Instructor Materials

Behavioral Health Needs in Local Jails

A Cross Training Program

These materials were made possible through the collaboration among the Kentucky Chapter of the National Alliance of Mental Ill, The Kentucky Department of Mental Health and Mental Retardation Services, The Kentucky Department of Corrections and the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and other Drug Abuse Disorders, and Dual Diagnosis

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Course Objectives

By the end of the training participants should be able to:

- Gain knowledge about legal issues surrounding the persons with behavioral health problems
- Gain knowledge regarding improved techniques for managing persons with behavioral health problems
- Identify basic characteristics of persons with behavioral health problems
- Display an increase in empathy for persons with behavioral health problems
- Identify potential crisis situations for persons with behavioral health problems and be able to better intervene to alleviate crisis
- Identify the essential questions for a model screening tool and identify risk factors for suicide
- Gain knowledge of improved ways to intervene with inmates who may be suicidal identification tool
- Develop a understanding for the need for collaboration to meet the needs of inmates with behavioral health problems

Course Material

This manual is meant to be a guide in the development of your training. The essential components identified must be included in the training but please feel free to supplement the information provided. There are many good training materials available and you are encouraged to utilize them. A table of resources is located at the back of this manual.

Method of Instruction

Each MHMR board is encouraged to utilize a team-training format when delivering this training. There are four essential members of each training team. The member of the jail staff, a mental health professional, a consumer and a family member of a person with a behavioral health problem are each viable members of the training team. The training curriculum was developed with this team approach in mind and the material may be assigned accordingly. There are a number of discussion exercises and experiential components included in the curriculum and are very helpful in engaging participants in dialogues about the covered material. Each training may be tailored to meet the individualized needs of a particular jail, i.e. small vs. large, urban vs. rural.

Instructors and Preparation

Divide the work between the four instructors. The training must be at least four hours in length but can be longer if the jail would like additional hours of training. Make sure that all the team members have adequate time to review the materials before the team meets to plan the actual training. Expect to spend at least four to six hours working together to prepare for teaching the class.

Divide the topics up evenly, basing the assignment on relative familiarity with the subject matter. For example, the jail staff may take the lead on the section related to "Managing Persons with Behavioral Health Problems" and the other portions of the course that directly impact on the administration of the facility. All the instructors should be available during the entirety of the training. Most importantly, the instructors should ensure that they are "working off the same page" in terms of understanding the concepts taught in the course. The site you select for the training should have space available for small group work as well as accommodating the entire class.

Local Resources

In advance of the training, information should be prepared regarding local resources, how to access those resources and the appropriate contact persons. At a minimum this should include information about the MHMR boards 24 hour crisis line, how and where to access emergency psychiatric care, the phone number for the Kentucky Alliance for the Mentally Ill (and a local number, if a chapter is close by). In addition having a copies of KRS 202A and KRS 504 available as a reference will helpful. There is a copy of both these statutes included with your manual.

Conduct of the Class Day

At the beginning of the day, establish "ground rules" relating to the confidentiality and mutual respect of all participants. Have each participant sign in on a sign in sheet because your agency will be responsible for reporting the number of staff trained each year to the DMHMRS. Make it clear that this training is not intended to replace the operational rules of the jail or to criticize others but rather to provide information that will be helpful to jailers and their staff as they carry out their daily responsibilities.

Throughout the day, encourage discussion that takes into the needs of both the inmates and the institution. Encourage participants to tell their stories during the discussion and analyze the situation according to the materials in the course.

At the conclusion of the training, each participant should complete an evaluation form. The form to be utilized is included in the appendix of this manual.

Section 1

Jail Mental Health Services And Legal Issues

Jail Mental Health Services and Legal Issues

Scope of Problem

- 17% or more of all incarcerated persons have behavioral health issues

- Less than 10% of jails have full time mental health staff
- Correctional staff are charged with the duty to manage this population with little training and few resources
- The population suffering from these disorders experience the highest risk of in custody injury and death

The Need for Collaboration

Development of a Behavioral Health Care Community Approach

- Know the Behavioral Disorders
- Understand the Victims
- Involve their Families
- Develop a relationship with the Regional Mental Health Providers
- Involve Police, Courts, Corrections, Consumers and Mental Health Professionals

Jails must be able to

- Identify offenders with behavioral disorders
- House these offenders in a manner preventing harm to them and others
- Manage their behavior and episodes of crisis while preventing harm to them and others
- Seek professional behavioral health care services for those identified as in need
- Deliver supervision, medication and management protocols in cooperation with prescribed care

Legally Prescribed Duties

Duty to protect

- Public safety
- Institutional safety

Duties to Provide a Constitutional Level of Care

- Health care
  - Medical
  - Mental Health Care

Policy and Procedure Development

- Policy- What, who and when something should be done
- Procedure- How it is to be done

Adequate training to assure P&P compliance

- Line staff

- Supervisory staff
- Administrative staff
- Treatment staff
- Consumers, family and volunteers

Supervisions of the implementation

Monitoring of identification, housing, supervision and a delivery of services
Report generation to document adherence to process
Report generation to document success of desired outcomes

Liability

Failure to Protect

- Escapes from custody
- Community placements resulting in harm
- Inmate on inmate assaults
- Staff on inmate assaults
- Inmate on staff assaults

Failure to Provide

Incustody deaths

- Suicides
- Restraint
- Medications
- Overdoes

Liability baselines

Negligence

- Unforeseen mistake that results in a harm

Deliberate indifference

- Wanton disregard for a potential harm resulting in injury

Remedies

Injunctive relief

- Stop doing what is wrong and start corrective action

Compensatory damages

- Monetary compensation for harm

Punitive damages

- Monetary award to punish action and prevent further

Civil Rights Investigations/ DOJ

- Civil penalties
  Agreed orders
  Consent decrees
- Criminal Charges
  Fines
  Incarceration

Identification of Behavior Health Disorders/The Process of Assessment

Identification of risk

- Danger to Public and Institution

Identification of need

- Delivering a Constitutional level of care

Instruments of Assessment

Intake Triage Instrument

- Asking the arresting or transporting officer if there is any indication of behavioral disorders
  Subsequent holding, supervision and treatment protocol

Booking Screening Instrument

- Asking the arrestee if they have any history of behavioral disorders
  Subsequent housing, supervision and treatment protocol

Primary Classification Instrument

- Gathering of the previous record combined with a face to face interview and instrument completion
  Subsequent long term housing, supervision and treatment protocol

Reclassification Instrument

- Regularly scheduled reassessment of risk and need
  Possible modification of housing, supervision and treatment protocol

Data Dictionaries

- Each instrument must have a data dictionary describing each data element
- The source of the data must be identified

- A definition of the element is required

Needed Sources of Information and Data to Support Identification and Assessment

- Current charging document
- Criminal History
- Institutional Behavioral History
- Critical Alert System
- Treatment Records
- Self report
- Family information
- Community Mental Health Record
- Officer observation

Evaluative Process

Process Auditing- Are things happening as they were intended to happen

- Form completion
- Accuracy of data sources
- Timely administration of process
- Development of a housing plan for needed separations
- Resource sufficiency for timely delivery of services

Outcome evaluation

- Are negative outcomes being reduced or eliminated
- Are systems being modified as the result of outcome measurement

Decision Support System

Housing and transport of offenders with behavioral disorders

Intake holding

- Passive holding
- Secure holding

Long term housing

- General population
- Segregated single cell

Cross classification separations and considerations

- Predator/ prey separation
- Charged offense considerations

Transport

- Transport separations

Program participation

- Separate or mix

Supervision of offenders with behavioral disorders

- Direct
- Indirect
- Constant
- Intermittent

Treatment of offenders with behavioral disorders

- **Secondary levels of assessment after initial identification**
- **Development of behavior disorder protocols for custody staff**
- **Professional mental health staff assessment and care orders**
- **Monitoring of professional care**
- **Issues of medication**
    - Initial distribution
    - Prescription
    - Storage
    - Distribution
    - Accountability
    - Release from custody protocols

Aftercare and Community Mental Health Interface

- The need for collaboration
- Need for continuation of care
- See section entitled Collaboration/Team approach

Section 2

Understanding Mental Illness - A Review the Disorders

Understanding Mental Illness

Defining Mental Illness

Mental illnesses are brain diseases. They are biologically based. They are not to be confused with weakness of character. They are true illnesses that respond to medical treatment. In fact, modern treatments for persons with mental illnesses have extremely high rates of success. For example, the "cure rate" for depression is higher than that for heart disease.

Clinical Definition of Mental Illness

A clinically significant behavioral or psychological syndrome that occurs within an individual and that is associated with distress (e.g., painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom.
This definition keys in on the following concepts:

- **Significant. Serious problems**. Not just the normal problems in living.

- **Syndrome.** The illness typically results in certain symptoms or behaviors that occur together.

- **Distress.** The illness causes discomfort or pain. This can be emotional pain.

- **Disability.** Unable to complete the tasks of everyday life. Examples: going to work; going to school; caring for one's children; having meaningful relationships (besides school, work, child care).

- **Significant impairment**. Unable to complete daily functions, may even include inability to take care of personal hygiene.

Facts about Mental Illness

- Mental illness has nothing to do with intelligence. It can happen to a genius or someone mentally retarded. If a person with mental illness seems "slow" this is usually related to the medication or to paying attention to one's "voices."
- Mental illness can happen to anyone. It is not a punishment for being bad or lazy.

- Symptoms of mental illness come and go. A person can get better with or without medication but often the person is subject to relapse. The rate of relapse varies by disorder and by the circumstances of the particular case.
- Mental illness can be treated but can not be cured. Mental illness is like diabetes. Medication does not cure mental illness. The medication controls symptoms rather than cures the illness. The medication needs to be taken consistently.
- Mental illness is long term. Typically, it begins early and can last a lifetime. Schizophrenia typically emerges in late teens or early twenties. Other illnesses can start in childhood or later in life.
- Mental illness is not contagious but is often very stressful to those who care for the person with the illness. Persons with mental illness may be difficult to interact with and often break the ordinary social connections that others would have available in times of difficulty. There may be a long history of difficulty with family; the public at large may shun the ill person. The medical system may become indifferent to the needs of those who need treatment for their illness.
- Mental illness is often difficult to diagnose and treat correctly. The misdiagnosis (and "missed" diagnosis) of serious brain disorders has caused endless suffering.
- A person with mental illness should never be confused with the terms "psychopath" or "sociopath", which are used to describe someone who has criminal tendencies. They are unrelated!

Symptoms of Mental Illness

- **Psychosis**: Out of touch with reality. Persons with mental illness experience the world differently, so their behavior may not make sense to others. This experience of the world may include hallucinations or delusions.
- **Hallucination**: Hearing, seeing, feeling, tasting or smelling something that is not there. The experience is very real to the person with mental illness. Auditory hallucinations, hearing things, are the most common in individuals having schizophrenia. Visual hallucinations, seeing things, are most common with substance ingestion or withdrawal, less likely with mental illness.
- **Delusion:** Fixed belief that is not real. There are many types of delusions. People may believe someone or some agency is out to get them; they may believe themselves to be a religious, heroic or historical figure; they may believe there is something unusual about their body such as snakes in the stomach or a machine in the brain.
- **Depression:** Deep feeling of sadness; typically, people with depression believe that they are bad, the world is bad and the future will be bad.
- **Paranoia:** An unrealistic fear. Fear can be "normal" as long as the fear has a basis in reality. However, when paranoid people are confronted with reality, they will typically misinterpret or re-interpret the reality to match their delusions.

General Signs Of Mental Illness

- Signs of mental illness are observable, not just reported by the person.
- The person may be in a state of panic; extremely frightened.
- Extreme confusion. Internal experience may be overwhelming.
- Disoriented. May not know own identity, recognize location or setting, or know what day it is.
- Hearing voices.
- Talking to oneself.
- Poverty of speech. Uses as few words as possible.
- Seeing things.
- Pressured speech. Talks very quickly, rarely takes a break.
- Feels everyone is plotting against him/herself.
- Feels everyone is watching or talking about him/herself.
- Hypervigilance. Darting looks.
- Memory problems.
- Displays no emotion (flat affect). No expression regardless of the activity or topic of conversation.
- Smells strange odors.
- Reports body ailments or conditions that are not possible.
- Sudden changes in behavior.
- Impulsivity. May simply act or react without thinking, or do things they may otherwise be able to resist.

- Note: Stress generally worsens impulsivity. Lowering stress often reduces impulsivity and other troublesome behaviors.

Psychosis

Psychosis is a state of profoundly altered thinking and behavior, described by many as "a living nightmare." Psychosis can be caused by both physical and mental health problems, and if the origin is unknown, will require a medical evaluation. Psychosis is not exclusive to schizophrenia. People in acute stages of mania or depression may also become psychotic. People with any of these illnesses may have difficulty thinking, formulating ideas, reasoning, remembering, and concentrating. People experiencing psychosis may withdraw into a delusional realm, which is frightening to them and to their loved one who are grounded in reality.

It is important to remember that psychosis may included symptoms that interfere with the person's ability to process simple directions or understand simple conversation. A

person who is experiencing a psychotic episode may hear voices, see things and think things that are not real. These hall marks of a psychosis will alter a person's ability to relate to others and to interact in a normal manner. 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 the confusion and distress. Simple directions, reassurance that they are in a safe place, and compassion will always work better than coercion.

Schizophrenia

Schizophrenia is a brain disease whose acute stage always involves a psychotic episode. The name "schizophrenia" means "to split the mind" - a term which vividly captures the idea of a rupture between reality and the person's psychotic thinking. Schizophrenia does not, however, mean "split personality" or "psychopathic behavior."Schizophrenia is far more common than multiple sclerosis or muscular dystrophy, affecting about 1 out of every 100 people. The onset of Schizophrenia is typically early adulthood.

Symptoms:

- People with schizophrenia have both positive and negative symptoms
- Positive symptoms include hallucinations (auditory, visual, olfactory, gustatory, tactile) and delusional thinking (false beliefs).
- Negative symptoms include apathy and withdrawal.

Symptoms In Jail:

- A person with schizophrenia may appear non compliant because they can not filter out the voices and hallucinations.
- They can be agitated by the voices and delusions and therefore look and act dangerous. They are actually responding to the internal stimuli and may not know what is going on around them at all.
- Someone who has command hallucinations to hurt a specific person may actually be dangerous, and risk precautions should be taken.
- Person with these symptoms are more unlikely to respond to clear, directions and reassurance in a kind tone of voice
- Hygiene may be poor and require extra assistance. This is because they are not aware of their surroundings enough to know that they are not clean.

Mood Disorders

- Mood disorders are serious medical illnesses with a high risk of mortality. All mood disorders have some aspect of depression – typically sad mood. The incidence of a mood disorder is extremely high among people who commit suicide, comprising 61%.

Depression is the most common mental illness. More women than men suffer from this disorder.

Major Depression

Symptoms:

- Its major feature is a sad mood that does not respond to personal appeal, or "talking to" to lift them out of their despondence and hopelessness.
- Depression can be displayed as extreme irritability
- Depression includes a markedly diminished interest or pleasure in daily activities that the person usually finds rewarding.
- Changes in daily functioning include increases or decreases in appetite, sleep, and arousal. The most universal of these is overwhelming fatigue — a total lack of energy that robs people of the vitality they depend on to be active and productive.
- Thought disorders include:
  A. inability to think, remember, concentrate;
  B. indecisiveness; difficulty making decisions
  C. feelings of guilt and worthlessness; and
  D. suicidal ideations
- Symptoms of depression require attention because they are physically debilitating and can involve a high risk of suicide.
- Because the "body" signs of depression can mimic other illnesses of the thyroid and adrenal glands (and illnesses like multiple sclerosis and heart disease are known to cause depression), these physical disorders need to be ruled out. Depression is also associated with changes in a person's hormonal balance. Serious depression requires a medical evaluation as part of diagnostic work-up.

Symptoms In Jail:

- Loss of interest in food and basic self care differentiates major depression from a situational sadness
- Many no longer care about the outcome of their legal situation
- Suicide risk is real and must be monitored if ideations are expressed.
- An increase in energy after medication is administered can increase the risk of suicide rather than decrease it, because the person has the ability to plan and execute a suicide.

Mood Disorder - Mania/Bipolar Disorder

Mania Symptoms

- When someone is having a manic episode, the primary mood is abnormally euphoric (elevated, high and happy) or touchy (irritable, critical and stubborn).

- There are typically three stages to a manic attack.
- The person starts out feeling absolutely fabulous, with no insight into the vivid elevation of mood that other people observe "from the outside." This stage is called hypomania. It involves the same symptoms as full-fledged mania but the symptoms are not severe enough to cause total impairment, nor is the person psychotic. People in this state can entertaining to those not close to them, and usually don't need to be hospitalized. They are characteristically elevated in mood, and show uncritical self-confidence and goal setting. But these moods will suddenly shift to irritability and rudeness.
- As the episode persists, mania enters the acute stage. Behavior becomes more disorganized and the mood darkens to one of hostility, aggressiveness, hyper-criticalness and abusiveness. Every feature of behavior is excessive, or overwrought, and ultimately goes out of control. In this stage, people feel enormous distress.
- The onset of acute mania can be swift. The disturbance in mood is sufficiently severe to cause marked deterioration in job functioning, social behavior, or relationship with others. Hospitalization may be necessary to prevent harm to self or others.
- In the third stage of mania, the person becomes psychotic.

Bipolar Disorder (Manic-Depressive Illness)

Persons with bipolar disorder have what are termed "mood swings." They suffer from periods of depression, and then swing into periods of elevated mood. There may or may not be periods of normal mood as the cycle progresses.

There are several subtypes of bipolar disorder.

- Bipolar I disorder is "classic" manic-depressive illness. The person suffers from severe depression and acute or third stage mania. Cycles are extended in duration.
- Bipolar II disorder involves persons whose mood swings from depression into hypomania, but never reaches acute stage mania. The person is more often depressed than hypomanic and, without treatment, may not even realize that the hypomanic portion of the cycle exists.
- Rapid cycling refers to the situation when mood swings occur very quickly.
- A "mixed state" occurs when the person experiences symptoms of depression and mania simultaneously.

Bipolar disorder is considered a separate illness from major depression. Very high proportions of those with the illness are helped by medication. However, persons who are untreated or whose medication is interrupted are very prone to relapse and over time their symptoms are likely to become more severe.

Symptoms:

- Persistently elevated expansive or irritable mood
- Inflated self esteem or grandiose thinking

- Decreased need for sleep
- More talkative or pressure to keep talking
- Flight of ideas or racing thoughts
- Easily distracted
- Increase in goal directed activity or motor agitation
- Excessive involvement in pleasurable activity
- Depressive episode has many of the same symptoms as major depression

Symptoms in Jail:

- Jail is often the consequence of manic, self destructive behavior.
- When manic, a person can be entertaining but their mood and behavior can rapidly turn ugly
- Can be restless, pacing, demanding and destructive
- Talkativeness can be irritating or entertaining to others
- When depressed, they often cry, feel hopeless, become suicidal and no longer have energy
- Are often non compliant and this is seen in refusal to take medication. Can seem uncooperative and belligerent
- Can be professional, well educated people

Anxiety Disorders

Panic Disorder and Obsessive-Compulsive Disorder are now classified as anxiety disorders. All of us have probably felt "anxiety" at one time or another; but panic disorder and OCD involve a level of fear, dread and physiological response that changes a person's daily behavior and hence their ability to function. In these disorders, internal body sensations of fear are interpreted as life threatening resulting in elaborate, debilitating patterns of avoidance to handle them.

Panic Disorder

Panic disorder affects one to two percent of Americans, with onset usually before age 24. Women are twice as likely to be affected as men, but only twenty-five percent seek any kind of psychiatric help. For many people, the symptoms of panic are easily confused with real physical problems such as heart attack, and the fear that they are possibly "going crazy". Panic attacks occur without any warning during activities that are routine and non-threatening. A person will experience intense fear, followed by heart palpitations, chest pain, shortness of breath, and dizziness. The worry that this is a sign of serious health problems, insanity or complete loss of control, perpetuates the problem. This disorder is successfully treated with structured cognitive behavioral treatment and medication. A

referral to a Mental Health Professional who is familiar with CBT treatment can help a person be fully functioning in relatively short time.

Symptoms:

- For panic disorder to be diagnosed, a person must experience recurrent, unexpected panic attacks, followed by
- Concern that the attacks will "strike again," or
- Worry that these attacks imply life-threatening illness or losing one's mind, or
- Avoidance of situations related to the attacks.
- Avoidance is a true diagnostic "identifier" for panic disorder. The urge to flee, to "get out," overwhelms the person when the panic attack hits. For many, the dread of recurrence becomes so great that they become phobic - too terrified to leave their home, use an elevator, attend social events or go anywhere in public. This condition, called agoraphobia, occurs in one-third to one-half of the victims of panic disorder.
- For others, every subsequent mild physical symptom brings fears of life-threatening illness. They develop chronic anxiety and may make excessive visits to the doctor. Eventually these preoccupations can lead to severe restriction of life activities, and to depression. Many patients become discouraged, ashamed and unhappy about the difficulty of carrying out their normal routines. These individuals often mistakenly attribute this problem to lack of "strength" or "character."
- Attacks typically peak within ten minutes, and then dissipate within half an hour.

Symptoms In Jail

- This disorder is rarely seen in the general jail population, possibly because jail is not a common trigger for panic.
- A referral to a MHP is always indicated

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) typically involves both obsessions and compulsions.

Obsessions are recurrent thoughts, images and impulses that invade the mind, causing intolerable anxiety. These preoccupations make no sense, or are repulsive, or revolve around themes of violence and harm.

Symtoms:

- The most common obsessions are

1. fear of contamination;
2. excessive concern about objects "having to be" in a certain order;
3. thinking you have injured someone, or left something on (or unlocked);
4. horrible impulses to hurt a loved one;

5. gross sexual imagery;
6. inability to throw anything away.

Compulsions are devised to relieve the unbearable anxiety and doubt of the obsession. The person will be driven to perform specific repetitive, ritualized behaviors calculated to temporarily reduce their discomfort. These behaviors take on a life of their own, literally imprisoning the individual in a pattern of peculiar activities:

Symptoms:

1. hand washing, showering or compulsive house cleaning;
2. excessive ordering and arranging; incessant checking and re-checking;
3. repetitive counting, touching and activity rituals;
4. excessive slowness in daily activities like eating and brushing teeth;
5. constant demands for reassurance that the perceived threat has been removed.

- People with OCD are not delusional, nor are they having hallucinations. But they cannot control their compulsive responses to the impulses driving their anxiety.
- many individuals will try to hide and cover up behaviors they believe are totally "off the wall." However, a significant number of individuals with OCD lack this insight, particularly during the throes of an episode, or if they suffer from the severe form of the illness.
- The ritual compulsions of OCD vary from mild (known only to the sufferer), to constant and extreme (occupying hours a day and involving family members in ritual activities). A diagnosis of OCD is made when obsessions and compulsions become so marked that they interfere with social and occupational activities, or cause intense subjective distress.

Symptoms In Jail:

- OCD is rarely seen in the jail.
- Typically if someone is in jail with this problem, they are usually in treatment and medication is monitored and maintained. They do not pose behavioral problems. If treatment has not been started, a referral is indicated.

Post-Traumatic Stress Disorder

Some people who are exposed to extraordinary stressors that are potentially life threatening or that evoke intense fear and helplessness develop a syndrome called post-traumatic stress disorder (PTSD). Stressors can include rape, assault, natural disaster, vehicle crashes or witnessing these events. The person re-experiences the event in painful memories, dreams or nightmares. There is "psychic numbing" or "emotional anesthesia," which means they feel detached from other people, from the outside world, and from activities that used to be enjoyable. The PTSD sufferer may have difficulties maintaining normal relationships or daily activities, especially if they evoke reminders of the experience

Symptoms:

- Exposure or experience with extremely stressful event that was potentially life threatening or evokes intake fear or helplessness.
- Painful memories, flashbacks,
- Further problems include anxiety, irritability, and depression, trouble falling asleep or staying asleep. keyed up; startle response is heightened.
- Often there is guilt about surviving when others did not, and guilt about the behavior that made survival possible. The guilt may be constant and painful.
- Symptoms often worsen after encountering situations that resemble those of the original trauma.
- People with PTSD often resort to drugs or alcohol to escape from the condition. Others may become self-defeating or suicidal.

Symptoms in Jail

- PTSD symptoms occur when a person does not feel safe. The jail environment may represent a safe environment or expose the individual to people and situations that represent extreme triggers for PTSD symptoms.
- For victims of assault or abuse, the loss of control and lack of privacy can be a trigger.
- Jail personnel or inmates may trigger flashbacks. Separation from those individuals may be indicated.

Personality Disorders

An individual with a personality disorder displays personality traits that are inflexible, maladaptive and cause significant impairment in social or occupational functioning, or cause the person substantial distress. These are long standing behavior or personality patterns, They are usually recognizable by adolescence and continue through adult life. Personality disorders have characterological origins, i.e. they tend to run in families, or are a product of childhood abuse, or neglect. They can coexist with other types of mental illness (e.g. schizophrenia and antisocial personality disorder).. Personality disorders are not “mental illnesses” per se. They are maladaptive personality patterns that may present difficult problems, either on their own or in conjunction with other issues.

Because a hallmark of their problems is impulse control difficulties, relationship conflicts and poor judgement, a large percent of all jail populations includes people with personality disorders. This means special care needs to be paid to having consistent policy and procedures with professionally trained custodial staff to implement them

Symptoms:

The types of personality disorders most likely to be seen in jail/prison include:

- Antisocial - “Con man”; feels no guilt; uses others; cannot delay gratification and so is easily frustrated. Can also be charming and easy to manage when management if fair. More males than females
- Borderline - Volatile; inconsistent in relationships; very emotional; often suicidal with history of attempts. Risk of self harm is real. Can also be charming and responsive to fair and consistent structure. More females than males

Other personality types that are not as frequently seen in jail include:
- Avoidant - Tries to avoid social interaction.
- Paranoid - Suspicious; questions other’s motives.
- Dependent - Needs the approval and care of others.
- Schizotypal - Eccentric to the extreme. Can be confused with schizophrenia
- Schizoid - Detached from social relationships. “Loner.” Does not express emotions.

Symptoms in Jail
- Symptoms are heightened in jail, becoming noticeable because of the tendency to act out problem behavior.
- Effective management behavior management requires consistent limit-setting. Extreme reactions to situations and the ability to make people respond to distress may “split” one or more staff against other staff . Consistent regulations and their enforcement is essential.
- The mood and reactions to the jail environment can range from charming to extremely difficult to manage, changing quickly from one presentation to another based on reactions to jail treatment. Consistent custodial care is therefore crucial
- .A person with a personality disorder, who is suicidal poses real and serious risk, because of their difficulty controlling their impulses. Despite the possible appearance of manipulative behavior or intentions, suicidal ideation must be taken seriously and treated with risk management techniques.
- Jail personnel must professionally manage housing unit, inmates and themselves.

Substance Abuse

People with substance abuse problems comprise 85% of the jail population., often precipitating incarceration. Offenses from DUI, possession and trafficking all speak to the different levels of involvement with drugs from use, abuse to dependence. Because of the high number of people who have co-existing disorders with substance abuse and mental illness, there are many people who think that dual diagnosis substance abuse offenders need treatment more than they need criminal consequences. Is substance abuse a mental illness, do the mentally ill use substances?- Yes and Yes. They need the same treatment.

Symptoms

Substance Use -The use of substances of some minor effect. The use would not be excessive and there would not be negative consequences to the use. Use could be planned or not planned, however it would be inconsequential to the environmental situation and if it did not occur, it would not matter.

Substance Abuse-The use of a substance for a major effect. The use is often excessive and results in negative physical, emotional, or social consequences for the individual, The use may be planned o unplanned and the individual still has the ability to stop use.

Substance Dependence-The use of substances for a specific effect. The use is usually excessive, and often results in major negative physical, emotional or social consequences for the individual. Use is planned and the ability to stop is greatly diminished. The individual often experiences some withdrawal if the substance is not consumed regularly

Symptoms In Jail

- Most jails offer drug and alcohol treatment services such as AA and NA or referrals to outside treatment programs.
- Risk related to overdose or withdrawal must be assessed and monitored in jail.
- Abuse of prescription drugs such as Lortabs and Oxycontin or Benzodiazapines such as Xanax, Valium, Ativan and Clonopin must be monitored for potential physical withdrawal.
- Failure to medically monitor for potential physical withdrawal can result in seizures, heart problems and death.
- Drugs can mimic other mental illness. For example withdrawal from a combination of drugs such as Benzos, cocaine, and alcohol may occur 10-14 days after the last use. Symptoms look like a psychotic episode.
- Withdrawal from hallucinogens will mirror a psychotic episode. An individual may be unable to answer questions or engage in any appropriate verbal exchange. Behavior can be bizarre. Symptoms may last 2-3 weeks, improvement is typically both rapid and obvious.
- Alcohol withdrawal typically includes visual hallucinations and notable confusion regarding their whereabouts. In Lexington, they may believe they are waiting for a bus.
- Because of the high potential of abuse of prescription psychotropic drugs, jails must closely monitor their storage and administration. Crushing them or limiting what is allowed in jail are two options to decrease abuse of prescription drugs in jail.
- Long term substance abusers, particularly those who are alcohol dependent or paint huffers have dementia. This is irreversible. These individuals need to be treated like a person with Alzheimer's or developmental disability.

Dementia and Other Cognitive Disorders

These conditions can be related to substance abuse: alcoholism, glue sniffing, or to medical conditions such as dementia or stroke, or to injury such as head trauma: frontal lobe damage from severe concussion.

Symptoms

- Memory problems. These can relate to recent memory or memory of the past.
- 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.
- Impaired thinking. The person may be unable to complete simple tasks like dialing a phone or reading simple signs.
- 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.

Symptoms in Jail

- Treat the individual as you would with any disability. Their inability to remember or follow directions is not intentional.

Mental Retardation

Mental illness is not mental retardation but a person can have both problems i.e., be "dually diagnosed." As discussed earlier, mental illness is not linked to intelligence. Mental retardation is low intelligence and poor adaptive functioning from birth.

The term "developmentally disabled" applies to a wide variety of impairments, many of which have little to do with intelligence. A person with developmental disabilities may also have co-occurring mental illness.

Co-occurring Disorders (SAMI)

You will often encounter individuals suffering from mood disorders, anxiety disorders, PTSD and schizophrenia having a "dual" diagnosis of substance abuse and mental illness (SAMI).

In an attempt to sustain the manic high, pull out of depression, calm down anxiety or quiet voices, many people will self-medicate with their own drugs of choice. Doing so may relieve pain temporarily but sends the person into a spiral of depression and dependency, which frustrates efforts to get them into treatment.

It was once thought necessary to determine in each individual case whether it was the substance abuse or the mental illness that was "primary" in dual diagnosis cases. It has now been determined that both the mental illness and the substance abuse are "primary," "co-occurring" disorders. Treatment must be directed at both the substance abuse and the mental illness simultaneously.

- Rates of dual diagnosis are very high.
- Greater than 60% of people with a mood disorder have a substance disorder;
- 50% of people with schizophrenia have a substance disorder;
- 37% of people with alcohol addiction have diagnosable psychiatric disorders;
- Greater than 50% of people with drug addiction have diagnosable psychiatric disorders.

It is difficult to treat people who face SAMI issues. Often, the substance abuse or mental illness problem is not recognized so it goes untreated. Often the SAMI patient does not participate in treatment. Medications often do not work as well for SAMI patients. Violence is also an important SAMI issue. SAMI patients are more violent than those persons who have mentally illness without substance abuse issues. SAMI patients have increased paranoia, anxiety, impulsiveness and craving.

Substance abuse and mental illness share many common factors.

Substance Abuse	**Mental Illness**
Brain disease	Brain disease
Patient fails to see the problem	Patient fails to see the problem
Chronic	Chronic
Involves family	Involves family
Patient feels shame and guilt	Patient feels shame and guilt
Need treatment	Need treatment

Schizophrenia Simulation

SCRIPT

- We are now going to try a skill workshop on the subject of communication. We will be doing an experiential exercise based on certain key principles. If you understand these principles, then these approaches to communicating with persons with mental illness will make more sense.
- We are not teaching communication skills because we think you are "doing it wrong". What we do believe is this: When you encounter someone with a brain disorder, their capacities for communication are sometimes drastically altered.
- Every illness we have studied in this course involves problems in attention, memory and information processing. People with brain disorders experience a high degree of perceptual overload. In depression, one is hypersensitive to the slightest degree of noise and confusion; mania brings a rush of fragmented thoughts; in panic disorder and OCD, people are distracted by a flood of internal fears which make it impossible to attend to anything else.
- Nowhere is this problem more apparent than in brain disorders where people become psychotic.
- Having a thought disorder interferes with the capacity to understand communication. Having schizophrenia means you are overwhelmed with information by thoughts and feelings from within, and by bombardment of sounds from outside. People with this disorder appear to have a faulty "shut-off" mechanism and cannot filter out noise; they also have difficulties with working (or "short term") memory. The upshot of these processing deficits are:

1. Inability to concentrate, or screen-out incoming stimuli.
2. Inability to "track" complex communications.

- As a result, people with schizophrenia have difficulty limiting their thoughts and they cannot focus easily on any one thing. They often appear distracted and remote. There is an onslaught of competing memories, sensations and thoughts.
- Listen to these first-person accounts:

"Everything seems to grip my attention although I am not particularly interested in anything. I am speaking to you just now, but I can hear noises going on next door and in the corridor. I find it difficult to shut these out, and it makes it more difficult for me to concentrate on what I am saying to you.

- "Sometimes when people speak to me my head is overloaded. It's too much to hold at once. It goes out as quick as it goes in. It makes you forget what you must have heard, because you can't get hearing it long enough."

”RUNNING THE EXERCISE

Tell the group you are going to ask them to enact the situation of a person with a thought disorder: Some will play the role of the “patient” in the hospital; others will simulate the patient’s “mental environment.” Have them count 1-2, 1-2 around the group. All #1’s will be the patient; all #2’s will enact the mental environment.

(If someone does not wish to participate, ask him/her to be an “observer” and sit next to the leader during the main exercise.)

CO-LEADER STAYS WITH Group 1. Get them to sit next to one another in a line. Exp1ain they will be asked a simple drawing exercise. Hand out 3 x 5 cards and pens.

(CO-LEADER PARTICIPATES WITH GROUP I IN THE EXERCISE AND STAYS WITH THEM THROUGH THE DEBRIEFING).

LEADER calls a short “private” meeting with Group 2 (out in the hall). Explain to Group 2 that you want them to stand behind the patient’s chairs and be a “chorus” of (a) the “voices” in his head; (b) incidental voices and noises in the patient’s “environment.”. Pair them up, and give them each a “voices” or “environment” CUE Card. (Make sure to ask if the cue card is OK for each pair to read). Tell them to wait for their CUE: You will first give some instructions. When you say, “All right, let’s begin”, Group 2 should start speaking, in chorus, repeating the message on the cue cards until you say “Stop!” Tell them to speak moderately softly so you can be heard.

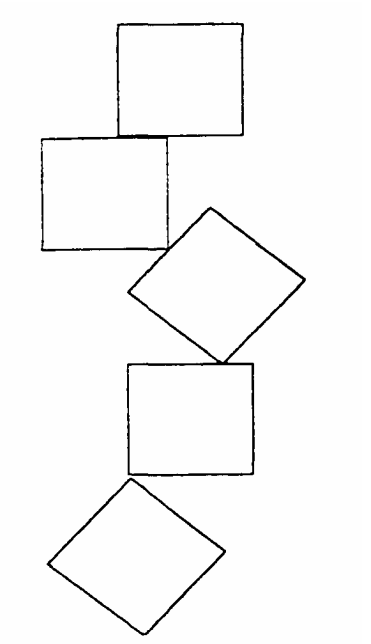
Leader asks Group 2 “pairs” to line up behind Group 1 “patients”.

(LEADER SITS FACING THE 2 GROUPS.)

Leader tells the “patients”: This is not a test; no one will be checking their performance. But there are rules, as follows: “Please do not ask questions, look at your neighbor’s paper, interrupt me, or make any comments until we are finished with this exercise.”

Giving the “cue line”, Leader says, “All right, let’s begin”.

•



LEADER READS: (Without expression in a strong voice)
Draw a square.
Draw a second square, placing its right side at the midpoint on the bottom of the first square.
Draw a third square at an angle at its middle, placing the top of it midpoint, on the right bottom point of the second square.
Draw a fourth square, placing its top midpoint on the lowest point of the third square. (LEADER: CALL STOP)
Draw a fifth square, placing its top point on the bottom left hand point of the fourth square.

"DEBRIEFING" THE EXERCISE

- Ask for people's reactions to the exercise, starting with the group sitting down who played "the patient".
- Ask each one what they felt:

1. **Uncertainty?**
2. **Confusion?**
3. **Anxiety?**
4. **Did they tune out, give up, and not try at all?**
5. **Did they feel disoriented?**
6. **Frustrated?**

- Point out that their reactions are just like those of people with mental illness.
- Ask the group in the back row about their experience. Could they hear the "wall of sound" they were making?
- Did everyone get a sense of how difficult the "life of the mind" must be for people under duress, particularly when someone is approaching them with complex information?

LEADER NOTE: ASK CLASS TO MOVE CHAIRS BACK TO THEIR PLACES.
GET EVERYONE SETTLED BACK DOWN.
We are trying to learn about people with mental illness by understanding their world. If we have empathy for what they are experiencing we will more readily accept some of the difficulties they have. We will no longer expect them to respond "as if" none of this was happening.
If we can understand the "shattered screen" our relative is coping with, we will see the reason for the following basic communication guidelines.
LEADER NOTE: DIRECT CLASS TO CLASS HANDOUT #1. PROCESS NOTE: ASK CLASS TO READ THE GUIDELINES ALOUD, IN TURN.

Schizophrenia Exercise Materials List

3 x 5 cards and pens for “patients”

Cue cards for those playing “voices”* and the “mental environment”**

*CUE CARDS FOR “VOICES” (3 SEPARATE CARDS)

1. “Don’t trust the person doing this exercise. She is trying to trick you so they can lock you up... They are all trying to make it look like you are crazy!” (REPEAT UNTIL EXERCISE STOPS)
2. “You’ve got to get away. If you stay here in this room they will hurt you! Hurry! You can get out now while they’re not looking!” (REPEAT UNTIL EXERCISE STOPS)
3. “This person is evil. The devil has sent this person to get you to do bad things: Don’t do what they are asking you. You will go to eternal damnation!” (REPEAT UNTIL EXERCISE STOPS)

**CUE CARDS FOR “MENTAL ENVIRONMENT” (3 SEPARATE CARDS)

1. “I looked in on the patient today and he still seems psychotic. He’s not responding fully to the medication. Let’s take the dose up to the next level.” (REPEAT UNTIL EXERCISE IS OVER)
2. “This is your weather station with morning weather on the hour. The barometer is rising and today will be milder with a high of 55; cloudy tomorrow”. (REPEAT UNTIL EXERCISE IS OVER)
3. “Hello, dear! I wanted to call to see how you are doing. How’s the Zyprexa working? We sure hope it will help. Do you need any clean clothes? We’re coming over Sunday”. (REPEAT UNTIL EXERCISE IS OVER)

Section 3

Effective Communication

Keys to Communication

You will need to build trust and rapport to obtain information quickly and accurately. Use these three helping skills:

- **Empathy** is the ability to accurately describe the emotional state of another. Don't confuse this with sympathy, in which you become "weighed down" by your own feelings as well as those of the person in crisis.
- **Warmth** comes from your understanding and commitment to staying with the person until the present crisis is resolved.
- **Genuineness** is simply being aware of your own feelings and displaying behaviors that correspond to those feelings. This is what produces a "realness" about you.

You must also be able to be both objective and subjective in your communications. You need objectivity to make accurate evaluations, and subjectivity to understand the pain the person in crisis is going through.

One useful technique that combines both objective and subjective elements is reflective listening. To use reflective listening, take the messages, feelings and ideas sent out by the person in crisis and return them in a slightly modified form. This lets the person know you understand the feelings involved.

Use the "Vocabulary of Feelings" chart to help yourself build up a collection of "feeling" words to use in reflective listening

Promoting Communication

Listening

Listening is one of the most important skills used during crisis intervention. Listening effectively establishes trust and allows you to understand information more thoroughly.

To be an effective listener in a crisis situation, remember to:

- attend to verbal content and to nonverbal cues,
- hear and observe,
- avoid distractions,

note extra emphasis the person in crisis places on words or phrases, and
notice speech patterns and recurring themes.

Listening is a skill that requires practice and is not always easy to learn.

Clarification

Sometimes a person in crisis will make a statement that you do not fully understand, or the person's words and behavior may not seem to agree. 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:

- Restate. Rephrase the person's statement in a way that encourages the person to clarify.
- Repeat. Repeat key words. This focuses attention on particular thoughts and feelings.
- Clarify. Admit confusion or misunderstanding of a statement and ask for clarification.
- Question. Ask "open ended" questions to obtain better understanding.

Dealing with Silence

You may find yourself faced with silence during crisis intervention. Instead of letting the silence become discomforting, use it as a time to observe the person's behavior.

Respond Effectively

Knowing how to respond to another person's feelings is a very difficult matter. You should handle the feelings of the person in crisis with care and concern. You should always treat the person's feelings as legitimate. It is essential that during an intervention you do not judge, give advice or belittle the person.

Maintain Personal Space

Use your best skills to determine the amount of body space to keep between yourself and the individual experiencing the crisis. This is a crucial element for effective communication, and is different for every individual in crisis. Carefully observe the person's reaction to close proximity, watching to see if the person appears to become more uncomfortable as the amount of space between you decreases.

Open-ended Questions

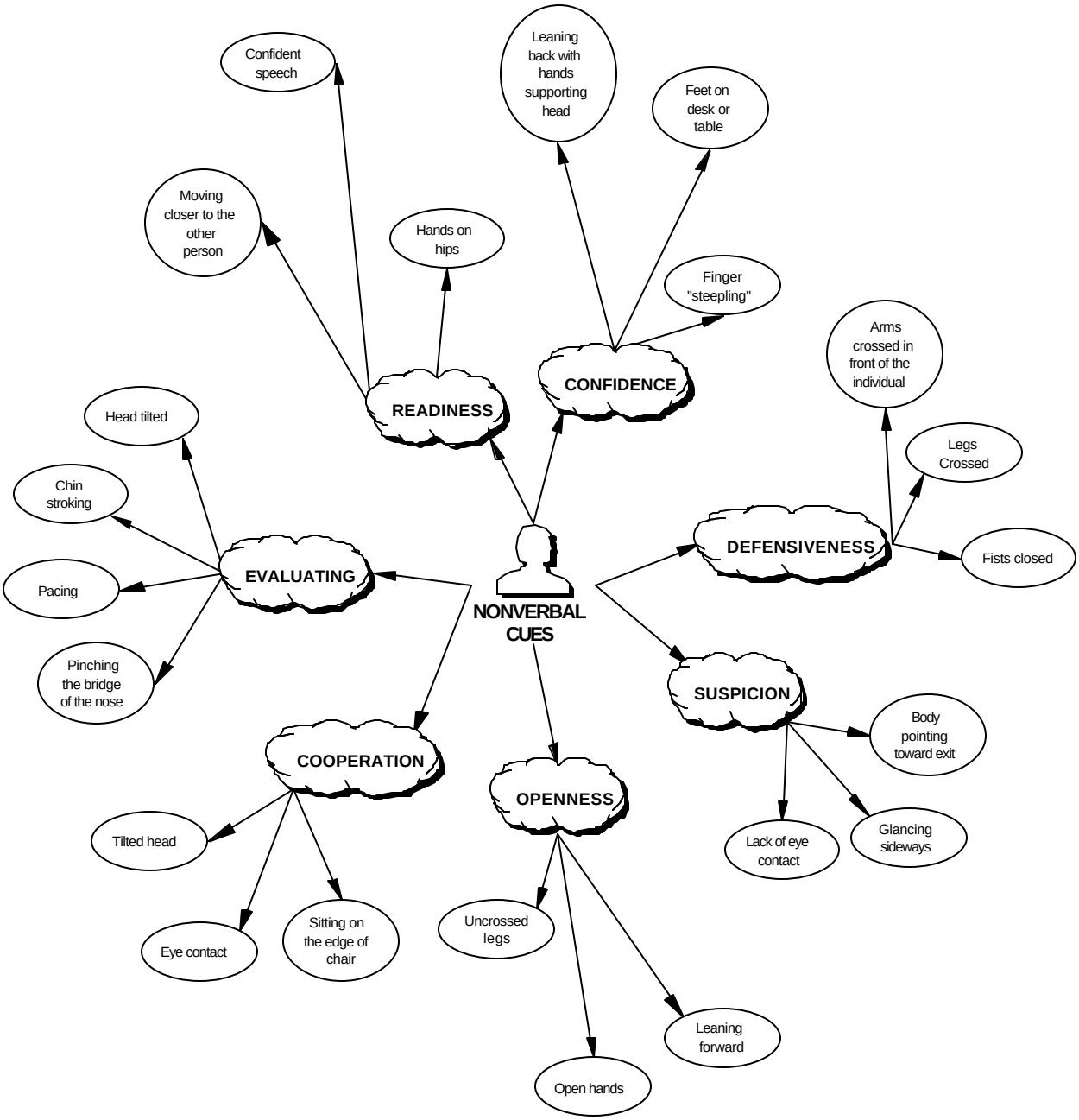
Draw out information from the person in crisis by asking open-ended questions, questions that allow the person to give any answer he wishes. This type of questioning allows the person to examine his own thoughts and feelings at a deeper level. Closed-ended questions tend to stifle communication.

Nonverbal Cues

Make sure you give nonverbal cues that let the person in crisis know you are listening. The person may also be giving some of his own cues, providing a deeper insight as to what the person is feeling.

Basic Communication Guidelines

- Use short, clear direct sentences. Long, involved explanations are difficult for people with mental illness to handle. They will tune you out.
- Keep the content of communications simple. Cover only one topic at a time; give only one direction at a time. Be as concrete as possible.
- Do what you can to keep the "stimulation level" as low as possible. A loud voice, an insistent manner, making accusations and criticisms are painfully defeating for anyone who has suffered a mental breakdown.
- If the person appears withdrawn and uncommunicative, back off for a while. Your communication will have a better chance of getting the desired response when the person is calmer and in better contact.
- Assume that a good deal of everything you say to the person will "fall through the cracks." You will often have to repeat instructions and directions. Be patient.
- Be pleasant and firm. If you do not "waffle" or undermine what you are expressing, the person will not as readily misinterpret it. Communications are our "boundaries" in dealing with others. Make sure your boundaries are sturdy and clear.
- Praise all cooperative behavior. It will help increase the desired results.
- Practice reflective listening. Use phrases like:
  - Sounds like your feeling (angry, upset, sad)- Is that right?
  - You're pretty (angry, upset, sad) right now, aren't you?
  - I want to make sure that I'm understanding what you are saying - are you telling me that you are…?
- Remember a mentally ill person may be further agitated by your interventions, even when they are necessary. Do not take it personally.
- Non verbal communication speaks volumes. Pay attention to your own use of authority posturing and remember, it may provoke aggression and not give you the results that you want. A cooperative and open stance may be more effective.


NONVERBAL CUES
READINESS
Confident speech
Moving closer to the other person
Hands on hips
CONFIDENCE
Leaning back with hands supporting head
Feet on desk or table
Finger "steepling"
EVALUATING
Head tilted
Chin stroking
Pacing
Pinching the bridge of the nose
DEFENSIVENESS
Arms crossed in front of the individual
Legs Crossed
Fists closed
SUSPICION
Body pointing toward exit
Lack of eye contact
Glancing sideways
COOPERATION
Tilted head
Eye contact
Sitting on the edge of chair
OPENNESS
Uncrossed legs
Leaning forward
Open hands

Vocabulary of Feelings

Happy	Caring	Depressed	Inadequate	Fearful	Confused	Hurt	Angry	Lonely	C
thrilled on cloud nine ecstatic overjoyed excited elated sensational exhilarated fantastic terrific euphoric delighted marvelous	affection for captivated by devoted to adoration loving infatuated enamored cherish idolize worship	desolate dejected hopeless alienated gloomy dismal bleak in despair empty barren grim grieved	worthless washed up powerless helpless impotent crippled inferior useless finished like a failure	terrified frightened intimidated horrified desperate panicky dread vulnerable paralyzed	bewildered puzzled battled perplexed trapped confounded in a dilemma befuddled in a quandary full of questions	crushed destroyed ruined degraded wounded devastated tortured disgraced humiliated anguished forsaken rejected discarded	furious enraged seething outraged burned up bitter galled vengeful hateful vicious indignant fighting mad	isolated abandoned all alone forsaken cut off	s u h d d h r e
Cheerful serene wonderful up aglow light-hearted jovial elevated in good spirits	fond of regard respectful admiration concern for prize taken with close trust	distressed upset downcast sorrowful demoralized discouraged miserable pessimistic tearful rotten awful terrible lost	defeated incompetent overwhelmed ineffective lacking deficient unable incapable small insignificant unimportant incomplete no good	afraid scared fearful apprehensive lumpy shaky threatened distrustful risky alarmed butterflies awkward defensive	mixed up disorganized foggy troubled lost at loose ends disconnected frustrated in a bind disturbed helpless going around in circles	belittled shot down overlooked abused depreciated criticized discredited laughed at mistreated ridiculed devalued mocked exploited	resentful irritated hostile annoyed upset with agitated mad aggravated offended belligerent mean spiteful vindictive	alienated estranged remote alone apart from others insulated from others	a g r c t l c
glad good contented satisfied gratified pleased fine	warm toward friendly like positive toward	unhappy down low bad disappointed sad glum	uncertain inefficient lacking confidence unsure of yourself	nervous anxious timid shy worried uneasy fiery on edge	uncertain unsure bothered uncomfortabl e undecided	put down neglected overlooked minimized let down unappreciated taken for granted	uptight disgusted bugged put out irked perturbed ticked off dismayed	left out excluded lonesome distant aloof	r v e a i r f b g l

Discussion Exercise: Recognizing Critical Signs

Joe was brought into the detention facility by Sheriff King to be booked. During the booking process, Joe was very talkative and had trouble sitting still in his chair. When Joe was asked for his address, he didn't seem to remember it. By the end of the booking, Joe had become verbally abusive and hostile to the correctional officer. Even after Joe was confined to his cell, he continued this behavior by pacing and yelling obscenities.

The correctional officer made regular rounds to closely monitor Joe's behavior. After several hours of being confined to his cell, Joe had slowed down and had become calmer. The correctional officer checked Joe again after a couple of hours. At this time he noticed that Joe was sitting in his bed shaking, sweating profusely, and holding his stomach as if sick. When the officer tried to question Joe about how he felt, Joe could barely answer. He only mumbled.

Is this a medical emergency? Is Joe really in a crisis situation? What action should the correctional officers take in this situation? What resources may be available to help the correctional officers? Could Joe be in a life-threatening situation if the correctional officers acted inappropriately?

Section 4

Crisis De-escalation

Crisis Defined

A crisis most commonly occurs when an unexpected and sometimes tragic event brings about undue stress upon a person. If this stress continues over a period of time, coping skills and ability to regain control deteriorate and can become ineffective. As a result of this ineffectiveness, anxiety increases, and disorganization of thoughts begin or persist. If unable to reduce the crisis, a severe, disabling condition may follow.

The event that brings about a crisis situation can range from a natural disaster, personal assault, destruction of personal property, death of a loved one, or an acute episode of serious mental illness.

It is important to remember that the event is in the eye of the beholder. What may be a virtually stress-free event to one person may be crisis producing to another.

What Is Crisis Intervention?

Crisis intervention is the timely and effective involvement in a person's life, providing the person with what he cannot provide for himself. This can include a physical or emotional support to lean on, or providing direction at a time when self-direction is impossible. The emphasis is on bringing the person in crisis to a pre-crisis level of functioning.

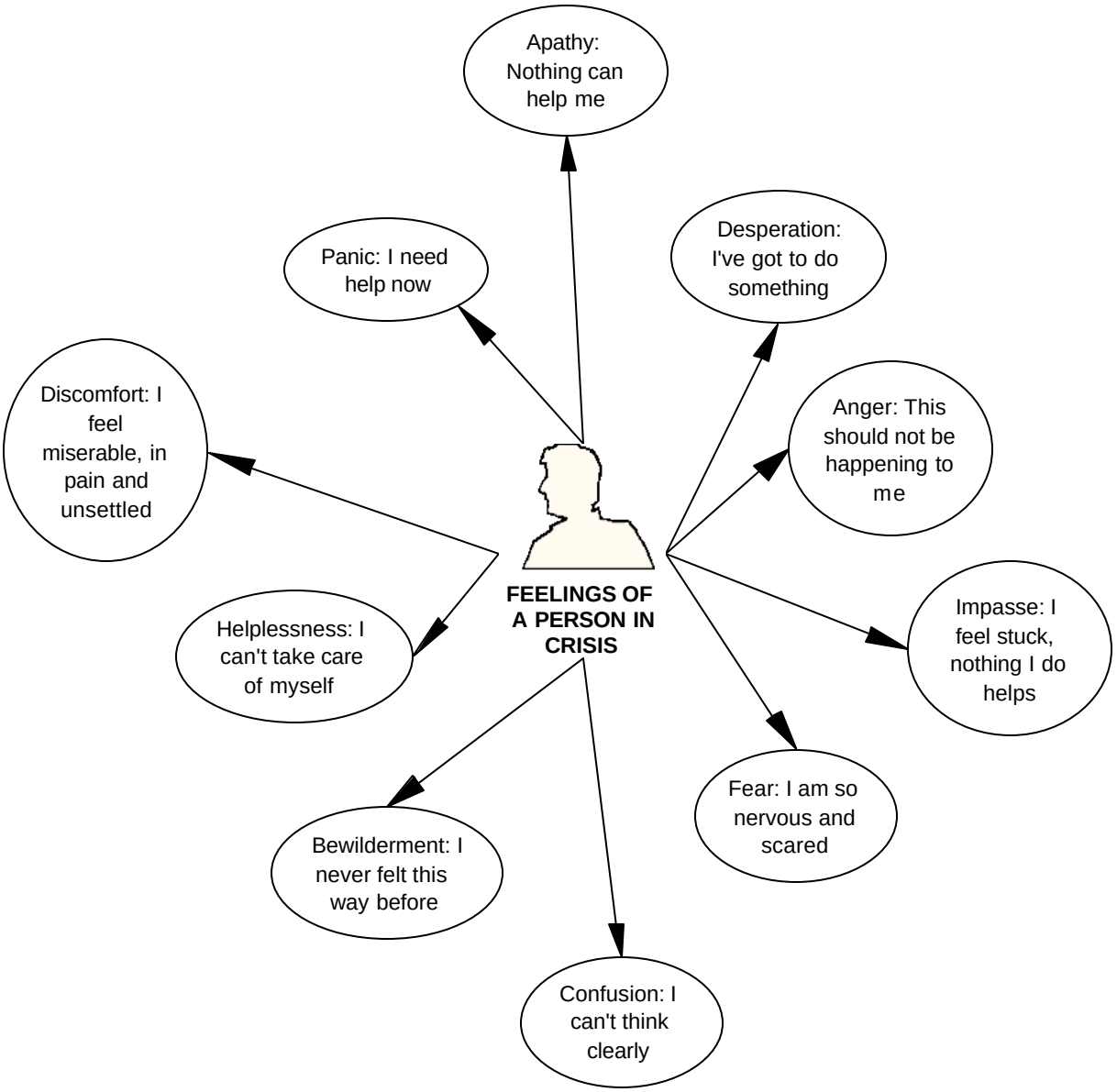
It is important for you to know that you are not expected to provide short-term psychotherapy. Your role is to manage the situation, not find a resolution to the problem that precipitated the crisis.

However, you must use your skills effectively. Work to handle the situation effectively, keep the crisis from becoming more traumatizing. If the person becomes more disabled, the safety of all concerned may become at increased risk.

Recognizing A Person In Crisis

A person in crisis is obviously not in total control of life at that point and may be feeling the panic of that realization. You may see extreme feelings of fear, anger, grief hostility, helplessness, hopelessness, as well as alienation from self, family and society.

Your recognition depends on becoming aware of what the person is communicating, both verbally and nonverbally. This awareness, or empathy, is important, since people manifest being in crisis in a variety of ways, such as crying, exploding, verbalizing, withdrawing, or displaying signs of a serious mental illness. If possible, you should obtain information from family and friends about the person's pre-crisis behavior and note any ineffective functioning. See the following chart for some possible profiles of a person in crisis:



Violence

- Because of the bizarre and frightening aspects of behavior manifested in the major mental illnesses, many myths exist — that people with mental illness are all dangerous, or they are all potential "psychopathic" killers (a common confusion with the term "psychotic".) None of these are true. In fact, people with schizophrenia and mania who take medication regularly are no more aggressive than the rest of the population. In fact, most people with schizophrenia are customarily withdrawn, frightened and passive.
- However, people with schizophrenia and mania who refuse medication, and remain untreated are indeed more prone to violence than those who do not have a brain disorder. Individuals with schizophrenia and mania who are untreated are 6 times more liable to commit a violent act.
- The combination of major mental illness and substance abuse is another significant predictor of aggressive behavior. Persons with mental illnesses who are also on street drugs such as crack, cocaine, speed, PCP or who are abusing alcohol, are even more likely to act on the violent thoughts and paranoid delusions they are having.
- The likelihood of violence is greatest among males in their late teens or early 20's.
- The best prediction of future behavior is past behavior. There is good reason to be wary of an individual who was aggressive before becoming ill, or of individuals who have previously been violent when they were particularly disturbed. People who have never been aggressive, or never aggressive in a period of psychosis, are unlikely to become so.
- Warning signs of imminent physical violence to look for include:
    1. **Tremor,**
    2. **rigid posture,**
    3. **clenching jaws and fists,**
    4. **pulsing arteries in the temples,**
    5. **verbal abuse and profanity, and**
    6. **hyperactivity**

Effective Crisis Intervention

- Reducing stress, not increasing force, often brings the best results. Stress usually brings people to crisis in the first place.
- People who are severely mentally ill are usually very frightened by the entire process of incarceration from arrest, transport, booking and custody. Understanding the confusion and disorientation jail causes is essential to have appropriate response to threatening and violent behavior.
- Talk people down. Use a quiet voice. Explain what is expected in simple language, one step at a time. Praise all cooperation one step at a time. Be patient, this may take a while.
- Pay attention to body posture and nonverbal language. The authoritative stance, threatening voice, aggression in your face or behavior that may be needed with some criminal inmates will provoke fear, hostility, lack of cooperation and possible aggression with mentally ill inmates

5 Key Stages of Successful Interventions

Immediacy

Take immediate action. Stabilize the situation by working to reduce anxiety, preventing further disorientation, and ensuring that the person does not harm self or cause harm to others. Remember to approach all crisis situations slowly and carefully. Use all your senses, staying aware of all that you see, hear, feel, sense and touch.

Assuming Control

Assume control, but not by trying to conquer or overwhelm the person in crisis. Instead, provide the structure the person needs until the person can regain control. The person in crisis often seeks stability. When you appear stable, supportive, and calm, you may be able to provide the structure and control the person needs.

- When establishing communication with the person in crisis,
- Ask open-ended questions.
- Give clear directions.
- Do not promise things that might not happen.
- Guide the person with your eyes and voice rather than with physical force. If physical force is the only and last recourse, you should follow your own department's policies and procedures.
- Remember, a person in a crisis will often respond to structure and to a person who represents it if the person senses it is genuine and not just a ploy.

Assessing the Situation

Begin to evaluate and assess the situation immediately. Your assessment needs to be comprehensive enough to give a total picture of the crisis situation. Several techniques can be used:

- Find out what is troubling the person and why there is a crisis at this point.
- Use direct questions; avoid getting a lengthy life history. Ask short, direct questions and allow the person time to answer each one.
- Do not ask too many questions at once. Allow moments of silence to occur. This will show you are not trying to rush the person.
- Let the person talk. Interrupt only to clarify.
- Make sure you watch for what's not being said.
- It is extremely helpful: to guide the person to see the crisis as a temporary state that can be resolved successfully.

- It is vital that you avoid judgments and putdowns, and don't belittle the person or make light of the crisis situation.

Safety Concerns

In almost all crisis situations, there is a possibility of injury to the intervener regardless of professional capacity. The following are some basic safety guidelines, which are intended to supplement your department's procedures, when responding to a crisis call:

- If possible, always intervene with a partner.
- Listen before entering the room or cell..
- Perform a "visual" frisk of all persons in the room.
- Keep their hands in sight at all times.
- Note any objects in the room that could be used in a violent way.
- Step into the room only a few feet at a time.
- Be prepared for unexpected behavior of others involved in the situation.
- Know where the entrances and exits are - make sure you have a clear path to an exit.
- Speak at eye level with the inmate and maintain eye contact.
- Do not turn your back on the person in crisis.
- Do not position yourself in a corner.
- Do not back the person into a corner.

Situation Management

People in crisis often develop tunnel vision. They are simply not aware of available options. Your effective intervention can help the person become more receptive to exploring options, thinking creatively and solving problems. At this point, guide the person in organizing personal resources and identifying and developing options – these can lead to ways out of the immediate crisis.

After the Crisis

Once the crisis has been stabilized, determine if the person is in need of emergency hospitalization. Get in touch with medical or psychiatric staff for further instructions, whether or not you think that the crisis was a "legitimate" one. Always reassess for potential suicide risk. Determine if the person ordinarily takes medication, and if its use has been interrupted for any reason. If so, immediately advise medical/psychiatric staff. Make sure the behavior that demonstrates the mental health aspects of your contact is well documented.

Discussion Exercise: Violence Associated with Mental Illness

Pete Wood came to work the next afternoon thinking about the weekend. He was all prepared for a quiet evening in the detention facility where he worked. There were only three prisoners there and none of the three had ever given him any trouble The other correctional officers had talked about the terrible temper displayed by Clyde Jones, an individual who was in the facility. They had suggested that he should be referred to the community mental health center. But Clyde had always responded well to Pete's requests and had never even raised his voice.

This evening, Pete prepared the supper meal and dished it onto plates for the three prisoners. When he took the food back to the cell, Clyde handled it suspiciously and then flung it across the cell. "You are one of them. You are trying to poison me," he said. "That food's no good for me."

Pete was startled by the action and became angry because Clyde's supper was now all over the cell. "Don't you ever do that again," Pete said. "Now, clean it up or I'll write you up."

With that, Clyde began to shake the cell bars violently. He screamed obscenities and reached through the bars trying to catch hold of Pete. Finding that he couldn't reach Pete, Clyde moved back in the cell and grabbed hold of Marvin, another prisoner, shaking him and slapping him. Pete continued to yell at Clyde and to threaten him with consequences if he didn't stop it immediately. Finally, Pete became concerned that Clyde would really hurt Marvin or himself. Pete went to the office and called for help.

When a deputy sheriff arrived, he and Pete together told Marvin to move close to the door of the cell so they could open it quickly and get him out. He was placed in another cell. Clyde was still raging and throwing things around the cell. They reclosed the cell door, locked it, and recommended to the sheriff that they get a mental heath professional to evaluate Clyde immediately. The sheriff called the community mental heath center and a psychologist came to make an assessment of the situation. It was determined that Clyde was mentally ill and dangerous. With the help of several deputies, he was moved to a psychiatric hospital right away.

What did Pete do in this incident that was correct? What mistakes did he make?

Section 5

Suicide/Suicide Prevention

Identification and Handling of Suicidal Offenders

Suicide is a leading cause of death in jails and lockups. Based on the latest data available, the suicide rate in county jails and lockups is approximately nine times greater than that of the general population.

Facts about Jail Suicide

Warning is usually given

- Research shows that of any 10 persons, who kill themselves, eight have given definite warnings of their suicidal intentions
- Most people who commit suicide have made either direct or indirect statements indicating their suicidal intention. .These can be direct statements ("I'm going to kill myself"). Others may be subtler ("You won't have to worry about me any more"). Even a simple "Goodbye." The statements can be made in either a serious, sarcastic or even a joking manner. They may be made to anyone, including correctional officers, court staff and other inmates as well as to family members or others. The point is that people planning to commit suicide often speak about their plans and feelings and that it is crucial that these not be ignored.
- Most suicidal acts represent a carefully thought out strategy for coping with various personal problems.
- Within the jail environment, it is difficult to commit suicide on impulse. Plans must be made regarding the best method and the best time.

A History of Prior Attempts Increases Risk by 33%

- 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.
- If a person has made a serious attempt on his life, psychological barriers or taboos against taking one's life have been broken. Other attempts then become easier. Although some attempts may seem minor and merely attention-getting behaviors, they are calls for help. If these calls for help are ignored, other more serious attempts are likely.
- If other members of the person's family have committed suicide, the risk of suicide for the inmate is five times greater than for other.

Most People are Ambivalent about Death

- 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.

- Since most suicidal people give definite warning signs of their suicidal intention, it is evident that on some level they wish to be saved. They may not be intent on dying, but at that particular time, they see no other choice.

Talking to a Person about their Suicidal Intentions is Helpful

- People do not become suicidal just by your showing interest in their welfare by discussing the possibility of suicide. That is a myth
- Questioning the inmate in a concerned, non-judgmental manner will encourage the person to discuss the existing ideas. This, in turn, may help to relieve the psychological pressure the inmate is feeling. In addition, bringing the inmate's thoughts into the open can enable the officer to obtain help for the inmate.

Presence of a Mental Illness Increases the Risk of Suicide

- National data show that ,of the people who have committed suicide, the following have met diagnostic criteria for a mental illness:

  61% - Depressive Disorder
  40% Substance Abuse Problems
  10% Anxiety Disorder
  6% Schizophrenia
  42% Personality Disorder

- The person who attempts suicide may look and act quite normal. The suicidal person may be extremely unhappy, but not necessarily so ill as to be psychotic. Studies of suicide notes have shown that persons who attempt suicide are often unhappy and depressed but rarely psychotic. A person does not need to be psychotic or acting in a bizarre manner to be suicidal.

The Rate Of Jail Suicide Is Nine Times Greater Than In The General Population.

- Because of the structure and the supervision available, jails and lockups may seem unlikely places to commit suicide. However, because of the inherent stress of incarceration, a person is likely to see suicide as the only choice. When people are in jail, the options are limited, their control is reduced, their future is more unpredictable, and they may develop a sense of hopelessness. All of these factors increase the likelihood of suicide.
- Viewing any suicide attempt as manipulation is not useful. Any one who make an attempt is at higher risk for future attempts.
- Evaluating suicidal risk by the degree of severity or lethality of a previous attempt is dangerous. Even if you feel the threat or actual attempt was a manipulative gesture, the inmate, if not adequately supervised, could kill

himself or herself by accident. Self-mutilation needs to be viewed as a suicide attempt and considered high risk behavior.

Most Jail suicides Can Be Prevented

- Overcoming this "obstacle to prevention" is perhaps the greatest challenge in suicide prevention training. A comprehensive suicide prevention program can thwart most suicides.

Understanding Suicidal Behavior

- Most suicidal behaviors are acts to end intolerable feelings: Anger, depression.
- During the crisis, the person's coping patterns are not working.
- "Tunnel vision" interferes with person seeing other possible alternatives. Victim's thought processes are rigid and extreme.
- Motivation for suicide may not be death but to escape emotional pain, to make a change in life, a change in a relationship or to attempt to be heard. Suicide becomes a solution to escape the pain.
- Often the person feels they have not been heard or understood or responded to by important people in their life.
- The person is ambivalent about the decision to commit suicide. Even in the most seriously suicidal individual there remains some desire to live.

Why Jails Are Suicide-Prone Settings

- **Authoritarian environment**. Persons not used to being regimented can encounter traumatic difficulty in the jail setting. Based on interviews with suicide attempt victims, this factor alone can trigger a suicide attempt.
- **No apparent control over the future, including fear and uncertainty over the legal process**. Following incarceration, many jail inmates experience feelings of helplessness and hopelessness. They feel powerless and overwhelmed.
- **Isolation from family, friends and community**. For incarcerated individuals, support from family and friends may seem far away, especially with restricted visiting and telephone privileges.
- **The shame of incarceration**. Feelings of shame (often felt in misdemeanants) are often inversely proportionate to the gravity of the offense committed. Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history. As noted in the list of characteristics of one national study of jail suicides, 75% of the victims were arrested for non-violent offenses. It was not uncommon for jail suicides to be committed by intoxicated persons held under "protective custody" until sober, or by individuals arrested for traffic violations, disturbing the peace or other minor offenses.
- **Dehumanizing aspects of incarceration**. Viewed from the inmate's perspective, confinement in even the best of jails is dehumanizing. Lack of privacy, association with acting-out individuals, inability to make your own choices in the regulation of your life, and strange noises and odors can all have a devastating effect. Many facilities are old, with a substandard environment. Common overcrowding creates stress.
- **Fears.** Fears, based on stereotypes of jails seen on television and in movies, and stories carried by various media, heighten anxieties on the part of some individuals about other inmates and, sometimes, about staff.
- **Officer and other staff insensitivity to the arrest and incarceration phenomenon.** Most, if not all, persons working in the criminal justice field have never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they become to the emotional effects of arrest and incarceration, particularly for the first-time arrestee. This is considered one of the factors which influences suicides in jails.

Data on suicides in jails indicate that in the firs72 hours of incarceration 53.7% of suicide are attempted.

- **Officers and other staff overlooking signs and symptoms of mental illness due to lack of knowledge or insensitivity.**
  A well designed intake and booking process that captures the history and current mental health status of an inmate will provide the basis for appropriate housing and supervision of people at risk for suicide. Policies for supervision and referral of inmates who become symptomatic while in jail reduces the risk of liability. Collaborative relationships with Community Mental Health Center can assure that jails receive the consultation they need to manage high risk inmates.

Terms Related To Suicide

- **Ambivalence**. The simultaneous existence in an individual of two opposite feelings or attitudes. In suicidal cases, it refers to the state of mixed emotions about taking one's life. Even in the most seriously suicidal individual there remains some desire to live.
- **Lethality.** The potential of a given method of suicide for ending the individual's life. The ability to provide rescue intervention between the time of the act and death determines lethality The use of a gun increases lethality by 58%.. The span of time between pulling the trigger of a pistol and the occurrence of death is much less the time between ingesting an overdose of sleeping pills and death. This difference determines lethality.
- **Ideation**. A person has thoughts about suicide and a desire to die. The severity of the ideation is determined by the lethality of the plan.
- **Attempt**. - A person has committed an act of suicide but was not successful
- **Gesture** - A person has committed an act of suicide that is considered low lethality. This is a dangerous classification because it implies that risk is low. Gestures must be taken as seriously as any other attempt.

Assessment Tool

The SAD PERSON is a simple tool that provides a quick way to recognize high risk individuals based on demographics, history and current situation

Sex - Men are 6 times more likely to commit, women attempt 3 times more often

Age - 40% of suicides are age 25-45,

Depression - 61% are clinically depressed at the time of the suicide

Prior attempts - 33% have made prior attempts

Ethanol - 41% have used at the time of death or have history of abuse

Rational thought loss - 41% have personality disorders, which include thought problems, depression affects rational thinking, 6% have Schizophrenia,

Social support losses - Losses are often the causal factor for suicide

Organized plan - The more lethal the plan, the more likely - 57% are by handguns, 85% of fire arm suicides are fatal

No significant other - divorced, separated, and elderly are most at risk-

Five Patterns Of Suicide

Impulsive

Some major disappointment or frustration such as a failure to achieve a promotion, a business failure, failure to gain admission into a professional school, or failure to achieve some important personal goal, resulting in a major blow to the individual's pride, self-esteem, confidence or honor. The humiliation and embarrassment are too great for the individual to bear. Suicide is therefore seen as a way to end the situation without prolonged suffering

Depressed

The individual is seriously depressed. Depression may be long standing or of recent origin. In such a state, the individual finds no meaning, purpose or happiness in life. The individual feels that the present life situation will not change. The person is so depressed as to be unable to realize that the feelings about the worthlessness of life are temporary and due to the depressed condition. The future is seen as hopeless. Since life is not worth living, suicide becomes the only logical alternative

Escape from Suffering

In this pattern, suicide becomes a way of escaping from intolerable pain and anguish. The pain may be caused by a serious physical illness, especially if the disease is likely to be terminal. Suffering may also be part of an emotional disorder in which the person sees no hope for improvement and despair becomes overwhelming. The prospect of living under these circumstances becomes unbearable and the person decides to end the suffering by suicide

Communication Suicide

This pattern is one in which the individual does not desire to end life as much as to change the way other people act toward him or her. The attempted suicide is a way of communicating some message to an important and valued person in the person's life. By this dramatic attempt on his or her life, the person may seek to gain sympathy, affection and understanding of a loved one, which could not be obtained in other ways. The message may also be one of guilt; the individual attempts suicide to evoke great guilt on the part of someone who has rejected or deprived him or her of affection

Loss of a Loved One

This pattern involves the loss of someone very close and important. Most commonly caused by death, but also is seen in divorce or physical separation. While loss is usually recent, it may have occurred at some previous time. Person lost is usually a spouse, parent, sibling or very close friend. Continued absence of

loved one becomes unbearable and suicide is seen as a way of reuniting with the loved one in death. This may often be seen in older individuals who attempt suicide on the birthday or date of the death of a deceased spouse.

Indicators of Suicide Risk

Psychological Risk Factors

- Acute depression with symptoms of major depression including sleeplessness agitation, severe anxiety, and loss of interest in activities
- Panic attacks (with co-morbid major mental illness)
- Rapid-cycling type of affective illness (bipolar or "manic-depressive" disorder)
- Alcohol intoxication or withdrawal with suicidal ideation
- Demographic Risk Factors - Increasing age , middle age male, Caucasian are highest risk group in KY, Unmarried or divorced,
- Recent suicide attempt. The risk of successful suicide increases with each attempt.

Social Risk Factors

- Lack of support system and social isolation
- Believe that support will be withdrawn
- Absence of responsibility for children
- Loss of interest in current affairs
- Losses - job, home, property, spouse, or significant other
- Loss of professional status

Behavioral Warning Signs

- Social isolation in jail
- Loss of interest in current affairs and outcome of legal situation
- noticeable change in routine
- Cries frequently
- Suicidal talk
- Giving things away
- Withdrawn, speaks slowly
- Exhibits sudden changes in moods and behavior

Risk Associated with Legal Status

- Charges of murder or manslaughter or a serious charge involving a crime against a family member. Especially if it involved the death of family members.
- Suicidal ideation present within the first 72 hours of incarcerations.

- Facing new charges, indictment or sentencing
- Upcoming legal hearing involving potential increase in period of incarceration

Risk Related to Time of Year

- Around own birthday
- Approaching anniversary date for crime
- Approaching anniversary date for commitment
- December—January shows low suicide rate; peaks in March—April for young, August for elderly

Risk Related to Physical Health

- Chronic illness
- Suffers from AIDS
- Poor physical health

Long Term Risk Indicators

- Severe hopelessness
- Continuing suicidal ideation
- History of suicide attempts
- Perfectionism

Intervening In An Attempted Suicide

- Make the environment safe. Isolate the individual from further tension and provocation. Take action, remove means. Make immediate referral to hospital, other protective environment or community mental health center
- Evaluate the suicide risk using a emergency assessment scheme such as the following
    1. Age
    2. Method
    3. Previous attempt
    4. Presence of alcohol or other drugs
    5. Cause
    6. Resources
    7. Social integration or isolation
    8. Emotional background of individual
    9. Individual's present state of mind

- Let the individual know that you take his or her threat seriously. Be careful not to argue with the way a person feels.. Listen with interest and sensitivity and let the individual know you will develop follow up care.
- Do not hesitate to talk about the individual's plan for suicide. Talk directly about suicide; don't hedge.
- Do not lie or promise what you cannot give. Do not argue, moralize or judge. Do not ask "why." Do not use guilt ("how suicide would affect others") or argue about moral, ethical, religious aspects. Don't try to analyze or interpret the "hidden" reasons for the individual's behavior.
- Review plans for involvement with or referral to a mental health professional.

Preventing Jail Suicides

Pre-Incarceration

The first step in preventing jail suicides is to encourage good decision-making by the officer on the street. The officer often has a choice of disposition at the time of his contact. Appropriate identification and referral of individuals who need suicide-prevention treatment to a mental health facility may prevent these difficult cases from coming to the jail or lockup during their crisis phase.

Admission Screening

- Use a formal screening worksheet on admission to assess suicide potential. Be alert to risk factors and take the proper steps to put individuals on suicide watch or hospitalize them when indicated.
- Pay attention to the mental state of inmates as you perform your normal duties. Make sure you look out for clues relating to the suicide risk factors. Do additional screenings using your assessment form whenever you see a person's psychological condition deteriorating. Make sure inmates receive their medication and take their medication under proper supervision to prevent "hoarding".

Summary

Suicide prevention programs work because they identify potential risks on a timely basis, and take action to reduce risks as appropriate. The truth is that almost all jail suicides can be prevented, provided that a written prevention plan is followed, and that the plan relies on capable and properly trained staff, intake or admission screening, classification, and increased monitoring.

Section 6

Collaboration/Team Approach

Introduction

Jails of all sizes experience similar problems and frustrations in meeting and managing the needs of persons with behavioral health issues. To address these needs adequately, an effective team approach is absolutely necessary. This means that the solutions rest both with the community as well as the jail. In order for all the stakeholders to work cooperatively to meet the needs of inmates, an emphasis on shared goals is critical.

I. Shared Goals for Mental Health Care of Jail Inmates

1. Diversion of inmates in need of care from jail custody to appropriate community care and treatment, to the greatest extent possible.

2. For those that remain incarcerated:

- ***A. The provision of an adequate level of care and treatment while incarcerated.***
- ***B. To insure the safety and well being of inmates, staff and other people entering the jail, by effectively managing and supervising inmates.***

3.To maximize continuity of care and treatment of inmates in the community, following their release from custody, by establishing linkage with community based services.

The first and third goal are best accomplished by the establishment and operation of a unified and comprehensive systems link between individuals and agencies ranging from law enforcement, prosecution , courts, medical, mental health and substance abuse providers and others.

The second goal involves primarily setting up a workable system within the jail facility for identifying and evaluating inmates in need of care, providing short term treatment, and effectively managing and supervising them.

III. Steps to Meeting Shared Goals

- Screening and identification of inmates with possible mental health /substance abuse disorders.
- Evaluation of inmates with such disorders
- Classification of inmates for programs and housing
- Diversion of inmates to from jail to more appropriate placement
- Crisis prevention and intervention
- Provision of emergency mental health and related services
- Referral for appropriate care providers both within and outside of the jail.
- Supervision and management of inmates within the facility
- Provision of short term treatment
- Suicide Prevention
- Discharge planning for effective aftercare services

IV. The Team Approach within a Jail Setting

Options include:

- Having medical and mental health professionals on staff, as employees of the jail
- Formal contractual arrangements by which professionals care providers provide an agreed upon level of care in the facility but they are not employees of the facility.
- Informal agreements in which providers provide an agreed upon level of care but there is not a formal written contract. At the minimum, written memorandums of agreement are recommended to avoid confusion and misunderstanding about roles and responsibilities.

V. Characteristics of a good working system

- Shared understanding of the overall vision, mission and values in regards to the treatment and care of inmates with mental illness/substance abuse disorders and is committed to carrying out that vision.
- All stakeholders are involved in the planning and in regards to policy and operating procedures.

- Establishing comprehensive written documentation regarding all aspects of the program to assure good communication.
- Formal and informal verbal communication as to common problems, concerns, solutions and approaches regarding inmates.
- Ongoing commitments to review the way things are done to improve procedures and to assure comprehensive care for inmates.

VI. Formal Agreements for Provision of In Jail Mental Health Services

At a minimum, a memorandum of understanding should include:

- The purpose of the agreement
- The range of services to be provided, whether it be screening, assessment, seeing inmates on referral, medication management, individual or group counseling, crisis intervention or training.
- Time frames for the provision of services
- Remuneration, if applicable
- Expectations of the jail in terms of such issues as documentation, telephone referrals, medication administration, etc.
- Confidentiality issues
- Mechanism for review , evaluation and modification of the agreement.

VII. The Team Approach in Diversion and Aftercare Programming

The realization of the first and third goals of diversion and re-entry respectively, usually involves efforts to change and improve the current legal and community service delivery system, in order to establish an appropriate level of service for inmates and for those eligible for diversion from jail. In order to provide a comprehensive range of services for people in the criminal justice system, it is important to do systematic planning to get the people from the different systems involved (law enforcement, jails, courts, mental health and substance abuse providers, prosecutors, public defenders, etc), so that they may work together towards the achievement of the common goals. The ultimate goal is integrated

provision of services, to the maximum possible extent, through the establishment of good linkages and working relationships across all the systems involved.

VIII. A Comprehensive Range of Services
A comprehensive service array would include, at a minimum, the following:

- Improved legal system assistance or intervention via the development of BOTH drug and mental health courts or an integrated model.
- Effective and timely treatment of inmates disorders while incarcerated
- Placement in effective programming, such as day treatment programs, support groups, and psycho-social rehabilitation programs.
- Linkage with consumer an family support groups (NAMI and KYCANN
- Housing assistance
- Educational Programming
- Linkage with entitlement programs such as SSI/SSD, food stamps, etc.
- 8.Linkage with other support programs based on inmates' needs.

IX. Systematic Planning for Persons with Behavioral Health Needs at the Interface the Criminal Justice System

According to the National Gaines Center, a technical assistance collaborative the focuses on the needs of persons with co-occurring disorders who are involved in the Criminal Justice system, the planning for this array of services typically moves through four sequential steps. These steps are:

Cooperation- this is the most basic level of systems change. At this level, representatives begin working together cooperatively. They begin to meet to identify mutual problems, concerns and goals and to try to figure out how to work together to address the problems identified. The basic task at this stage is to create a "safe, open atmosphere" for people from different agencies to talk about history, turf issues, their own perspectives of each others roles, etc. The agencies and people try to work out their differences, or at least their perceived difference and start to move towards the next stage: coordination. A typical methodology to formalize the effort now is the formation of a task force to address the issues identified.

Coordination- In this stage, people from different systems start trying to structure their working relationship and engage in more coordinated planning. The work of the task force continues, and additional members from other disciplines may join. The primary task at this stage is to achieve specific results within designated time frames. Members of the group take responsibility for working on specific tasks and for accomplishing agreed upon goals and objectives.

Collaboration- In this stage, the group members move beyond basic coordination and begin developing comprehensive responses to problems identified by the group. The typical outcome at this point is the development of specific programs and services. There is a high level of working relationship at the collaboration stage. IN some instances, the task force develops its own policies and procedures.

Integration- this stage is the highest level of systems linkage. In this stage, various agencies and programs providers work together to provide fully integrated services in a comprehensive manner. A coordinated approach to service delivery is the keystone of this stage. Often, new delivery models are formed, which operate in a much more efficient manner than previous models.

These stages work in any community, large or small, the only thing that varies is the complexity of the process. The steps remain the same in both a rural and urban settings.

Key Issues to Address

- Identification of the problems/needs
- Identification of the barriers
- Identification of workable solutions/development of an action plan

- **Two Resources for Technical Assistance**

1. **National Institute of Corrections Jail Center** 1-800-995-6429
Mental Health Services in Large Jails Workshop (Colorado)
Planning and Implementing Effective Mental Health Service Workshop (provides local TA)
2. **The GAINS** Center for People with Co-occurring Disorders in the Justice System 1-800-311-GAIN
On site technical assistance

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