psychological distress Ex: extreme sadness and crying
 6. Pessimistic attitudes about future
 7. Does not effectively deal with present, is preoccupied with the past
- E. Behavioral warning signs:
1. Previous suicide attempts and/or history of mental illness
 2. Withdrawal from social activities or silence, increased isolation
 3. Changes in appetite and/or weight
 4. Sudden changes in an inmate's mood, behavior, and/or regular sleeping patterns
 5. Loss of interest in people, appearance, or activities
 6. May act very calm once the decision is made to kill themselves
- F. Key times to observe signs and symptoms:
1. At arrest and booking
 2. During transportation
 3. First 24 hours of confinement
 4. Before sentencing/waiting for trial
 5. Impending release
 - a. Due to inmate being institutionalized and unable to function without the structure provided by a facility.
 - b. Fear of repercussions/retaliation stemming from criminal organizations and associates.
 6. When there is decreased staff supervision
 7. Holidays

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5.3.4 Identify the Screening Form for Suicide and Medical/Mental/ Developmental Impairments and the Continuity of Care Query (CCQ).

INSTRUCTOR NOTE: Provide the Students with a copy of the required TCJS Screening form found here: <https://www.tcjs.state.tx.us/mental-health/>

A. Basic Information

1. The Screening Form for Suicide and Medical and Mental Impairments was revised to achieve three main goals. To:
 - a. Create an objective suicide risk assessment with clear guidance for front-line personnel of when to notify superiors, mental health providers, and magistrates.
 - b. Assists sheriffs to meet all statute requirements such as Code of Criminal Procedure §16.22.
 - c. Be user friendly for the typical range of experience of a Texas county jailer.
2. Intake screening is the first step and is crucial to determine which inmates require more specialized mental health assessment. "Unless inmates are identified as potentially needing mental health treatment, they will not receive it."
3. The purpose of intake screening is for correctional staff to triage those who may be at significant risk for suicide; identify inmates who may be in distress from a mental health disorder/psychosis or complications from recent substance abuse; and assist with the continuity of care of special needs inmates.
4. Per Texas Commission on Jail Standards §273.5 Mental Disabilities/Suicide Prevention Plan, an intake screening form must be completed on all inmates immediately upon admission into the facility.
5. Additional screenings should be completed when staff has information that an inmate has developed a mental illness, or the inmate is suicidal at any point during an inmate's incarceration. Any additional screening forms must be maintained in the inmate's medical file.
6. For counties that will create an electronic copy or import the form into their software package, all questions from this form must be present along with required notifications.
7. For counties that will use a paper format, counties may insert blank space into the comments sections of the Word version of the form to create more writing space.
8. The form should be completed by a trained booking jailer or medical/ mental health personnel.
9. The form must be filled out completely and in its entirety.

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10. If the inmate is unable to or refuses to answer questions, notify supervisor and place the inmate on suicide watch until a form can be completed.
 - a. Note the reason why the form cannot be completed.
 - b. Complete a new form when the inmate is able to answer the questions.
- B. First Section: Basic Information and Medical Information
 1. The first section consists of basic identifier information and medical information.
 2. All applicable boxes should be checked. Provide additional information where required.
 3. The below two medical questions require that a supervisor or medical personnel be notified if jailers receive a “yes” answer:
 - a. Do you think you will have withdrawal symptoms from stopping use of medications or other substances (including alcohol or drugs) while you are in jail?
 - b. Have you ever had a traumatic brain injury, or loss of consciousness?
 4. Medical personnel or supervisors should assess and take appropriate action.
- C. Second Section: Self-Report Questions
 1. If the inmate is unable to answer questions, note the reason why, notify supervisor and place inmate on suicide watch until a form can be completed.
 2. Questions 1a-d are strong indicators of inmates at high risk of suicide. Any “yes” answer requires notification to supervisor, magistrate, and mental health immediately, and placement of inmate on suicide watch.
 3. However, if for any reason a jailer believes an inmate to be at risk of suicide regardless of the answer to 1a-d, the jailer should place the inmate on suicide watch and notify a supervisor.
 4. Inmates should only be removed from suicide watch after assessed by qualified mental health personnel.
 5. Questions 2-12 include questions about mental health symptoms and risk factors that warrant supervisor/magistrate notification. Self-report symptoms relate to possible psychosis, schizophrenia, bipolar disorder, depression, and PTSD. Question 11 also attempts to detect possible developmental disability.
 6. If a screener receives a “yes” answer, please ask follow-up questions to gain a better understanding of the symptoms.
- D. Third Section: Observation
 1. Make careful observations of the inmate’s demeanor and appearance.
 2. Look for cuts to the wrist, impressions around the neck, or any other evidence of self-harm.
 3. Notate when applicable.

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4. A comment box is provided for any additional information that the screener believes is relevant, including an exact or CCQ match. This completed form will likely be viewed by magistrates and mental health professionals so additional information will be beneficial.
- E. Fourth Section: Notification
 1. A “yes” answer to most questions on the form will require notification to a supervisor, magistrate, or mental/medical personnel.
 2. Space is provided for each notification. Jailers shall notate when they make required notifications.
 3. In addition, magistrate notification shall include method of notification of either electronic or written notification. A completed copy of this form should be sent to the magistrate.
- F. Code of Criminal Procedure Art. 16.22 Early Identification of Defendant Suspected of Having Mental Illness or Intellectual Disability

5.3.5 Identify methods for monitoring an inmate on suicide watch.

- A. Facility policies, procedures and post orders should clearly include suicide prevention guidance.
- B. Suicides most frequently occur in private spaces such as bathrooms, showers, mop closets, or cells.
- C. Important prevention measures include:
 1. Frequent rounds
 2. Not allowing inmates to cover windows
 3. Establishing professional and meaningful relationships
- D. Cells that are designated for inmates on suicide watch:
 1. Violent Cell – A single occupancy padded cell for the temporary holding of inmates harmful to themselves and or others. (Texas Commission on Jail Standards 253.1 (35) Definitions)
 2. Administrative Separation – The assignment of an inmate to a special housing unit, usually a separation or single cell, when staff determines that such close custody is needed for the safety of inmates or staff, for the security of the facility, or to promote order in the facility. (Texas Commission on Jail Standards 253.1 (1) Definitions)
 3. Single Cell – A cell designed to accommodate 1 inmate. The cell minimally contains 1 bunk, toilet, lavatory, table, and seat. (Texas Commission on Jail Standards 253.1 (31) Definitions)
- E. Place at-risk inmates in higher visibility cells.
- F. Monitor the clothing, bedding, property, and meals allowed for inmates on suicide watch.

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G. Supervision requirements of inmates on suicide watch are:

1. Observation shall be performed at least every 30 minutes in areas where inmates known to be assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior are confined. (Texas Commission on Jail Standards 275.1 Regular Observation by Jailers)
2. Supervision – Provisions for adequate supervision of inmates who are mentally disabled and/or potentially suicidal and procedures for documenting supervision. (Texas Commission on Jail Standards 273.5 (5) Mental Disabilities/Suicide Prevention Plan)
3. Refer to departmental policy regarding supervision and documentation of suicide watch.

H. Behaviors to observe and document during a suicide watch:

1. Is the inmate eating meals?
 2. Is the inmate sleeping normally?
 3. What is the inmate's behavior when awake?
 4. Is the inmate attentive to personal hygiene?
 5. Does the inmate communicate appropriately with jailers and other inmates?
- I. Refer to departmental policy for discontinuing suicide watch and/or regarding the contacting of a mental health provider during and after business hours.

5.3.6 Identify methods for responding to a potentially suicidal inmate.

A. If you believe inmate is in danger of suicide, implement suicide prevention protocols and keep the inmate in a safe place.

1. Maintain contact.
2. Address inmate by name.
3. Express concerns to the inmate, about the inmate.
4. Eye contact - Show concern, not disapproval or disgust.
5. Try to keep the inmate's sense of future positive.
 - a. Focus on programs available to inmate, i.e., school, vocational training, substance abuse, etc.
 - b. Support from family and friends that care.
 - c. Find something in their past to give them hope in the future.
6. Provide a feeling of control.
7. Help them discover a reason to live.

B. Barriers to effective communication:

1. Treating the inmate as non-person.
2. Provoking or escalating the situation.
3. Acting sarcastic, teasing, or making jokes about the situation.
4. Using reverse psychology, such as challenging inmate to follow through with threat.
5. Suggesting a more lethal method.
6. Ignoring, discounting, or making unpleasant remarks about inmate's feelings.

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7. Being afraid to ask direct questions about suicidal ideation.
8. Accepting the inmate's denial of suicidal ideation too quickly.
9. Offering solutions or giving advice.
10. Making promises that you cannot keep.
11. Making a diagnosis or diagnosing the inmate.
12. Becoming angry, judgmental, or threatening.
13. Ignoring the risk or threat.

5.3.7 Identify methods for responding to an inmate attempting suicide.

A. When approaching a responsive suicidal inmate, do:

1. Remain calm.
2. Call for assistance.
3. Develop a plan and follow it.
 - a. Rushing to rescue increases the risk to all those who are involved.
 - b. Inmate may attempt to have others harm them/take their life.
4. Be alert.
5. Scope out the situation.
6. Ask the inmate to remove the means if time permits.
 - a. This allows them to take action for their own safety.
 - b. Ironically, taking the means away from them as a show of force can trigger a suicide.

B. Inmate attempting to hang self

1. First jailer on scene will conduct visual assessment of inmate from outside cell to determine if inmate has article around neck and is attempting to hang self.
2. If possible, observe inmate's hands for possible weapons.
3. First jailer on scene shall stay at cell front to observe and request backup and a medical response.
4. Once a minimum of two (2) jailers have arrived at cell, if possible, staff shall enter the cell.
5. Cut victim down immediately. Avoid cutting the knot for investigative purposes, if possible.
 - a. One person should hold the body up.
 - b. The other person should cut the noose with a readily available tool.
6. Lay the inmate on the floor and remove the article around the neck;
7. Begin basic life-saving techniques, health care staff will assume the lead role in life-saving techniques assisted by jailer if necessary.
8. Refer to department policy for first aid methods.

C. Unresponsive Inmate

1. Conduct a visual assessment from outside cell to determine if inmate is either unconscious or experiencing a medical emergency.
2. First jailer on scene shall stay at cell front to observe and request backup and a medical response.

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3. First staff on scene will observe inmate's hands for any objects that may be weapons.
4. Once a minimum of two (2) jailers have arrived at cell, if possible, staff shall enter the cell.
5. Jailers will enter the cell with caution and be prepared to use force if necessary, but move quickly to secure the inmate.
6. Begin basic life-saving techniques as applicable, health care staff will assume the lead role in life-saving techniques assisted by jailers if necessary.