



**MISSOURI DEPARTMENT OF CORRECTIONS
TRAINING ACADEMY
LESSON PLAN**

COURSE TITLE:	Divisional
CLASS TITLE:	Working with the Mentally Ill – P&P Journeyman Training
MODULE TITLE:	Working with the Mentally Ill

PROGRAM OVERVIEW

This program will provide tenured Probation and Parole Officers with an opportunity to examine the challenges of and recommendations for supervising an offender with a mental health condition. Staff will examine signs and symptoms used in detecting possible mental health issues; use communications skills to improve interaction with mental health offenders; evaluate resistance issues that offenders may be experiencing; examine internal and external resources; discuss the affects that drugs may have on a mental health offender; monitoring offenders for crisis issues and intervening when offenders become a danger; and lastly staff will discuss personal precautions and dealing with stress.

PARAMETERS

Date: May 2007

Credit Hours: 16 (Projected)

Target Audience: P&P Officers – 18 month tenure

Number of Participants: 24

Required Training Space: Large classroom

PERFORMANCE OBJECTIVES

EVALUATION TECHNIQUE

At the conclusion of this lesson, participants will:

Evaluation techniques utilized by the trainer(s) to determine if the performance objectives have been met.

1. Given information on mental health signs and symptoms, compare and contrast this against personal mental health concepts.
2. Through a role play activity, consider the impact that mental health issues have on offender resistance.
3. Given drug and mental health profiles, specify differences and determine how to address each, according to the information provided.
4. Using information on personal safety and stress mgt, create a personal action plan identifying three ways to apply this to your job.

1. Trainer observation
2. Processing questions
3. Participant feedback

INSTRUCTIONAL STRATEGIES

Lecture, case study, role play, small group analysis, action plan

REFERENCE(S)

The following books and / or materials were used as a basis for this lesson plan. The instructor should be familiar with the material in these reference documents to effectively present this module.

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1. Meeting the Behavioral Health Needs of Inmates by the New York State Office of Mental Health

5. Mental Health in Corrections: An Overview for Correctional Staff by Wesley Sowers, M.D., Kenneth Thompson, M.D., Stephen Mullins, M.D.

2. Missouri Department of Mental Health, Division of Alcohol and Drug Abuse

6. Interacting with the Special Needs Offender – MDOC training program

3. Treatment of Offenders with Mental Health Disorders Edited by Robert M. Wettstein

7. Mental Illness and the Criminal Justice System by The American Psychiatric Association

4. Mental Health Disease and Conditions The MayoClinic.com

8. Mental Illness Facts by the National Alliance for Mental Illness

Prerequisite Training/Certification: P&P Basic Training

Curriculum Prepared by: Edward Yahnig

Curriculum Content Approved by: Dr. Mariann Atwell, Director DORS

Date Approved

Curriculum Design Approved by:

Date Approved

Original/Revision Date

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Revision Date:

Revision Date:

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ANTICIPATORY SET

“Nearly two million new jail admissions are of people with mental illnesses—35,000 individuals a week.” (Based on admission rates reported in Bureau of Justice Statistics Bulletin, Census of Jails, 1999 (August 2001, NCJ 186633, p. 5) multiplied by the percentage of jail inmates with a mental illness (16.3%) reported in Bureau of Justice Statistics Special Report, Mental Health Treatment of Inmates and Probationers (July 1999, NCJ 174463).

“At the end of 2000, nearly one million individuals with mental illnesses were in the criminal justice system.” (Calculated using the respective rates of mental illness reported in Bureau of Justice Statistics Special Report, Mental Health Treatment of Inmates and Probationers (NCJ 174463) and year-end jail and prison population numbers reported in Bureau of Justice Statistics Bulletin, Prisoners in 2000 (August 2001, NCJ 188207) and probationers reported in Bureau of Justice Statistics press release of August 26, 20001.)

“More than 16% of jail inmates have a mental illness, according to the United States Department of Justice.” (Excerpt from the Bureau of Justice Statistics Special Report, Mental Health Treatment of Inmates and Probationers (NCJ 174463).

“Seventy percent of jail inmates with mental illnesses are there for nonviolent offenses.” (*Id.*)

“Three times as many mentally ill are in US prisons as opposed to US mental health facilities.” (Excerpt from [Mental Illness and the Criminal Justice System](#) by The American Psychiatric Association – quoted from “Prisons No Place for the Mentally Ill,” San Diego Union-Tribune, Feb. 13, 2004).

“About 74% of State prisoners and 76% of local jail inmates who had a mental health problem met the criteria for substance dependence or abuse.” Bureau of Justice Statistics, http://nami.beardog.net/AdvHTML_Upload/090606DOJReport.pdf

Offenders with Mental Illness

In 1955 the state mental hospital population was 559,000 but in 1999 it was less than 80,000. There are a number of factors that have perpetuated this shift such as new medications to control mental health problems and the belief that these drugs would work better in the community and changes in laws which mandate less restrictive settings of mental health treatment, just to name a few. Yet even though the mental hospital population had decreased mental disorders are still common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 (3.5 million people)— who suffer from a serious mental illness. So where do they go?



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The growth in jails and prisons show the opposite trend and the impact of this growth on Probation and Parole have continued to expand. With the passage of the Community Mental Health Centers Act some forty+ years ago, a vision to release people with mental health needs from the institutions and into the community for help. However, this vision was never adequately defined or funded. This along with the shift in law enforcement to more punitive policies which result in widespread arrests and incarceration of non-violent offenders, has led to a shift of people with mental illness out of mental hospitals and into jails.

Ask Participants: What affect has the influx of mental health needs offenders had on your role as a Parole Officer?

Possible Responses: More challenging interviews, tougher placement to meet needs, more personal danger, harder caseload, etc...

Ask Participants: What affect would the reduction or removal of mental health offenders have on your caseload?

Possible Response: More time to devote to offenders who are left, more time to focus on necessary programs, more cost effective use of budget, etc...

Imagine, a caseload that didn't have a person with a mental health issue and those that did have mental health issues would receive the care they deserve in the proper setting? However, this probably isn't going to happen anytime soon and unfortunately this training module isn't going to provide you with the means to make this occur. What this training program will do is to provide you with some suggestions that will help you manage the mental health offenders that you supervise but before we discuss what this program has to offer I want to know what you expect.

Group Exercise:

In your groups you need to first introduce yourself and then discuss and determine what your expectations are for today, what you really want to receive from this program. As you identify your expectations, I want you to have your scribe to write that expectation on a piece of cardstock. Please place only one expectation per card, with at least one expectation per table member. (If you have 6 people at your table then you need to have 6 expectations.) I'm going to give you 15 minutes to complete this exercise.

Note to Trainer:

Have participants place their expectations on cardstock (one expectation per card with at least one card per person). As the expectation is introduced have the cards placed on the wall with Stick-Tac. After each break review the expectations and remove any that have been met, from the wall.



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Once your group has finished this project I am going to go around the room, having the tables introduce themselves. What I would like to do is have a spokesperson prepared to introduce each person at the table, along with where they work and the one of the challenges that they feel they face when working with a mental health offender.

After their introduction, I want a second spokesperson to tell us what your expectations are. Hold up the card that reflects the expectation and once all of the expectations are introduced, please place that card stock on the wall. We'll be referring back to these expectations as the day progresses, so it's important that we capture them.

Note to Trainer: Another option would be to have each group place their expectations on an easel pad and mark them off as the day progresses.

Great, now that the expectations are all on the wall, I want you to keep them in mind because after each break we are going to revisit them, removing the ones that have been addressed. By doing this we should, with any luck, address all of them by the end of the day.

Before we cover the course objectives I want to address a couple of your needs.

Note to Trainer: Cover housekeeping (restrooms, fire escapes, breaks, meals, training agenda, etc.) and cover ground-rules. It is recommended that the ground rules be collected through a brainstorm which allows everyone to speak.

Now that we've had an opportunity to look at your needs and expectations, I want to look at the expectations that this training program has for you and they come in the form of **performance objectives**.

At the conclusion of this lesson, participants will:

1. Given information on mental health signs and symptoms, compare and contrast this against personal mental health concepts.
2. Through a role play, conduct an interview and identify possible mental health signs or symptoms according to the provided material.
3. Given drug and mental health profiles, specify differences and determine how to address each, according to the information provided.
4. Using information on personal safety and stress mgt, create a personal action plan identifying three ways to apply this to your job.

INSTRUCTIONAL INPUT



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Okay, the first thing we need to probably discuss is the role you play in the life of the offender, not just those with mental health issues but all offenders. Let's start with the hat of the case manager. You've probably been hearing a lot about the **case management** and while staff often believes that they are performing case management however, there is usually more to this than meets the eye. Case management is integrated with supervision and employs the strategic collaborative use of resources at the case level to enhance community safety through the prevention of future crimes. It seeks to reduce recidivism and relapse, preparing offenders to be successful and accountable in support of safer and healthier communities. It assesses, motivates, and provides targeted interventions to offenders during incarceration, during a release phase, and after release to the community to address the offenders' risks and needs. It is an extremely important factor to ensure that continuity of care occurs.

The **case manager** is the driving force behind this management principle. As a case manager, you act in the capacity of probation/parole officer, counselor, teacher and a liaison between the agencies, the offender and all the people that are involved with the offender. You are responsible to assist with a lot of daily living issues. As a case manager you have to maintain documentation, keep in contact with all treatment providers and keep the offender informed of what is going on with treatment. The offender should always be aware that as a case manager you are talking to their significant other and treatment providers to ensure that the services will be responsive to the person's full range of needs as they change over time (comprehensiveness and flexibility) and watching for changes in the offender stability. You need to be there to help individuals overcome obstacles and gain access (accessibility) the service and to ensure that the service match the offender's needs (appropriateness).

To clarify, this doesn't mean that you will diagnosis but the role of **Pseudo-Clinician** falls under case manager, and while we are not trained or certified counselors or psychiatrist we cannot treat an offender for their mental illness, but in our position we listen to the offender, provide direction(s) and support. These actions put us in a situation of counseling, but we need to always remember we are not trained certified professionals and offenders needing counseling for serious issues should always be referred to certified mental health professionals.

It is important to remember that it is not our job to do things for the offender. Our job is to provide them with information, and "**direct and guide**" them to the things they need to do. The offender is responsible for meeting the expectations and requirements of supervision and treatment. They must learn to be more independent rather than dependent on the officer or case manager to do all the work for them. However, with a mental health caseload, it is important that if at all possible to stay with the caseload as



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long as possible. A lot of offenders do not have stable family member, treatment providers or friends and they need a consistent element in their life. Constant change adversely affects the offender and they develop difficulty with trust, therefore, jeopardizing their treatment, safety to the community and themselves. Additionally, consistency in how the offender is treated is an absolute. They have to be given specific expectations and the consequences have to be clear. All expectation and consequences should be fair to the offender's level of functioning.

Officers need to remember that although these are mental health offenders, they are not always mentally slow. Any offender whether mental offender or not, should be treated with **respect**. Officers need to learn to put themselves in the shoes of offender and ask, "Is this how you would expect or want to be treated in this situation?" This doesn't mean that you should "coddle" the offender but you may need to exhibit more patience than you normally would. However, you need to take care that this patience isn't mistaken for something more than part of your job.

As a professional you must be aware of where the **Professional Boundaries** of your position lay and so should the offenders on your caseload. Your role needs to be explained and at times reiterated with offenders. You are their parole officer, although you are there to help and provide support, you are still only there to help and not to become involved with them beyond a professional level. This needs to be clear and consistent with the offender and this role ties directly to accountability. We have the responsibility of holding the offender accountable for their actions or inactions. This is in their best interests (although they may not agree).

Ask Participants: Why do you think it would be in their best interest to hold them accountable?

Possible Response: It will assist them in the realization that they have to be self-sufficient and meet the norms of society; it will provide them with successes that will help them realize that they can achieve their goals.

Accountability and maintaining professional boundaries are critical to preserving our responsibility of ensuring the safety of the community and at the same time we are ensuring the offender's needs are being met in the least restrictive environment.

Another important aspect as with all offenders that are supervised is **documentation**. However, with a mental health offender the documentation could be used for hospitalizing the offender for their safety. During the course of supervision, other officers or supervisor could have contact with the offender so it is in the best interest of the offender to continually note what is going on with the offender. It is important that we (all of us) are there to



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provide support for offenders with mental health because this isn't always the case.

Ask Participants: Would you mock someone who has breast cancer?

Of course not and while most people would never think of mocking someone with breast cancer, mental health disorders and conditions are often fair game for ridicule.

Mental illness has traditionally been surrounded by community misunderstanding, fear, and stigma. **Stigma** towards people with a mental illness has a detrimental effect on their ability to obtain services, their recovery, the type of treatment and support they receive, and their acceptance in the community.

Ask Participants: Exactly what is stigma?

Possible Response: Stigma means a mark or sign of shame, disgrace or disapproval, of being shunned or rejected by others. It emerges when people feel uneasy or embarrassed to talk about behavior they perceive as different.

When someone appears to be different than us, we may view him or her in a negative stereotyped manner. People who have identities that society values negatively are said to be stigmatized. Stigma is a reality for people with a mental illness, and they report that how others judge them is one of their greatest barriers to a complete and satisfying life. Society feels uncomfortable about mental illness. It is not seen like other illnesses such as heart disease and cancer. Due to inaccuracies and misunderstandings, people have been led to believe that an individual with a mental illness has a weak character or is inevitably dangerous. Mental illness can be called the invisible illness. Often, the only way to know whether someone has been diagnosed with a mental illness is if they tell you.

Ask Participants: Why does stigma surround mental illness?

Possible Responses: People are ill-informed, have preconceived ideas, are influenced by television and the media or are uneasy because the mentally ill may be different than they are.

Why does stigma of mental illnesses continue? For one thing, the term "mental illness" suggests that it's not the same as a medical or physical illness. To some, the word "mental" suggests that the illness is not a legitimate medical condition but rather a problem caused by your own choices and actions. People may blame you and think your condition is "all in your head." They may think that a mental health disorder means that you're



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weak or lazy. They may think that you should just "get over it." And you may begin to think these things about yourself, too.

We all have an idea of what someone with a mental illness is like, but most of our views and interpretations have been distorted through strongly held social beliefs. The media, as a reflection of society, has done much to sustain a distorted view of mental illness. Television or movie characters that are aggressive, dangerous and unpredictable can have their behavior attributed to a mental illness.

Mental illness also has not received the sensitive media coverage that other illnesses have been given. We are surrounded by stereotypes, popular movies talk about killers who are "psychos" and news coverage of mental illness only when it related to violence. We also often hear the causal use of terms like "lunatic" or "crazy," along with jokes about the mentally ill. These representations and the use of discriminatory language distort the public's view and reinforce inaccuracies about mental illness.

What are the effects of stigma? The stigma surrounding mental illness is so strong that it places a wall of silence around this issue. The effects are damaging to the community as well as to the person with the illness and his/her family and friends. If you became physically ill, you would go to a doctor. Once you got better you would expect to get on with life as usual. Life, however, does not always fit back into place for people diagnosed with a mental illness. Everyone has the right to fully participate in his or her community, but individuals struggling to overcome a mental illness can find themselves facing a constant series of rejections and exclusions.

Due to stigma, the typical reaction encountered by someone with a mental illness (and his or her family members) is fear and rejection. Some have been denied adequate housing, loans, health insurance and jobs due to their history of mental illness. Due to the stigma associated with the illness, many people have found that they lose their self-esteem and have difficulty making friends. The stigma attached to mental illness is so pervasive that people who suspect that they might be mentally ill are unwilling to seek help for fear of what others may think. Spouses may be reluctant to define their partners as mentally ill, while families may delay seeking help for their child because of their fears and shame.

Earlier I stated that, "We all have an idea of what someone with a mental illness is like" but do we? After all what is mental illness? Where does it come from? How is it treated? What are the facts?

Mental illness is any disease or condition affecting the brain that influence the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can vary from



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mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands. (Reference: WebMD & MedicineNet http://www.medicinenet.com/mental_illness/article.htm)

Ask Participants: What causes Mental Illness?

Possible Response: Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of **genetic, biological, psychological and environmental factors**.

One thing is for sure -- mental illness ***is not*** the result of personal weakness, a character defect or poor upbringing, and recovery from a mental illness is not simply a matter of will and self-discipline.

Heredity (genetics): Many mental illnesses run in families, suggesting that the illnesses may be passed on from parents to children through genes. Genes contain instructions for the function of each cell in the body and are responsible for how we look, act, think, etc. But, just because your mother or father may have a mental illness doesn't mean you will have one. Hereditary just means that you are more likely to get the condition than if you didn't have an affected family member. Experts believe that many mental conditions are linked to problems in multiple genes -- not just one, as with many diseases -- which is why a person inherits a susceptibility to a mental disorder, but doesn't always develop the condition. The disorder itself occurs from the interaction of these genes and other factors -- such as psychological trauma and environmental stressors -- which can influence, or trigger, the illness in a person who has inherited a susceptibility to it.

Biology: Some mental illnesses have been linked to an abnormal balance of special chemicals in the brain called neurotransmitters. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. In addition, defects in or injury to, certain areas of the brain also have been linked to some mental conditions.

Psychological trauma: Some mental illnesses may be triggered by psychological trauma suffered as a child, such as severe emotional, physical or sexual abuse; a significant early loss, such as the loss of a parent; and neglect.

Environmental stressors: Certain stressors -- such as a death or divorce, a dysfunctional family life, changing jobs or schools and substance abuse --



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can trigger a disorder in a person who may be at risk for developing a mental illness.

Mental illnesses are very common; in fact, they are more common than cancer, diabetes or heart disease. According to the U.S. Surgeon General, an estimated 23% of American adults (those ages 18 and older) -- about 44 million people -- and about 20% of American children suffer from a mental disorder during a given year. Further, about 5 million Americans adults, and more than 5 million children and adolescents suffer from a serious mental condition (one that significantly interferes with functioning). One out of four Americans will experience a mental disorder during their lifetime, affecting people of all ages, in all kinds of jobs, at all educational levels and from all cultural backgrounds. Although mental illness affects both males and females, certain conditions -- such as eating disorders -- tend to occur more often in females, and other disorders -- such as attention-deficit/hyperactivity disorder (ADHD) -- more commonly occur in children. But, people can get better. With proper treatment, most people with a mental illness recover quickly, and the majority do not need hospital care, or have only brief admissions. So how do you know if the individual that you are working with has a mental health issue?

Mental Health Problems

It is estimated that 1 in 4 people will suffer from a mental health problem at some point in their lives. Therefore it is not surprising that many people experience this while in a stressful environment. It can be difficult to recognize when tiredness or other problems are an appropriate response to one's current demands, or a mental health problem that requires to be challenged. There are some signs and symptoms that people with mental health issues may exhibit, including:

Common Signs & Symptoms

- Poor appetite, or compensatory overeating
- Excessive tiredness
- Poor concentration
- Deterioration in self-care skills e.g. personal hygiene
- Impaired motivation
- Difficulty in remembering things
- Problems in making decisions
- Loss of drive, energy and interest
- Disturbed sleep pattern
- Feeling low or miserable much of the time, even despairing at times
- Thoughts of suicide
- Withdrawal from social events/contacts
- Fears re attending lectures and/or tutorials



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- Hearing or seeing things that others seem not to
- Increased irritability
- Odd thinking

These signs and symptoms along with others, may apply to one or many mental illnesses. Unfortunately, signs and symptoms are often incorrectly identified for a mental illness and this is mostly due to the individual's lack of knowledge when it comes to mental illness.

To help you better serve the offenders you interact with it's important to know not only the signs and symptoms of a mental illness but how they may affect that individual. To do this we need to first look at the category of illness that you are exposed to and to introduce you to these categories we're going to use a group activity.

GUIDED PRACTICE

Note to Trainer: Break participants into 4 groups and provide each group a category of mental illness.

Instructions: In your groups, I want you to write the category that you are assigned at the top of an easel pad and then discuss your category based on your understanding of that category. What "it" is and what signs and symptoms it may have. Outline these on the easel pad. You have 10 minutes to complete this activity.

Categories of Mental Illness

1. Psychotic Disorders
2. Mood Disorders
3. Personality Disorders
4. Anxiety Disorders

Note to Trainer: Monitor the groups and at the end of 10 minutes (earlier if they are ready) provide them with detailed information on the category that was assigned to them. The group should then be given 15 minutes to analyze the information, comparing the new information to their ideas of the assigned category. They should chart the new **accurate** information on a separate easel pad and be prepared to present the information at the end of the timeframe. Have all four groups present the information, allowing questions over the material before you process the activity.

Now that you've had a chance to compare the "accurate" information to your personal thoughts on your assigned categories let me ask you a couple of questions.

Ask Participants: What affect do you think inaccurate information has on people who interact with the mentally ill?



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Possible Response: It can be frightening to both individuals, it can cause people to avoid the mentally ill, or cause them to discriminate against them.

Ask Participants: How do you think that inaccurate information on an offender's mental state might affect your ability to help them?

Possible Response: Unable to appropriately refer them for treatment, inappropriate communication methods, or possible concerns that the offender may react violently.

Ask Participants: What can you do to prevent this from occurring at your office?

Possible Response: Become better versed in the field of mental health, if I am in doubt I should refer them for the correct diagnosis, or discuss it with a more experienced peer who can help guide me.

The ability to visually detect subtle signs or symptoms that may stem from a mental health issue is important as it relates to truly helping the offender but this ability is only one part of collecting information. Interview skills will also play an important role. While I realize that you have all had at least one training program on a communication skill, there are some aspects that you need to focus on when interacting with someone who may have a mental health issue.

INSTRUCTIONAL INPUT

To begin with, when communicating with an offender regardless of their mental health status, you need to remember that there is a disparate power relationship between you and the offender on communication. This means that the offender may be reluctant to provide information or to "open-up", so you're going to have to nurture the lines of communication **without** crossing the professional boundaries. Skillful communication requires you to listen, clarify and interact in a socially intelligent manner.

Ask Participants: What do you think "social intelligence" means?

Desired Response: Understanding others and acting wisely in social situations.

Note to Trainer: Social Intelligence was a concept that was originally created by Edward L. Thorndike a great learning theorist and Psychologist and then later expanded upon by John F. Kihlstrom, University of California, Berkeley; Nancy Cantor University of Michigan
(Reference: R.J. Sternberg (Ed.), *Handbook of intelligence*, 2nd ed. (pp. 359-379). Cambridge, U.K.: Cambridge University Press, 2000.
http://socrates.berkeley.edu/~kihlstrm/social_intelligence.htm)



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Acting wisely in a social situation basically refers to treating those you are talking to with courtesy and respect. Try to keep in mind that an offender who is mentally ill has a neurobiological disorder of the brain and they deserve our respect just as much as someone with a heart disease. However, this doesn't mean that you aren't responsible for managing their behavior.

Ask Participants: What type of behavior problems do you think you'll run into?

Possible Responses: Some of the common behavior management problems you'll run into (especially for those of you working with offenders in the facilities) maybe:

- Displaying unpredictable behavior making it difficult to know how they might react to "normal" events
- Be at a higher risk for suicidal or self-harming behavior
- Be unable to follow conversations, answer questions or comply with simple instructions
- Have somewhat limited social skills which can increase the likelihood of them being victimized or exploited
- Have poor hygiene and unusual behavior, making them undesirable
- They may be incarcerated longer than other offenders since they often lack effective support systems to assist them with legal action or release plans
- Engage in behavior that we don't understand, such as non-stop talking, being frightened, or isolating themselves from others

These problems can be quite challenging to manage but there are several techniques that you can use, including:

Use Caution – First of all as with all offenders you need to always use caution during interaction but with an offender who has mental health issues you shouldn't assume that your reality is their reality. Hallucinations and delusions are real for persons with a mental health illness. Remember that an individual's perception is reality! Responses to psychotic symptoms may seem unpredictable to us but are meaningful to them.

Pay Attention to Non-verbal Clues – One key is to closely observe the non-verbal behavior that the offender is exhibiting. Monitor the way that tension may be expressed (pacing, breathing, tone of voice, or hand position.) You also need to monitor eye movement (darting back and forth, or the inability to maintain eye contact). Watch for consistency between verbal and non-verbal communication and for incongruity of emotion in relation to the situation.



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Do Not Crowd – You need to be aware of the individual's personal space. People experiencing paranoia need more personal space. A simple touch on the shoulder may result in a defensive reaction and you should avoid approaching the offender from behind because this may be perceived as threatening.

Be Patient - Patience allows the person to process information and to respond. A calm, relaxed posture sends a different message than when we stand with our arms crossed. Speak in a low, calming voice and allow the person the time to regain control. Reassure the person that you will not let them get out of control.

Facilitate Understanding Through Listening – Earlier we discussed communication skills but if you really listen to the offender who has a mental health issue you can increase your ability to manage their behavior. Allow the person the opportunity to tell you their problem in their own words. Ask open-ended questions and avoid interrogating. Avoid arguing or asking “why” questions. Try to be an impartial listener and to not appear judgmental. Listen for the feelings behind the words. Do not tell a depressed person to “just snap out of it.” Do not argue about the person's feelings. Do not argue about distorted perceptions.

Facilitate Understanding with Explicit Directions – Remember that persons with mental illness often have difficulty processing information. So be sure to give directions by using simple, concrete instructions. Break complex tasks into simple, smaller tasks. Speak slowly and distinctly and confirm understanding by asking them to repeat the instructions to you.

Minimize Stimulation Within the Environment as Much as Possible - A loud, crowded environment creates stress for everyone. When intervening, find a quiet, private, secure place. An audience only increases the risk of trouble and may limit the person's willingness to accept assistance. Separate the person from others who may be harmed or disturbed.

Reinforce Positive Behavior - It is best not to challenge undesirable behavior that does not present a risk. You need to consider whether your intervention in the behavior will be worth the possible outcome. Remember that some behaviors are beyond the person's control. So pick your battles and whenever the opportunity arises reinforce positive behavior.

Respond as Soon as Possible to Requests – We all know that basic needs are important, but they are especially to a person with mental illness (bed, clothing, meals, coffee, and cigarettes). The ability to delay gratification may be limited so this behooves us to respond to needs quickly if possible. Delays may result in continuing requests and increased frustration for all parties.



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Don't Make Promises You Can't Keep – This has always been a good idea and a foundation of which to build trust. A broken promise can create problems with all the offenders you interact with but broken promises can be especially serious when mental health issues are involved. Promises “to try” are often more effective and honest.

Maintain Confidentiality – By policy there are many topics that are considered confidential so remember to maintain private information and share only with those who “need to know.” Casual discussions can destroy the rapport that you’ve built with the offender. However; this doesn’t mean that you shouldn’t share any information that presents a safety risk. In fact there are times when you are obligated to share information and we’ll be covering those times in a few moments.

Demonstrate Concern and Acceptance – Treat all offenders with dignity and respect. If a person feels they are accepted, the task of gaining cooperation is more easily accomplished. Reassurance and positive reinforcement can increase the development of rapport. Teasing and ridiculing those with mental disorders increases the frustration of those targeted and are a risk to the safety of the staff and the public. This is where the old adage of **Being Firm, Fair and Consistent** applies. Inconsistency creates stress and confuses people with mental disorders. Roles should be consistently enforced by all staff and limits should be enforced in a calm and fair manner.

Additional tips for communicating with someone during a “mental health crisis” are provided by the **National Alliance on Mental Illness**:

Tips for Communicating During a Mental Health Crisis

A person with mental illness may...

- *have trouble with reality*
- *be fearful*
- *be insecure*
- *have trouble concentrating*
- *be over-stimulated*
- *easily become agitated (not to be confused with dangerous)*

So you need to...

- *be simple, truthful, not sarcastic*
- *stay calm*
- *be accepting*
- *be brief; repeat*
- *limit input, not force discussion*
- *recognize agitation, allow retreat*



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- *have poor judgment*
- *not always expect rational discussion*
- *be preoccupied*
- *first get his/her attention*
- *be withdrawn*
- *initiate conversation*
- *have changing emotions*
- *disregard and have patience*
- *have confused plans*
- *stick to one plan*
- *have little empathy for you*
- *recognize this as a symptom*
- *believe delusions*
- *ignore or change the subject; don't argue*
- *have low self-esteem and motivation*
- *remain positive*

Interacting with offenders can be challenging but this can be especially true for those who have a mental health disorder. And while we can discuss the different strategies that you can use to interact with the offender, the best place to start is to “walk a mile in their shoes” as it were. So how can you see what it’s like to be sitting on the other side of the desk, trying to communicate but not having any luck? In the next activity you’re going to begin to understand the challenges that someone with a mental illness may be going through.

GUIDED PRACTICE

“Voices” Experiential Exercise – role play

Instructions: In this exercise we are going to explore what it is like to hear voices that may not be there. You’re going to each be assigned a role and have an opportunity to experience what the MH offender may feel. Once you get your role read the information without sharing it with the group. I’ll give you 5 minutes for this and then all the groups will start at once.

Note to Trainer: Break participants into even number groups, 6 to 7 per group. Have the group arranged in the following manner:

- Person playing PO should be seated directly in front of the person playing the offender. They should sit 3 to 4 feet from them.

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- Person playing offender should be seated directly in front of the person playing the PO. They should sit 3 to 4 feet from them.
- The individuals who are playing the voices should sit in a horseshoe shape around the person playing the offender. They should sit 3 to 4 feet from them. These “voices” can get up and move around the group. They can yell and wave at the person playing the offenders but they are not allowed to touch them.

And make the following assignments:

1. Participant one will play the emotionally disturbed offender. This participant will have no script but have been briefed on the topic of the conversation. Their responsibility will be to focus on the person playing the role of the Parole Officer and respond to their questions.
2. Participant two will play the role of the Parole Officer and will provide questions to the participant playing the role of the emotionally disturbed offender. The questions will come in the form of a script.
 - a. Parole Officer conducting an interview to gain information during a weekly contact. The questions need to be very detailed and should contain follow up questions that would occur in a normal interview.
2. The other participants will play the roles of voices that the offender is hearing. Each “voice” will have a different script to read from and will address the following:
 - a. One voice will be extremely paranoid and will repeatedly state in a loud manner that the Parole Officer is attempting to set them up.
 - b. One voice will be their mother who will be admonishing them for being in jail and being a bad person.
 - c. One voice will be God or an angel and will be giving them orders.
 - d. One voice will be the Devil or a demon who will be telling them to kill.
 - e. One voice will be the voice of the offender’s child even if they have no child (**optional should you have an odd numbered group**).

Participants playing voices role should start talking at the same time the participant playing the role of the Parole Officer begins. Allow 30 minutes for the exercise. Stop exercise every 3-4 minutes to switch participants’ roles and move them from group to group, regardless if they are finished with the role play. Continue the role play until everyone has had the experience of being the emotionally disturbed person.

Then ask the following processing questions:

Ask Participants: How did it feel playing the role of an emotionally disturbed person?

Possible Responses: Confusing, frustrating, impossible to concentrate, scared.

Ask Participants: How did you feel playing the role of the Officer?



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Possible Responses: Frustrated, concerned, determined.

Ask Participants: How can this exercise help you when working with an emotionally disturbed person?

Possible Response: It will help me to understand the tremendous pressure that some of these people are under.

Ask Participants: What steps will you take to more effectively communicate or interact with an offender that may be an emotionally disturbed person?

Possible Response: Try to take my time when interacting with them, consider referrals more often.

As I mentioned before, interacting with offenders can be challenging but this can be especially true for those who have a mental health disorder. However, you need to remember that you're not in this alone.

INSTRUCTIONAL INPUT

As the agency moves forward with its reentry efforts it continues to gain support from other agencies that have a vested interest in the success of the offenders.

Ask Participants: Why would other state agencies care whether the reentry effort is successful or not?

Desired Response: They are often seeing the same people that we are and if the offender is successful in their efforts to integrate back into society that is one less person that they can drop from their caseloads,

This vested interest is critical when applying case management and that's an important aspect that you need to know. **Case Management** as mentioned earlier is integrated with supervision and employs the strategic collaborative use of resources at the case level to enhance community safety through the prevention of future crimes. It brings together key "players" in the offender's life (i.e. medical, mental health, Probation & Parole, custody etc...) who jointly work toward assisting the offender in their areas of need, ultimately leading to successful reintegration into society.

Ask Participants: Why use case management as opposed to other forms of oversight?



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Possible Response: Case management has been proven to work, it is what other agencies use and it will make it easier to work together if we all use the same thing.

Experience indicates that proper and timely attention to criminogenic issues, medical and related social problems can reduce the incidence of recidivating and decrease the need for extensive intervention. This is what case management focuses on.

Case management, in some form, is practiced in most public mental health agencies. While definitions and models vary greatly, case management typically involves coordination of offender services to assure continuity of care and accountability for service provision. Within the public mental health system, advocacy is generally considered to be an important element of case management. Advocacy involves representation of the needs and interests of people with serious mental illnesses in order to obtain services, assure fair and reasonable accommodations for special needs, and promote opportunities for maximum independence in the community. Advocacy may include interpretation of offender needs to providers, consultation and technical assistance in reducing and eliminating barriers, and assertive efforts to assure adaptations and accommodations. In some instances, advocacy can be an adversarial process directed toward forcing a system, resource or provider to serve the offender.

Collaboration with internal and external partners has been and will be a critical component to case management. You don't have to do everything alone because there are other members of the case management team who can step up to assist. After all the majority realizes that they are serving the same clientele and it is unnecessary to provide duplicate work so that services can be provided. Case management has been employed in the medical/mental health field for years and now we are becoming part of that team.

I know that this training module is about mental health offenders but it should be noted that the concept of case management will be the same regardless of the offender's medical or mental health status. Our goal is to reduce recidivism and relapse, preparing offenders to be successful and accountable in support of safer and healthier communities and case management is a great tool to make this happen. It assesses, motivates, and provides targeted interventions to offenders during incarceration, during a release phase, and after release to the community to address the offenders' risks and needs. While true with all offenders this is especially true with the mental health offender, who often needs community support to assist them. Critical to this is your role in coordinating with mental health providers or with the Department of Mental Health to get the offender assistance that they need.



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While treatment has always been a fundamental way to help the offender to change, your interaction with the offender has a major impact. Regardless of the position you hold, your interaction with the offender can affect their future. The importance of this is that you need to ensure that your action is positive and that aids the offender in positive change.

The most important facet of the integrated case management and supervision model for Reentry is that its goal is: **Community Safety and Crime Prevention**. What better way to prevent crime than to assist the offender in integrating back into society? It seeks this goal through enhancing the ability of offenders to successfully reintegrate into the community without re-offending. Case management is a new (at least to some of us) and better way of doing business for our organization. However, this process won't happen overnight. It will take time and effort on everyone's part. It will be a team effort and at the root of this effort will be the case management team.

The **Case Management Team** is department or contract staff, community resources and family members that impact an offender's life. This team changes as the needs of the offender are being addressed.

Ask Participants: How could this need change and how would you meet this change?

Possible Responses: Will vary based on experiences of participants.

Not all members of the team will be involved with the offender at the same time and will not necessarily meet at the same time but one constant will be the Case Manager who will collaborate with team members to ensure that the offender receives the services that are required. As the offender's parole officer you will also be their case manager.

Ask Participants: How have you solicited team members and how have they assisted you?

Possible Responses: Will vary based on experiences of participants.

Note to Trainer: Build on the responses of the participants and have them submit comments to show the importance of working as a team.

There will be several members of this team and you're the one who will need to coordinate with all those involved. You should first consider internal staff who may be involved such as the institutional psychologist or psychiatrist who provided care for the offender during their incarceration. They will be important to ensure that effective care is continued in the community as they interact with community mental health providers. You should also discuss



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problems or challenges with your peers or supervisors. Their experience will help you make good decisions as it relates to the offenders care. Obviously external sources and providers should be considered and contacted. These resources are critical to help the offender make a productive transition from the prison to the community. The first outside contact you should make is the offender's family and friends. Support from family and friends are extremely important and can help create a positive environment for the offender to live.

Family and friends also allow you to obtain releases of information regarding the mentally ill offender when this is necessary. That insures the offender is aware you will talk to their family, and share information with the family. The family is also a great source of information regarding the offenders past behaviors and indicators of problems. These are a useful resource for officers that should be tapped into whenever possible.

When you're connecting offenders to services it's important that you consider the following 5 aspects:

Collect Information

- If offender is telling you they have a diagnosis, ask who diagnosed them, when, and where.
- If the client received treatment ask for the name of the provider and the date of services.
- Assess offender's willingness to return to treatment. Would they go back to the same provider?
- Can they return to that provider?
- If not, is it an issue of access, or dissatisfaction with services?
- Interview client about the presence of any current symptoms which may require crisis intervention, e.g. thoughts of suicide, thoughts of harming others, command hallucinations.
- If an offender ever reports to have received mental health treatment, request the offender to complete a Release of Information Form so that you can obtain a copy of her or his treatment records.

Assess Offender Resources

- Ask client if he has insurance, Medicare, or Medicaid.
- If not, have they applied for Medicaid, or do they have access to insurance?
- Find out if they are currently under medical care even if they have no coverage. Perhaps they go to a clinic or have a family doctor who has continued to treat them.
- Is there a family member who could help them?



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Choosing Initial Referral

- If the offender has private insurance, have them make an appointment with licensed mental health professional such as a psychiatrist, psychologist, social worker or a licensed professional counselor. This may require them to go through their primary care physician.
- If the offender has Medicaid, two courses of action may be pursued.
 - If the offender needs psychiatric care, and could also benefit from case management services, refer to the Dept. of Mental Health's Administrative Agent.
 - If the offender is not in need of case management services, the offender can be referred to any psychiatrist that accepts Medicaid.
 - × If the offender is not in need of case management services, the offender can be referred to any mental health professional that accepts Medicaid.
 - × It is important to identify mental health professionals in your community who offer a sliding fee for offenders who do not qualify for Medicaid or who do not have a funding source.



Note to Trainer: Refer participants to list of DMH administrative agents.

- If the agent refuses based on lack of coverage, ask if they have some way of extending coverage to your client pending receipt of Medicaid benefits. (The Administrative Agent's response will vary from provider to provider.)
- If the provider tells you that there is no way treatment can be offered, ask the Administrative Agent where they send patients who do not qualify for services. If they suggest no resource, ask them if they know someone else who may know.
- Be persistent and follow all suggestions until exhausted.

Dealing with Failure, Regrouping

- What do you do if all your efforts to locate psychiatric care fail?
 - Sometimes general practitioners will be willing to prescribe medicines to treat previously diagnosed mental illnesses.
 - Call your local Access Crisis Intervention (ACI) Hotline and ask about a referral.
 - Contact your local chapter of National Alliance of the Mentally III (NAMI).

Note to Trainer: Refer participants to list of hot line numbers and the local chapters of NAMI.

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- Contact local charities which may assist with medical bills.
- If your client becomes pregnant, Medicaid can be extended to the mother who will cover psychiatric care.
- If your client is charged with a municipal violation, check to see if your county has a mental health court. If so, refer the client if appropriate and eligible. Participation in a local mental health court may lead to treatment resources for the client.

Worst Case Scenarios

At times, despite our best efforts, we cannot find appropriate resources for clients, this may place us in the unenviable position of waiting for the situation to change. This may mean waiting for resources to be available, or waiting for the client to become ill enough to receive treatment in a hospital setting. If you are forced to wait, *it is **CRITICAL** to engage in a process of ongoing assessment, **particularly risk assessment***, until the situation changes.

- Be on the alert for signs of suicide or violence.
- Ask the client specific questions about their condition.
- When and if the client becomes sufficiently ill before resources can be brought to bear, crisis intervention will be necessary.
- If intervention efforts lead to hospitalization, new opportunities for treatment may present themselves. Whenever possible visit clients when hospitalized and talk to staff.
- Every hospital has social work staff. Seek the assistance of social work staff in constructing a discharge plan that provides for ongoing care.
- Be assertive; don't let the hospital discharge without an adequate discharge plan.
- Let them know if the plan is unworkable.

If the DMH Administrative Agent has previously denied services, a recent hospitalization may open that door. Many hospitals have Medicaid specialists. If your client is hospitalized and has no coverage, the hospital's Medicaid specialist will be motivated to help in applying for benefits for your client.

Medication

Medication is another issue that will need to be addressed and often the offenders you supervise who have significant mental health issues will be on some type of a subscription. Prescribed medication is very necessary for the offender to cope with the different challenges that they will face however, they can also have some strong or severe side effects. Psychotropic



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medication is any medication capable of affecting the mind, emotions, and behavior but it's important that this medication just as aspirin can reduce a fever without clearing up the infection that causes it, psychotherapeutic medications act by controlling symptoms. Like most drugs used in medicine, they correct or compensate for some malfunction in the body.

Psychotherapeutic medications do not cure mental illness, but they do lessen its burden. In many cases, these medications can help a person get on with life despite some continuing mental pain and difficulty coping with problems. For example, drugs like chlorpromazine can turn off the "voices" heard by some people with schizophrenia and help them to perceive reality more accurately. And antidepressants can lift the dark, heavy moods of depression. The degree of response ranging from little relief of symptoms to complete remission depends on a variety of factors related to the individual and the particular disorder being treated.

How long someone must take a psychotherapeutic medication depends on the disorder. Many depressed and anxious people may need medication for a single period perhaps for several months and then never have to take it again. For some conditions, such as schizophrenia or manic-depressive illness, medication may have to be taken indefinitely or, perhaps, intermittently.

Like any medication, psychotherapeutic medications do not produce the same effect in everyone. Some people may respond better to one medication than another. Some may need larger dosages than others do. Some experience annoying side effects, while others do not. Age, sex, body size, body chemistry, physical illnesses and their treatments, diet, and habits such as smoking, are some of the factors that can influence a medication's effect.

The four common categories of medication are as follows:

Antipsychotic medications

Antipsychotic medications, also called neuroleptics, are typically used to treat psychotic disorders, such as schizophrenia. A person who is psychotic is plagued by delusions and is unable to maintain a hold on reality.

Antipsychotic medications may also be used to treat severe cases of depression accompanied by psychosis. Antipsychotic medications include clozapine (Clozaril), olanzapine (Zyprexa) and many others. **Source:** <http://www.mayoclinic.com/>

Antidepressant medications

Antidepressants are used to treat various types of depression. Several types of antidepressants, grouped by how they affect brain chemistry, are



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available. Antidepressants can help improve such depression symptoms as sadness, hopelessness, lack of energy, difficulty concentrating and lack of interest in activities. Antidepressants are often used to treat illnesses besides depression, including nonpsychiatric conditions. Antidepressant medications include citalopram (Celexa), paroxetine (Paxil, Paxil CR) and many others.

Source: <http://www.mayoclinic.com/>

Anti-anxiety medications

Anti-anxiety medications, as their name suggests, are used to treat anxiety disorders, such as generalized anxiety disorder and panic disorder. They may also be useful in helping relieve agitation and insomnia. These medications are typically fast acting, helping relieve symptoms in as little as 30 minutes. A major drawback, however, is that they may cause dependency. Anti-anxiety medications include alprazolam (Xanax), lorazepam (Ativan) and many others. **Source:** <http://www.mayoclinic.com/>

Mood-stabilizing medications

Mood stabilizer is the colloquial name given to psychiatric medications that treat both manic and depressive symptoms. Mood stabilizers are most commonly used to treat bipolar disorder, which is characterized by alternating episodes of mania and depression. Mood stabilizers may also include anti-seizure medications. Mood-stabilizing medications include lithium (Eskalith, Lithobid), divalproex (Depakote) and many others. **Source:** <http://www.mayoclinic.com/>

Ask Participants: Why is it important that you know something about these medications?

Possible Response: The offenders will be taking them and it's important to know how they may act or how I should interact with these individuals.

In addition to knowing how the individual should act you also need to know if they are having an adverse reaction to their medication. Unfortunately, these medications have some undesirable side effects that can sometimes cause serious problems. Rather than just go through a laundry list of possible side effects I'm going to give you an opportunity to discuss not only the effects but how these side effects might impact your ability to supervise the offender.

GUIDED PRACTICE

Note to Trainer: Break participants into 4 groups. Assign each group a common category of medication and provide them with information on each.



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Instructions: Individually read the information about the common category of medication that your group has been assigned. In a group discuss and chart the symptoms of the mental illness that your medication would be prescribed for and the side effects that the medication could cause. Then discuss and note on the chart how these illness symptoms or medication side effects could affect you ability to supervise the offender and how you would work through this issue. You have 15 minutes to complete this activity at the end of which the spokesperson you select needs to present your notes.

Ask Participants: What did you discover about the information that you reviewed?

Possible Response: That many of the different medications have side effects that are similar but people are affected differently,

Ask Participants: How can you use this information at your worksite?

Possible Response: This will help me recognize signs, symptoms and side effects and will let me more accurately refer the offender to a mental health provider.

INSTRUCTIONAL INPUT

Brainstorm Activity

Note to Trainer: Ask the following question and chart the responses.

Ask Participants: Side effects maybe one of many reasons that offenders may not want to take psychotropic medications. What do you think the others might be?

Possible Responses:

- Stigma
- Lack of education regarding the medication
- Negative past experience with medications
- Denial: Person does not believe s/he is mentally ill
- Long term nature of treatment
- Lack of control over one's own body and mind
- Symptoms improve
- Mistrust psychiatry
- Feel that medications stifle creativity

While people may have many why they don't want to take psychotropic medication, the reality is that there is a greater adherence to taking



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psychotropic medication than for standard prescriptions for conditions such as diabetes, infections, and high blood pressure. When offenders complain about taking medication the complaint should be taken seriously and referred to medical and mental health providers. Often people are expressing intolerable emotional and/or physical pain associated with the medication.

Ask Participants: What if the offender refuses to take the medication?

Possible Responses: Document the refusal, including the offender's stated reason for the refusal. Notify medical staff and document any observed changes in behavior or appearance of the offender.

We mentioned symptoms and side effects earlier but what exactly should you look for? Some of the symptoms or side effects maybe difficult to detect, after all it's a little hard to observe that the offender has a dry mouth. All staff that interacts with the offenders regardless of their role in the agency can help monitor the offender. Staff may receive complaints from the offender or observe the following changes in behavior:

Note to Trainer: These are applicable to facility staff as well as field staff.

- Changes in eating habits
- Sleep patterns
- Physical appearance and hygiene
- Confusion
- Change in mood
- Unusual movements or stiffness
- Any physical complaint from the offender

Should you become aware of any of these behavioral changes document it and share it with mental health and medical staff. While this is critical you need to make certain exactly what you're reporting on because they may have more than one issue.

A person who has alcohol or drug problems and emotional/psychiatric problems is said to have co-occurring disorders. (*'Dual diagnosis' is an older term for 'co-occurring disorders'.*) To recover fully, the person needs treatment for both problems. Co-occurring disorders are more common than you might think. According to a report published by the Journal of the American Medical Association:

- Thirty-seven percent (37%) of alcohol abusers and fifty-three percent (53%) of drug abusers also have at least one serious mental illness.



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- Of all people diagnosed as mentally ill, twenty-nine percent (29%) currently abuse either alcohol or drugs and sixty percent (60%) will abuse either alcohol or other drugs sometime during their lifetime.

Ask Participants: What kind of mental or emotional problems are seen in people with co-occurring disorders?

Possible Response: The following psychiatric problems are commonly found in persons with co-occurring disorders:

- **Mood disorders**, such as depression and bipolar disorder.
- **Anxiety disorders**, including generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and phobias.
- **Other psychiatric disorders**, such as schizophrenia and personality disorders can also occur.

Don't be surprised if you aren't sure whether the offender's substance abuse problem or their mental health issue is their main problem. Even physicians at the initial examination, may find difficult to tell. Since many symptoms of substance abuse mimic or mask other psychiatric conditions, the person must go through withdrawal from alcohol and/or other drugs before the physician can accurately assess whether there is a psychiatric problem also.

So if a person does have both an alcohol/drug problem and an emotional problem, which should be treated first? Actually both problems should be treated simultaneously. For any substance abuser, however, the first step in treatment must be detoxification -- a period of time during which the body is allowed to cleanse itself of alcohol or drugs. Some persons with co-existing psychiatric problems will need mental health evaluation and treatment to get through detoxification. Treatment for a psychiatric problem depends upon the diagnosis. For most disorders, individual and group therapy as well as medications are recommended. Expressive therapies and education about the particular psychiatric condition are often useful adjuncts. A support group of other people who are recovering from the same condition may also prove highly beneficial.

The Role of Family and Friends

If the offender has a positive relationship with their family this relationship may assist the offender in recovery. Regardless of whether the treatment is for substance abuse or a psychiatric problem, education, counseling sessions, and support groups for the offender's family are important components of overall care. The greater the family understands of the problems, the greater the chances for a lasting recovery by the offender. A relative or friend of the offender can play an important role in encouraging a person to stay in treatment. The role of friends and family in the recovery of



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substance abuse or mental health problems can differ and your knowledge can help them support the offender.

Substance Abuse - If the offender has a substance abuse problem they need to learn to stop enabling. Enabling is acting in ways that essentially help or encourage the person to maintain their destructive behavior pattern. For instance, a woman whose husband routinely drinks too much might call in sick for him when he is too drunk to go to work. That's enabling. When family and friends participate in the recovery program, they learn how to stop enabling. If they act on what they've learned, the recovering substance abuser is less likely to relapse to drinking or taking drugs.

Psychiatric Condition – If an offender has a mental health issue the family should be calm and understanding, rather than frightened or critical. They should be warm and open, rather than cool or cautious. Although it is fine to ask the person matter-of-factly about psychiatric treatment, that shouldn't be the only focus of conversation.

The more you know about co-occurring disorders, the more you will see how substance abuse can go hand-in-hand with a psychiatric condition. As with any illness, a person with co-occurring disorders can improve once proper care is given but you have to make sure they make it to the correct person before this care can occur. To do this it will help if you can tell the difference between a substance abuse condition and a mental health condition and in the next exercise you're going to have an opportunity to do just that.

GUIDED PRACTICE

Note to Trainer: Break participants into 4 groups and provide each group one of the following profiles: Marijuana/depression; Crack /Manic; Meth/Anxiety; PCP/LSD/Schizophrenic

Part #1 - Instructions: Individually you need to read the profile of the offender that your group has been provided and then as a group you need to determine the following:

- What drugs or mental health issues are present?
- How do the drug/ mental health issue compare?
- Do they have a mental health issue, a substance abuse issue or both?
- What should you do?
- What if they have a clean UA? What do you do?

Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Co-occurring Disorders Activity



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Case Study #1

Instructions: Individually you need to read the profile of the offender that your group has been provided and answer the questions at the end of the case study. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Jack is 25 years old and was recently placed on probation for Receiving Stolen Property. Jack was scheduled for his first appointment but failed to report. He was contacted by phone and rescheduled. When Jack attended his first appointment, his supervising officer completed the assessment for his initial case summary. During the assessment, Jack admitted to past use of marijuana, but reported he had quit using several years ago. He relayed that he experimented with other controlled substances, but his drug of choice is marijuana.

During the course of his supervision Jack repeatedly missed appointments and struggled with finding employment. He was unable to maintain employment due to his constant problems with attendance. During the appointments that Jack did attend, he appeared to be notably depressed. When interviewed he would make comments such as, "It would better if I just was never born." And, "Who would miss me if I was gone anyway?" Jack denied any family history of mental illness.

Jack had provided one urine specimen which was positive for marijuana and was sent to treatment. Jack was unable to successfully complete treatment due to missing classes; however, his urine specimens were negative. Routine home visits were made and when they occurred afternoon Jack was often found sleeping. During conversations with Jack's mother, it was learned there is family history of mental illnesses, but she was unsure what if any mental illnesses were diagnosed.

- What drugs or mental health issues are present?
- How do the drug/mental health issue compare?
- Do they have a mental health issue, a substance abuse issue or both?
- What should you do?
- What if they have a clean UA? What do you do?

Answer Case Study #1:

- What drugs or mental health issues are present?
 - Depression and the use of marijuana.
- How do the drug/mental health issues compare?
 - Lack of motivation, loss of interest, inactivity
- Do they have mental health, substance abuse issues or both?
 - Both,
- What should you do?
 - Test for drugs
 - Refer to mental health evaluation
- What if UA is clean?



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- Refer to mental health evaluation

Co-occurring Disorders Activity

Case Study #2

Instructions: Individually you need to read the profile of the offender that your group has been provided and answer the questions at the end of the case study. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Johnie Mae is 45 years old and is currently on probation for Possession of a Controlled Substance. She was found in possession of Crack Cocaine in an area of Kansas City, which is also a known area of prostitution. Johnnie Mae has an extensive criminal history including arrests for: prostitution, littering, trespassing, property damage, simple assault, and alcohol related offenses.

When she was initially placed on probation, Johnie Mae was well groomed and was able to maintain stable employment. She was consistent with her appointments and her court obligations. Recently however, her appearance has begun to change and it appears that she is now neglecting her grooming as her appearance has become somewhat shoddy. She has become sporadic in her reporting, and was recently arrested for Prostitution.

Contact with her employer revealed she was terminated due to recent outbursts at work, and attendance problems. Her supervisors also reported she was having difficulty keeping on task. Contact with her family revealed they were unsure where she was going at night and she was sleeping very little. During her office visits, Johnie Mae would ramble and could not stay focused on the conversation.

- What drugs or mental health issues are present?
- How do the drug/mental health issue compare?
- Do they have a mental health issue, a substance abuse issue or both?
- What should you do?
- What if they have a clean UA? What do you do?

Answer Case Study #2:

- What drug or mental health issues are present?
 - Mania (bi-polar) cocaine use
- How do they compare?
 - Increased physical activity, not sleeping, mood swings, decreased physical appearance, lack of concentration
- Do they have mental health, substance abuse or both?
 - Both
- What should you do?
 - Refer to mental health evaluation



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- Urine screens
- What if the UA is clean?
 - Refer to mental health evaluation and treatment

Co-occurring Disorders Activity

Case Study #3

Instructions: Individually you need to read the profile of the offender that your group has been provided and answer the questions at the end of the case study. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Matt is 19 years old and was placed on probation for Tampering with a Motor Vehicle. During the offense he attempted to avoid arrest and was involved in a high speed chase with officers. During appointments with Matt, officers noticed that he appeared to be very “jumpy”. However, he denied the use of any controlled substances with the exception of marijuana and reported he does not consume alcohol.

During the course of his supervision Matt was able to obtain employment but has struggled with maintaining his employment. He reported it was do to stress at work and difficulty getting along with other people. Matt has a history of traffic violations for speeding, driving while revoked, and simple assault. Academic records also reflect that while in elementary school Matt was placed in special education but was not diagnosed with any specific behavioral problem. However, it was noted that Matt displayed difficulty with being in enclosed placed such as the class room, while in school. His academic history reflects a high school diploma and he had been attending college however, he recently dropped out.

Matt has had several recent visits to local hospitals as he suspected he was having a heart attack or a serious medical issue. He relayed having an accelerated heart rate, sweating, shortness of breath, chest pain, and a fear he was dying. Tests revealed no medical reason for the symptoms. During his supervision, Matt was contacted by police during a drug raid of a home in Independence, which was found to have a methamphetamine lab in the residence. Matt was not charged with the offense as he could not be connected with the lab. With the exception of his last urine specimen, all tests were negative.

- What drugs or mental health issues are present?
- How do the drug/mental health issue compare?
- Do they have a mental health issue, a substance abuse issue or both?
- What should you do?
- What if they have a clean UA? What do you do?

Answer Case Study #3:

- What drug or mental health issues are present?
 - Amphetamine and anxiety
- How do the drug mental health compare?
 - Increased activity, racing heart, shortness of breath, general



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"jumpiness"

- Do they have mental health, substance abuse or both?
 - Possible both, if drugs screens are positive
- What should you do?
 - Refer to mental health evaluation,
 - Drug testing
- What if they have clean UA?
 - Mental health evaluation.



Co-occurring Disorders Activity

Case Study #4

Instructions: Individually you need to read the profile of the offender that your group has been provided and answer the questions at the end of the case study. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Skip is a 23 year old male and was placed on probation for Burglary. During the course of his supervision, he has struggled with reporting, and has not maintained employment. Skip lives with his elderly grandmother, who has contacted his officer several times regarding Skip's behavior.

Skip has been known to become very agitated during his office visits and was recently arrested for assaulting another family member in their home. The family appears to be very concerned and is adamant that the attack was unprovoked. Further conversations with family members revealed that prior to the attack; Skip had become preoccupied with religion. He would lock himself in his room and make comments such as, "They are watching me," and "I know they are trying to trick me."

During office visits with Skip his speech would often be disorganized and what he would say would make little to no sense. During a recent office visit, Skip relayed a detailed account of a dog that talks to him. Skip has tested positive for cocaine, marijuana, PCP, and has provided positive breathalyzers. Tests usually indicate that Skip is positive for marijuana. When asked, Skip reports he smokes marijuana to help him sleep stating that "it reduces his thinking and helps relax him".

- What drugs or mental health issues are present?
- How do the drug/mental health issue compare?
- Do they have a mental health issue, a substance abuse issue or both?
- What should you do?
- What if they have a clean UA? What do you do?

Answer Case Study #4:

- What drug mental health issues are present?
 - Schizophrenia, PCP or hallucinogens
- How do the issues compare?

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- Loss of relativity, disorganization
- Do they have mental health issues, substance abuse or both?
 - Both if drug tests are positive
- What should you do?
 - Refer to mental health evaluation
- What if UA is clean?
 - Refer to mental health evaluation and treatment

Ask Participants: What did you learn from these case studies?

Possible Response: That symptoms often look alike and that you need to weigh all the clues of the offender's behavior before you make recommendations.

Now that you've had an opportunity to discuss the different types of mental health issues that some offenders face and compare the symptoms that may occur to the symptoms caused by certain substances I want to challenge you a bit more.

Part #2 - Instructions: Individually, read the profile of Offender Warren Peace. Once you have completed reading the profile I want you to work with your team to develop interview questions that you would have for Offender Peace. During the development of your questions you want to determine the following:

- What if any mental health issues are the offender currently struggling with?
- What if any substance abuse issues is the offender currently struggling with?
- What symptoms justify your concerns?
- What would you recommend for this offender?

Co-occurring Disorders Interview Activity

Part #2 - Instructions: Individually, read the profile of Offender Warren Peace. Once you have completed reading the profile I want you to work with your team to develop interview questions that you would have for Offender Peace. During the development of your questions you want to determine the following:

- What if any mental health issues are the offender currently struggling with?
- What if any substance abuse issues is the offender currently struggling with?
- What symptoms justify your concerns?
- What would you recommend for this offender?

Warren is one of three children born to his mother, Hope Ann Peace. Warren reported his father is Leo Tolstoy, but his aunt, Gabby Mouth, advised that Warren does not know his



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natural father. Warren was raised in foster homes due to his mother's numerous mental deficiencies. He remained in foster homes until his mother married her current husband, Willie Pray. Warren relayed to this officer that he has a very close relationship with his mother and step-father, but contact with his aunt revealed otherwise. According to Mrs. Mouth, her sister, Hope Ann Pray, only hears from her son when he needs financial help, is in jail or hospitalized.

The family most often sees Warren when he is sitting in the streets. None of the family members are willing to allow him a home plan, as he has a tendency to steal for drug money. The family has no knowledge of where Warren lives. Warren denied any juvenile arrests, but his aunt reported on-going juvenile contact. He was truant from school on a repeated basis, would often get in physical altercations at school, and was caught stealing. Warren did not complete high school, nor has he obtained his GED.

Warren has struggled with obtaining and maintaining full-time verifiable employment. Most recently he was working at a local car wash. However, he was terminated two weeks ago, due to sporadic attendance.

Warren has repeatedly denied any medical or mental health concerns. However, he did relay that as a teenager he had some "passing thoughts" of suicide. He expressed that at the time, he felt he just let everyone down. Warren's aunt relayed that Warren has a tendency to "stretch" the truth. She relayed Warren has a history of mental health hospitalizations. He has shown marked swings in his mood. He would go from happy to sad within a few hours. He has a history of religious preoccupation, and for a period of time believed he was Buddha.

She reported, Warren's mother is schizophrenic, and has been in and out of mental health hospitals Warren's whole life. Warren has a sister that suffers from Bi-Polar disorder, a brother who is autistic, and one sister who committed suicide. Warren described himself as a "peaceful" person. However, his criminal history reveals numerous arrests for simple assault, attempted assault, and destruction of property.

Mrs. Mouth reported a family history of violence, stating that Warren's grandfather was often physically abusive to her and her sister, Warren's mother. She also alleges that Warren was physically abused by his step-father, and verbally abused by his mother. Mrs. Mouth expressed that the family has suspected Warren was sexually abused, but Warren has denied this allegation.

According to Warren, he consumes alcohol, but his recent use has been a marked decline. He indicates that currently drinks socially once a week. He reported previously, he was drinking four to five times a week. Warren denied the use of any controlled substances yet Warren's criminal history indicated he has been arrested for possession of marijuana, possession of narcotics equipment, and littering.

1. What if any mental health issues are they dealing with?

- a. This answer is open to interpretation of officers, could be bi-polar, with psychotic features, could be schizophrenia, and needs to be diagnosed by mental health professional and NOT AN OFFICER.

2. What substance abuse issues?

- a. He is clearly consuming alcohol, substance abuse can only be determined through testing but he has used marijuana, narcotic



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equipment indicates there is some substance use going on and could be any drugs

3. What symptoms justify your concerns?

- a. Stealing from family for drugs, passing thoughts of suicide, marked mood swings, religious preoccupation, history of assaultive behavior, arrest for possession

4. What would you recommend for this officer?

- a. Needs a mental health evaluation, needs regular drug screening. Most likely will be diagnosed with a mental health issue and will need on-going mental health treatment including medication. If UAs are positive needs to be referred to treatment. Increase visits until mental health and substance abuse are under control.

Ask Participants: What challenges did you face during this activity and how does that equate to the offenders that you see on a regular basis?

Possible Response: Will vary but may include the challenge of identifying the correct decision regarding the issue of mental health and substance abuse and the recommendation.

Ask Participants: How can you apply what you've discovered in this section to your office?

Possible Response: Will vary.

Great job but in truth, it doesn't really matter if you have the correct diagnosis because diagnosing offender's physical or mental health issues isn't your responsibility. Does it help you in your job if you can identify symptoms or red flags that denote a substance abuse or mental health problem? Of course it does but you're not there to be a clinician. Your role is to help the offender succeed in their reentry into society and part of that success is to refer them should they require assistance. If you detect possible mental health symptoms or substance abuse problems, refer them in accordance with policy.

INSTRUCTIONAL INPUT

However, simply referring the offender doesn't satisfy your role in case management. Earlier I mentioned that case management should ensure that there is a continuity of care for the offender. To do this the following key functions of Case Management **must** be in place:



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- **Assessment:** A validated assessment is critical in determining the needs, risks and strengths.
- **Planning:** This could be a service plan, a home plan, a TAP, or a treatment plan but the important thing is that it is an individual plan of success developed for the offender.
- **Plan Implementation:** Execute the plan in a timely/accurate manner.
- **Service Coordination:** Linking the offender to the appropriate agencies and services.
- **Monitoring and Evaluation:** Adequacy and appropriateness of services over time.
- **Advocacy:** Ensure that the individual receives needed services, resources and entitlements.

Remember that while your role is to assist the offender you are also a representative of the MDOC and as such has a responsibility to ensure that the services provided the offenders are adequate. However, this isn't as easy as it sounds. To work with providers to address both substance abuse and mental health issues you need to ensure that a **Release of Information** has been signed. Without this **Release of Information** the mental health provider is legally bound to keep the information confidential.

Another important aspect is to **create a community partnership or "triad"** between you as a parole officer, the community mental health professional and the offender. This allows all to share information and work in harmony toward a unified goal. It also provides you with a clearer picture into the offender's needs, which among other things, will reduce your response time should some form of intervention be required.

Intervention may be required in a number of ways and while most will be nonviolent in nature there is always the chance that a violent situation could arise. This violence could be directed toward you or another authority figure, an immediate member of the offender's family or toward the offender themselves. This leads us to a discussion of violence, the mentally ill and recommendations of how to intervene.

Homicide/Suicide Intervention

As a probation and parole officer you're going to be faced with situations that are going to challenge all of your senses. One of these situations is dealing with an offender that is contemplating homicide or suicide. Violence is often mistakenly associated with mental illness but the reality is that approximately 90 percent of persons with current mental illness are not violent (*Source: NIMH Epidemiological Catchments Area Study*). Violent behavior of persons with mental illnesses represents only a minor contribution to all violent crimes. Research has shown that the vast majority of people who are violent **do not** suffer from mental illnesses.

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Recent research reported by the American Psychiatric Association suggests that a small subgroup of people with severe and persistent mental illness is at risk of becoming violent. However, with treatment and taking prescribed medication, these people are no more dangerous than the general population. In fact, a new study by researchers at North Carolina State University and Duke University has found that people with severe mental illness - schizophrenia, bipolar disorder or psychosis - are 2½ times more likely to be attacked, raped or mugged than the general population.

Recent studies have showed that alcohol and substance abuse far outweigh mental illness in contributing to violence. It has long been known that the strongest predictor of violence and criminal behavior is not major mental illness, but past history of violence and criminality. There is a lot of statistical information on violence and homicide rates but I want to focus on those statistics that relate to domestic situations because that will probably be the most common occurrence you encounter:

Note to Trainer: The chart reflects all types of homicide and not just those relating to domestic violence.

Homicide Facts

<i>National Homicide Statistics</i>			
Year	Population	Total Homicides	Rate per 100,000
2005	296,410,404	16,692	5.6
<i>Missouri Homicide Statistics</i>			
Year	Population	Total Homicides	Rate per 100,000
2005	5,800,310	402	6.9

Statistics Source: Uniformed Crime Report - FBI

- Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year to three million women who are physically abused by their husband or boyfriend per year. (*U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1998*)
- Intimate partner violence is primarily a crime against women. In 2001, women accounted for 85 percent of the victims of intimate partner violence (588,490 total) and men accounted for approximately 15 percent of the victims (103,220 total). (*Bureau of Justice Statistics Crime Data Brief, Intimate Partner Violence, 1993-2001, February 2003*)
- On average, more than three women are murdered by their husbands or boyfriends in this country every day. In 2000, 1,247 women were killed by an intimate partner. The same year, 440 men were killed by an intimate partner. (*Bureau of Justice Statistics Crime Data Brief, Intimate Partner Violence, 1993-2001, February 2003*)
- Ninety-four percent of the offenders in murder-suicides were male.
- Women are much more likely than men to be killed by an intimate partner. In 2000, intimate partner homicides accounted for 33.5 percent of the murders of women and less than four percent of the murders of men. (*Bureau of Justice Statistics Crime Data Brief, Intimate Partner Violence, 1993-2001, February 2003*)
- Seventy-four percent of all murder-suicides involved an intimate partner (spouse, common-law spouse, ex-spouse, or boyfriend/girlfriend). Of these, 96 percent were females killed by their intimate partners.



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- Pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause (*Horon, I., & Cheng, D., (2001). Enhanced Surveillance for Pregnancy-Associated Mortality - Maryland, 1993 - 1998. The Journal of the American Medical Association, 285, No. 11, March 21, 2001.*), and evidence exists that a significant proportion of all female homicide victims are killed by their intimate partners. (*Frye, V. (2001). Examining Homicide's Contribution to Pregnancy-Associated Deaths. The Journal of the American Medical Association, 285, No. 11, March 21, 2001*)
- Most murder-suicides with three or more victims involved a "family annihilator" -- a subcategory of intimate partner murder-suicide. Family annihilators are murderers who kill not only their wives/girlfriends and children, but often other family members as well, before killing themselves.
- Seventy-five percent of murder-suicides occurred in the home. (*Violence Policy Center (VPC), American Roulette: Murder-Suicide in the United States, April 2006.*)



With these facts known it prompts us to observe all the offenders on our caseload for signs of possible violence and not just those with mental health issues. However, signs of potential domestic violence may be easier to detect and may indicate a potential life endangerment.

Potential Life-Endangering Indicators

While all violence can lead to a potential life-threatening situation, signs of domestic abuse are something that should be specifically watched for. It is true that all abusers are dangerous, some are more likely to kill than others and some are more likely to kill at specific times. (Example: when a woman leaves an abusive relationship, she is more likely to be murdered by her abuser.)

Assessment is tricky, and never foolproof. Considering these factors may or may not reveal actual potential for homicidal assault. But the likelihood of a homicide is greater when these factors are present. The greater the number of indicators that the offender demonstrates or the greater the intensity of indicators, the greater the likelihood is of a life threatening attack. These indicators can come from many areas including:

Demographic Factors

- Age, violence peaks in late teens, early 20s, drops significantly after 50.
- Gender, males are more likely to hurt friends and strangers, females are more likely to hurt family.
- Residence, living in a high poverty area.

History

- Limited education, special education.
- Unstable employment.
- Unstable home plan

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- Family violence during childhood.
- Childhood physical abuse.
- Childhood neglect.
- Parental substance abuse and criminality, particularly among white persons.
- Maternal substance abuse, (males only).
- Father absent in early child hood.
- Male living with single father.
- Early parental loss.
- Juvenile delinquency.
- Prior violence.
- Has committed a variety of crimes.
- Males who have been a victim of male sexual abuse.

Clinical Factors

- **Presence of any major mental disorder with active symptoms is a modest predictor of risk.**
- **Recent psychiatric commitment.**
 - **Schizophrenia** MacArthur Violence Risk Assessment Study: 14.8% violence rate for schizophrenia within one year of discharge from acute care.
 - **Bipolar** MacArthur Violence Risk Assessment Study: 22% violence rate for bipolar within one year of discharge from acute care.
 - **Major Depression** MacArthur Violence Risk Assessment Study: 28% violence rate for depression within one year of discharge from acute care.

Substance Abuse.

- Major mental disorder with no substance abuse in first year post discharge from acute care 17%. (MacArthur Violence Risk Assessment Study)
- Major mental disorder with substance abuse in first year post discharge from acute care 31%. (MacArthur Violence Risk Assessment Study)
- Major mental disorder with substance abuse and a personality or adjustment problem in first year post discharge from acute care 43%. (MacArthur Violence Risk Assessment Study)

Personality Disorder

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Narcissistic Personality Disorder

Psychopathy



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- **Hare Psychopathy Checklist**

- For use by professionals.
- We should not attempt to diagnosis offenders as psychopaths, this is a very serious diagnosis to be done in a clinical setting only be trained professionals.
- Developed in the early '90s, this test was designed to identify the degree of psychopathic tendencies.
- MacArthur Study: 49.7% of those identified as “potentially psychotic” by this instrument were violent within one year of discharge from acute psychiatric care as compared with 21.9% of those labeled “non-psychotic”
- There are twenty traits measured by the Hare, as follows:
 - glib and superficial charm
 - grandiose (exaggeratedly high) estimation of self
 - need for stimulation
 - pathological lying
 - cunning and manipulative
 - lack of remorse or guilt
 - shallow affect (superficial emotional responsiveness)
 - callousness and lack of empathy
 - parasitic lifestyle
 - poor behavioral controls
 - sexual promiscuity
 - early behavior problems
 - lack of realistic long-term goals
 - impulsivity
 - irresponsibility
 - failure to accept responsibility for own actions
 - many short-term marital relationships
 - juvenile delinquency
 - revocation of conditional release
 - criminal versatility



Symptoms of Mental Illness in Measuring Risk

- *Auditory Hallucinations.* Most people do not act on command hallucinations, they ignore them or resist them. They are more at risk if they are in concert with a delusional belief that the voice is familiar to them, or if they believe there will be a negative income if they do not act on the command.
- *Delusions.* Persecutory delusions are the most likely to be acted upon. Also misidentification syndromes where the offender believes he is someone famous or powerful, or believes that someone close to him or her has been replaced by an imposter.
- Impulsivity
- Anger Control Problems

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- Sense of Hopelessness or Frustration
- Cognitive Deficits due to geriatric illness, low IQ, head injuries.

Additional Risk Factors

- Availability of victim
- Availability of weapons
- Familiarity with weapons
- Desensitization to violence
- Overly involved family support system affecting integration into community.
- Availability of drugs of abuse.

Note to Trainer: Risk factors are provided by Dr. Richard G. Scott PHD, head forensic examiner at St. Louis Psychiatric Rehabilitation Center in MO.

In addition to these factors there may also be other signs or “red flags” that could appear before actual violence and may serve as clues to potential violent acts.

Ask Participants: So what do you think these signs might be?

Note to Trainer: Chart the responses.

Possible Responses: The following signs often occur before actual violence and may serve as clues to potential violent acts:

1. Did he or she grow up in a violent family?
2. Does he or she tend to use force or violence to try to solve problems?
3. Does he or she have a quick temper?
4. Does he or she abuse alcohol or other drugs?
5. Does he or she have a past history of domestic violence?
6. Does he or she have “traditional” ideas about what a man should be and what a woman should be?
7. Does he or she indicate jealousy of their significant others relationships – not just with members of the opposite sex, but also with the same-sex friends or family members?
8. Does he or she expect their significant other to follow his orders or advice?
9. Does he or she go through extreme highs or lows, almost as though he or she is two different people?
10. When he or she becomes angry, does the significant other indicate that they fear their partner?
11. Does the offender make threats of homicide or suicide?
12. Does the offender fantasize about suicide or homicide?



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13. Does the offender feel he/she has “ownership” of their significant other?
14. Does the offender depend totally on their significant other to organize and sustain his/her life?
15. Has he/she isolated him/herself from the community?
16. Is the offender depressed or does he/she have a history of depression?
17. Has there been prior law enforcement involvement for domestic abuse?
18. Does the offender seem to act without regard to the legal or social consequences that previously constrained his/her violence?
19. Has the offender ever held their significant other, their children, or others hostage?
20. Does the offender have a history of setting fires or making threats of arson?

These signs are important to know and will assist you with intervention but a real key to intervention is pre-planning. Crisis Intervention begins with planning. Here are some pointers that may help you in the planning stage.

- First and foremost you need to carefully document all information the offender gives you. This not only gives you a record for possible legal issues that may arise but it will allow you to discover a pattern that may occur over time.
- You need to know who lives in the home with the offender and if they have been the victims of previous violence by the offender.
- Get emergency contact numbers for friends or relatives of the offender.
- Make sure all contact information is up to date in OP11. You don't want to be scrambling to find phone numbers in the midst of a crisis.
- Do a home visit early in the supervision process. It is critical that you know exactly where the offender lives if you need to direct emergency services to the offender's home. You need to know apartment numbers or special instructions needed to find the offender's home.
- Keep contact information for mental health providers up to date.
- Keep a current list of medications, dosing information, and dates of refill. This can be life saving information in the event of a suicide by overdose attempt.
- Lay the groundwork for intervention with the offender before the crisis occurs. Review any previous crises with the offender discussing what interventions occurred before, and what the outcomes were. Ask the offender what he would want you to do in a crisis. Assure the offender that you will act in his best interests during a crisis, even if that involves taking decisive action to ensure his safety.



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- Demonstrate your trustworthiness to the offender in small crisis to prepare for the big ones. Overreaction to minor crisis builds fear. The offender needs to know you will not go overboard if he shares manageable problems with you.
- Share the responsibility in planning, make sure treatment providers are actively assessing risk and keeping contact information up to date.

Remember, you're an important link in the intervention of a violent act and it's important that you are ready to respond. Don't ignore potentially dangerous situations just because you may not know what to do. Don't be afraid to ask for help from your peers, your case management team or your supervisor. Don't be afraid to call the police or ambulance. It's better to be "safe than sorry". Remember that you're a big part of the offender's support network.

One last very important thing to remember is to warn potential victims. If you come to the conclusion that someone is endanger by an offender on your caseload you need to let them know that they are in danger. I know that some of you are thinking; "Hey, what about confidentiality? What about the Health Insurance Portability and Accountability Act (HIPPA)?" Those are understandable questions and fortunately they have been answered by the courts who said that you have a duty to warn potential victims.

Duty to warn refers to the responsibility to breach confidentiality if a client or other identifiable person is in clear or imminent danger. In situations where there is clear evidence of danger to the client or other persons, the counselor must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm (Herlihy & Sheeley, 1988; Pate, 1992).

The court ruling applied this standard to counselors or mental health professionals whose position requires a higher expectation of confidentiality than does a parole officer.

Note to Trainer: The legal precedent of this concept was set in the case of *Tarasoff v. Regents of the University of California* (1976). In this case, according to Keith-Spiegel and Koocher (1985), a University of California student named Prosenjit Poddar was seeing a psychologist at the university's student health center because a young woman named Tatiana Tarasoff had spurned his affections. The psychologist, reasoning that Poddar was dangerous because of his pathological attachment to Tarasoff and because he intended to purchase a gun, notified the police both verbally and in writing. The police questioned Poddar and found him to be rational; they made Poddar promise to stay away from Tarasoff. Two months later, however, Poddar killed Tarasoff. When Tarasoff's parents attempted to sue the University of California, health center staff members, and the police, the courts dismissed the case.

Keith-Spiegel and Koocher (1985, p. 62), describe what happened next:
"The Tarasoff family appealed to the Supreme Court of California, asserting that the defendants had a duty to warn Ms. Tarasoff or her family of the danger and that they should



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have persisted to ensure [Poddar's] confinement. In a 1974 ruling, the court held that the mental health professionals indeed did have a duty to warn Ms. Tarasoff. When the defendants and several *amici curiae* [literally, "friends of the court," or entities who file a brief with the court even though they are not parties to the suit] petitioned for a rehearing, the court took the unusual step of granting one. In their second ruling (*Tarasoff*, 1976), the court released the police from liability without explanation and more broadly formulated the duty of mental health professionals, imposing a duty to use reasonable care to protect third parties against dangers posed by patients."

McWhinney, Haskins-Herkenham, and Hare (1992) note the effects of this case: "The case of *Tarasoff v. Regents of the University of California* (1976) imposed an affirmative duty on mental health professionals to warn a potential victim of intended harm by the client, stating that the right to confidentiality ends when the public peril begins. This legal decision sets an affirmative duty precedent in cases of harm to others that is generally accepted within the social work profession."

When you suspect that the offender has the potential to be violent to another person you need to collect as much information about the potential victim as possible, when someone talks about harming someone, ask them for their name and their relationship to them. Ask them for their name and phone number. Offenders are often very compliant in providing this information. Once you have the information, you need to act immediately to notify potential victim and intervene immediately with the offender. When warning the potential victims remember that while they do need to be appraised of the threat they don't need to know details of offender's probation and treatment.

Violence isn't always directed toward another person, sometimes it is turned inward in the form of suicide. Most people don't want to die but there are those who have lost the ability to cope and who have come to the conclusion that suicide maybe the only solution. Suicide is a long term process of the breakdown of the ability to cope with the stressors of life. If an offender can be helped through one attempt, approximately half will never try it again. That's pretty encouraging.

Ask Participants: So how great a danger is suicide, really?

Note to Trainer: Use some or all of the following facts to address the response to the question.

Suicide Facts

- An estimated 15% of persons who have been diagnosed with major depression die by suicide. Suicide risk is highest in depressed individuals who feel hopeless about the future, those who have just been discharged from the hospital, those who have a family history of suicide and those who have made a suicide attempt in the past. (*U.S. Department of Health and Human Services*)
- An estimated 20% of persons who have been diagnosed with bipolar disorder die by suicide. Hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals. (*U.S. Department of Health and Human Services*)



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- An estimated 15% of persons diagnosed with schizophrenia die by suicide. Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Between 75 and 95% of these individuals are male. (*U.S. Department of Health and Human Services*)
- Also at high risk are individuals who suffer from depression at the same time as another mental illness. Specifically, the presence of substance abuse, anxiety disorders, schizophrenia and bipolar disorder put those with depression at greater risk for suicide. (*U.S. Department of Health and Human Services*)
- People with personality disorders are approximately three times as likely to die by suicide as those without. Between 25 and 50% of these individuals also have a substance abuse disorder or major depressive disorder. (*U.S. Department of Health and Human Services*)
- People who die by suicide are frequently suffering from undiagnosed, under treated or untreated depression. (*U.S. Department of Health and Human Services*)
- Between 40 and 60% of those who die by suicide are intoxicated at the time of death. An estimated 18-66% of those who die by suicide have some alcohol in their blood at the time of death. (*U.S. Department of Health and Human Services*)
- For young people ages 15 to 24, suicide is the third leading cause of death. (*American Society for Suicide Prevention*)
- Suicide is fourth leading cause of death for adults between the ages of 18 and 65. (*American Society for Suicide Prevention*)
- More people die from suicide than homicide in the U.S. every year. (*American Society for Suicide Prevention*)
- Roughly 30,000 Americans commit suicide annually, while 500,000 attempt. (*American Society for Suicide Prevention*)
- Ninety percent of all people who die by suicide have a diagnosable psychiatric disorder at the time of their death. (*American Society for Suicide Prevention*)
- There are four male suicides for every female suicide, but twice as many females as males attempt suicide. (*American Society for Suicide Prevention*)
- Suicide took the lives of 32,439 people in 2004 (*This was the last complete statistical analysis - CDC 2004*).
- Missouri was ranked 22nd in suicide with 715 deaths or 12.4% per 100,000 populations. (*CDC 2004*)
- Suicide rates are generally higher than the national average in the western states and lower in the eastern and mid-western states (*CDC 1997*).
- An estimated 8 to 25 attempted suicides occur per every suicide death. Men and the elderly are more likely to have fatal attempts than are women and youth. In 2002, 132,353 individuals were hospitalized following suicide attempts; 116,639 were treated in emergency departments and released (*CDC 2004*).
- In 2001, 55% of suicides were committed with a firearm (*Anderson and Smith 2003*).
- Most suicide attempts are expressions of extreme distress and **not** harmless bids for attention, a myth that is often perpetuated. **A person who appears suicidal should not be left alone and needs immediate mental-health treatment.**
- Most popular press articles suggest a link between the winter holidays and suicides (*Annenberg Public Policy Center of the University of Pennsylvania 2003*). However, this claim is just a myth. In fact, suicide rates in the United States are lowest in the winter and highest in the spring (*CDC 1985, McCleary et al. 1991, Warren et al. 1983*).
- Suicide rates in jails over the last 10 years have been 69 per every 100,000 inmates with prison rates being lower at 14 per every 100,000 inmates. (*Bureau of Justice Statistics – August 21, 2005*)
- During the three-year period from 2000 through 2002, white jail inmates were six times more likely to commit suicide than black inmates and more than three times more likely than Hispanic inmates. The male suicide rate in local jails (50 per

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100,000 inmates) was more than 50 percent higher than that of female inmates (32 per 100,000). Violent offenders had a suicide rate (92 per 100,000) triple that of non-violent offenders (31 per 100,000). (*Bureau of Justice Statistics – August 2005*)

- Among all nonviolent offenders, only probation/parole violators had a suicide rate of at least 100 per 100,000 (118). (*U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report: Suicide and Homicide in State Prisons and Local Jails - August 2005, NCJ 210036*)

As with violence, suicide also has signs that it may occur and you're in a position to identify certain "**red flags**" that maybe in the offender's history, that they may exhibit or that you may discover through conversations with the offender's family, friends, or work associates. Rather than just giving you the answers I want your groups to talk about it and come up with a list in the next 5 minutes.

BRAINSTORM ACTIVITY

Instructions: In your groups discuss the following question: "What are some signs to look for of a Person of at Risk of Suicide?" Develop a list of possible "**red flags**", list them on your chart and be prepared to share them in 5 minutes.

Possible Responses:

- They may prepare for death by giving away prized possessions, making a will, or putting other affairs in order.
- They may withdraw from those around them.
- Change in Sleep Patterns - insomnia, often with early waking or oversleeping, nightmares.
- Change in Eating Habits - loss of appetite and weight, or overeating
- They may lose interest in prior activities or relationships.
- A sudden, intense lift in spirits may also be a danger signal, as it may indicate the person already feels a sense of relief knowing the problems will be ended.
- One or more diagnosable mental or including physical or sexual abuse substance abuse disorder
- Family history of mental or substance abuse disorder
- Family history of suicide including family, peers, or in news or fiction stories
- Family violence, including physical or sexual abuse
- Prior suicide attempt/attempts
- Exposure to the suicidal behavior of others, including family, peers, or in the news or fiction stories
- Recent suicide attempt by a friend/family member
- Recent Loss - through death, divorce, separation, broken relationship, loss of job, money, status, self-confidence, self-esteem, loss of

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- religious faith, loss of interest in friends, sex, hobbies, activities previously enjoyed
- Change in Personality - sad, withdrawn, irritable, anxious, tired, indecisive, or apathetic
- Change in Behavior - can't concentrate on school, work, routine tasks
- Diminished Sexual Interest- impotence, menstrual abnormalities (often missed periods).
- Fear of losing control- going crazy, harming self or others
- Low self esteem- feeling worthless, shame, overwhelming guilt, self-hatred, "everyone would be better off without me"
- No hope for the future - believing things will never get better; that nothing will ever change
- Suicidal impulses, statements, plans; favorite agitation, hyperactivity, restlessness or lethargy.
- Strong wish to die, preoccupation with death,
- Increased alcohol and/or other drug use
- Inability to tolerate frustration
- Inability or unwillingness to communicate
- Sexual promiscuity
- Neglecting personal appearance
- Theft &/or vandalism
- Depression
- Exaggerated &/or extended boredom
- Carelessness &/or accident prone
- Unusually long grief reaction
- Hostile behavior
- Family disruption, especially divorce
- Abrupt ending of a romance

REMEMBER: *The risk of suicide may be greatest as the depression lifts. They may now have the energy to commit the act.*

Note to Trainer: Other areas to consider when processing the brainstorm may be as follows:

- Gender, white males most often complete due to lethality of means.
- Mood disorders marked by anhedonia, mood cycling within an episode, depressive turmoil.
- Anxiety is a key factor, which is more important than depression, but often overlooked.
 - Short to moderate term anxiety, but not long-term anxiety, increases risk
 - Anxiety with alcohol is a predictor
- Panic attacks mixed with hopelessness are a very risky combination, suggesting that agitated and anxious individuals with few perceived options are at high risk
- Prior suicidal behavior – long term predictor
- Family history of suicide – long term predictor
- Hopelessness – long term predictor

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- Gun ownership, (of course this is prohibited while on supervision, but other people in the home may have firearms. It is useful to question the offender about prior ownership.)
- In persons with schizophrenia
 - Suicidal ideation occurs in up to 60-80%
 - Active suicidal behavior occurs in 20-42%
 - Completed suicides in 10-15% of offenders
 - Increasingly severe mood symptoms increase risk
 - Substantial increase in positive symptoms (relative to baseline) may increase risk
 - Younger age increases risk due (maybe due to increased frequency of attempts, dim view of future, poorer coping)
 - Recent traumatic stress
- Recent psychiatric discharge. The relative risk for suicide is 200 times greater among those recently released from psychiatric hospitalization.
- Early discharge from hospital or discharged against patient's wishes.

One thing that is important to note is that there is no typical suicidal personality and the reality is that when someone has truly made a decision to kill themselves, it is nearly impossible to stop them. You can only do what you are able to do and if the offender is intent upon ending their life, you can only do so much. You are **NOT** responsible for their behavior. Feeling responsible is a myth that some of us hold on to. If you witness some of the above signs, try to talk with the person and get them some help. That may sound simple but you need to know how you can help them.

Ask Participants: What type of things can you do to help them?

Possible Responses: Will vary.

How to Help a Suicidal Person

1. If someone threatens or makes statements referring to suicide, **TAKE THEM SERIOUSLY**. Many people have taken their lives when people thought their statements about suicide were "manipulative" or the person was being "melodramatic." Many people have died "accidentally." They may take some medication for example just to get others to hear them and feel they will be discovered and saved. Instead of calling attention to their needs, they in fact, died.
2. If the person is telling you either in person or over the phone that they ARE going to kill themselves, you call 911 **RIGHT NOW**. Law enforcement will come to the person's home or your office and take them to be evaluated by a mental health person. Even if you feel that they will not take their life, you go by what they are telling you. You need to call 911 immediately, regardless of where you are. If the suicidal person forbids you to call, is angry about it or upset, you call **ANYWAY**. If the person is calling from an unknown location and discusses suicide, try to find out where they are. You cannot send someone to them if you don't know where to find them.



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Maintaining confidence is always a concern, especially with the coming of HIPPA. Do you keep a suicidal threat confidential? NO! Suicidal discussion automatically ends confidentiality.

Intervention with the suicidal offender

Hopefully you've been able to determine that the offender needs help and have referred them before an incident occurs. However, if the warning signs have been missed, the first chance to intervene with a depressed, suicidal offender may come when the crisis is already peaking. The Parole Officer's task now is to keep the offender alive long enough to get appropriate follow-up care and this can be accomplished by applying some fundamental principles of crisis intervention.

When intervention is required

In the probation office

When an offender admits to thoughts of suicide in the office, you are at your greatest advantage. You are in a safe environment with immediate support. The offender may not have access to means of suicide while at your office. You can press the issue and use your authority most effectively here.

- Ask the offender not to leave.
- If they refuse, call the police, advise that person is suicidal, give car information and home address. Call family or friends to help.
- Use good communication skills, don't panic, you are in control.
- Don't be afraid to act decisively.
- Call an ambulance if needed.

When the offender is on the phone

When the offender is on the phone your most formidable task is collecting reliable information, you will need to quickly determine where the offender is and exactly what is happening. This can be difficult as the offender can withhold critical information, leaving you with little means to intervene.

- Don't hang up.
- Call another officer in to assist, you may need help.
- Make sure you know from where they are calling.
- Find out immediately if the suicide attempt has already begun.
- If the suicide attempt is underway, ask for the exact method. If cut, where and how badly. If overdose, what, how much and how long ago.
- Get help. Put another officer on the line while you call an ambulance.



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- If you call an ambulance, identify yourself as an authority and speak confidently. Seconds count in a suicide situation; don't worry about overstating the severity of the situation if you are unsure.
- Find out if there is anyone else in the home, find out who they are, where they are, and if they are aware of the suicide attempt.
- If there is someone at the offender's location who could assist, ask the offender to get their attention and seek their assistance.
- Talk to others in home if competent to assist. Have them remove lethal means if it can be done without risk. E.G. Taking away medications can be done with far less risk than taking a firearm.

In the field

Should you encounter an offender in the field who is actively suicidal or in the midst of a suicide attempt, you are at your most vulnerable. It is at this time that you should immediately seek emergency assistance in most situations.

- **Don't endanger yourself.**
- Be on guard against violence, highly agitated, suicidal people are at significantly higher risk to harm others. Suicidal individuals are often armed and may believe they will face no consequences of violent acts. You do not want to depend on the offender's moral sense as a protective factor with regard to your safety.
- If offender is hallucinating or delusional, exercise extreme caution. Reasoning may be of no help.
- Don't count on family support in a crisis. Family members may be ill or drug dependent, or may not understand offender's mental illness. Often family members buy into delusions or paranoia.
- Be quick to call for help. You are not on your home turf, call emergency services if you have any doubts about situation.

A person in crisis may not be aware that they are in need of help or be able to seek it on their own. They may also need to be reminded that effective treatment for depression is available, and that many people can very quickly begin to experience relief from depressive symptoms.

What do you say to someone who is Suicidal?

One of the most important things that we're going to do with someone who is contemplating suicide is talk to them. Our actions could determine what the person will do next. With that, we're going to discuss some do's and don'ts when dealing with suicidal individuals.

DO:



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- Be positive.
- Emphasize desirable alternatives.
- Make alternatives small.
- Get them to tell you how they feel
- Mention the family-if positive response is received, pursue this. If the response is negative, do not.
- Try to get them to call someone to whom they are close.

DON'T:

- Sound or act shocked at what is said.
- Say, "Do you know how your mother will feel if you kill yourself?"
- Apply the morality of suicide.
- Judge them
- Show anger toward them
- Provoke guilt
- Discount their feelings
- Tell them to "snap out of it"

Define the Problem. While some personal crises relate to a specific incident, many evolve cumulatively as the result of a number of overlapping stressors, until a "breaking point" is reached. In such cases, the offender himself may be unclear as to what exactly led to the present suicidal state. By helping the offender clarify what's plaguing him, non-lethal options and coping resources may be explored. It also shows that the Parole Officer is listening and trying to understand.

Note to Trainer: Trainer Role play – This can be completed by two trainers conducting the role play and processing each segment or the trainer can ask two participants to portray the officer and the offender, with the trainer processing in between segments.

Role play set up: You receive a phone call from an offender who was scheduled for an appointment. The offender is home and as he speaks to you it becomes obvious that the offender is on the edge. During the conversation he loses it...

Offender: My life is out of control. I don't see any way out.

Parole Officer: *What's out of control?*

O: Everything, man, everything. The job, my wife – it's all crap.

PO: *Can you give me an example? What about the job?*

O: The job sucks man. They work me like a slave and then they tell me there's no raises, overtime, or bonuses this year – that's after we already put the down payment on the new house. I knew we couldn't afford it but you seen the last house we lived in! I couldn't ask my family to live in the dump like that anymore.

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PO: *Is that related to the wife thing?*

O: Yeah, so she's all over me now because she's scared we'll lose the house. So it's nonstop fighting. And on top of that, I'm afraid that I'm going to go back to jail because of my last UA. I know I shouldn't have been smoking weed but everything is just piling up, you know? And on top of that now I've missed my appointment with you. I'm going back to jail for sure.

PO: *Let's not worry about the appointment with me right now. Just let me make sure I've got this all straight. So you got caught by surprise with the no-raise thing, plus you might have a dirty UA, and now all the family plans are backed up. And everybody's freaked.*

O: Yeah, that's about it.

Ensure Safety

Without seeming tricky or manipulative, the Parole Officer should encourage the offender to put even a few short steps between the idea of self-destruction and the action.

PO: *Is there anything in there with you that could hurt you?*

O: I got a butcher knife and yeah, that could hurt someone.

PO: *Any chance of you putting the knife away while we talk?*

O: So what, so you can all bust in here and drag me away to the nut house?

PO: *Actually, I just want to make sure you're safe. If you're gonna do something, then you're gonna do it; but for right now, how about laying the knife down on the table in front of you. That way, if you really want the knife, it's right there, but at least you'll give yourself a second to think about it.*

Provide Support

Remember that the purpose of crisis intervention is not to solve all of the offender's problems in this one encounter, but to instill just enough motivation for him or her to emerge from the danger zone. The Parole Officer should keep the conversation focused on resolving the present crisis, perhaps gently suggesting that the larger issues can be dealt with later – which subtly implies that there will indeed be a “later.” In the meantime, just “being there” with the offender helps reduce his sense of isolation.

PO: *When a lot of crap happens at once, it can seem like that's all there ever was, even if there was some good stuff tucked away in there.*

O: Good stuff, what good stuff?

PO: *Sometimes looking at things in a different way, trying things out you didn't do before, sometimes just staying away from certain people or situations, things like that. At least it may be worth a shot. But right now, all I'm saying is I hear where you're coming from, I hear a world of hurt, and I'm hoping you can get things together for yourself.*

O: I dunno, man, but hey, thanks anyway.



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Examine Alternatives

Often, subjects in crisis are so fixated on their pain and hopelessness that their cognitive tunnel vision prevents them from seeing any way out. The Parole Officer should gently expand the range of non-lethal options for resolving the crisis situation. Typically, this takes one of two forms: accessing practical supports and utilizing coping mechanisms.

Practical Supports - Are there any persons or groups that are immediately available to help the offender through the crisis until he or she can obtain follow-up care? The Parole Officer must always be mindful of the risks and liabilities of relying on these support people instead of professional responders, and should be prepared to make the call to commit the offender involuntarily if he truly represents a danger to himself.

O: I already told you, I'm not going to some damn hospital to be locked up and pumped full of drugs.

PO: *Okay, let's leave the hospital out of it. I know you told me about your problems with your job and your wife, but is there anyone you know out there who you trust, who could stand up for you and help you out?*

O: I dunno, maybe my brother Mike. We've been through a lot together, and we got to be really tight. He's a good guy, down to earth.

PO: *If Mike agreed to look after you for the rest of the weekend, till things cool off, would that be okay with you?*

O: I guess so.

Coping Mechanisms - These can consist of cognitive strategies, religious faith, distracting activities, accessing positive images and memories of family, or successful handling of crises in the past that show the offender that hope is at least possible.

PO: *You said something earlier about how you've had crap happen to you before. Can you give me an example?*

O: Well, about six years ago, I got fired from a job for stealing, but it was really some other guy who pinned it on me. Their investigation seemed pretty tight and my lawyer was no help and we ended up working out a deal but I still had to spending a couple of years in prison. Even though I wasn't guilty, I took the deal. I went to prison and ended up going to a trade school where I learned electrical work. I went to work as an apprentice electrician when I got out for the company I'm at now.

PO: *So you went from being busted to becoming an electrician. It was terrible to be falsely accused, but you handled it, and you made it come out the best way possible. When you put your mind to something, it seems, you're able to work it out.*

Make a Plan and Obtain Commitment



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Again, this involves a combination of practical supports and coping mechanisms, as well as both short- and longer-term plans.

PO: *Okay, I want to make sure we both have everything straight. First, you're gonna talk to Mike and get his help. You know if he says that everything is cool that it will be, right?*

O: Yeah, I've always been able to trust Mike.

PO: *Now let's talk about the other issues we have here. First there is a matter of the appointment that you missed. Since we've been talking today I can't see that you really missed anything, so I don't see this as a problem. The UA sample, the results haven't gotten back yet and even if it comes back hot it may not be that big of an issue. You don't have any drug arrests and if this is your first hot UA, it won't be that big of a deal. Now the last thing and that is the situation we having right now. We both know that you'll have to go to the hospital to be checked out, right?*

O: Yeah, I know. You really think that a hot UA won't be that big a deal?

PO: Well, we don't even know if it's hot yet and if it is I'm sure we can work something out but right now we need to make sure you're okay.

O: If I give up and go back to prison I'll still lose my house and probably my wife.

PO: You don't know that. You haven't done anything wrong other than admit that your under a lot of stress. You still have your job, your house and your wife. You haven't hurt anyone and your brother and I are going to help you through this.

O: Now I gotta see a shrink for the rest of my life?

PO: *Probably not. But you may need a few sessions just to straighten things out. Let's do this right, so that in a couple of months, it'll all be just a bad memory, okay?*

O: It's gonna be a long weekend, man.

PO: *Hey, I respect what you're doing; it's not easy. But you'll make it.*

If you have problems think about what your conversation should be about there are several questions that you can ask but to help you remember the correct ones think of the acronym "P.L.A.I.D. P.A.L.S."

Plan -- Do they have one?

Lethality -- Is it lethal? Can they die?

Availability -- Do they have the means to carry it out?

Illness -- Do they have a mental or physical illness?

Depression -- Chronic or specific incident(s)?

Previous attempts -- How many? How recent?



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Alone -- Are they alone? Do they have a support system? Partner? Are they alone right now?

Loss -- Have they suffered a loss? Death, job, relationship, self esteem?

Substance Abuse (or use) -- Drugs, alcohol, medicine? Current, chronic?

What if the person does not "qualify" for the above statements? Do you take them seriously? **YES! ALWAYS** take people seriously when suicide is discussed. If they truly want to die, they may not tell you the truth about their plan. If you feel the person is at risk of ending their life, even if they deny it, contact a health care provider or local law enforcement so that they can be evaluated.



Note to Trainer: According to the Missouri Revised Statutes - Chapter 632, Comprehensive Psychiatric Services, Section 632.305 - **Detention for evaluation and treatment, who may request--procedure --duration--disposition after application - Paragraph 3:** *A mental health coordinator may request a peace officer to take or a peace officer may take a person into custody for detention for evaluation and treatment for a period not to exceed ninety-six hours only when such mental health coordinator or peace officer has reasonable cause to believe that such person is suffering from a mental disorder and that the likelihood of serious harm by such person to himself or others is imminent unless such person is immediately taken into custody.* Upon arrival at the mental health facility, the peace officer or mental health coordinator who conveyed such person or caused him to be conveyed shall either present the application for detention for evaluation and treatment upon which the court has issued a finding of probable cause and the respondent was taken into custody or complete an application for initial detention for evaluation and treatment for a period not to exceed ninety-six hours which shall be based upon his own personal observations or investigations and shall contain the information required in subsection 1 of this section.

There is one more thing that I want to discuss concerning offenders and suicide and that's your safety. Unfortunately, some of those who have decided that suicide is a reasonable solution to their problem have chosen you to be the method of their death or have elected to take you with them. "Suicide by Cop" is a police colloquialism for a form of victim-precipitated homicide in which a suicidal individual engages in calculated, life-threatening and criminal behavior in order to compel the police to use deadly force. In these killings, the initiator is a direct, positive precipitator of his or her own death. "Suicide by Cop" is an act whereby a person presents a threat to a police officer in order to compel the officer or officers to use deadly force to stop that threat. The result is a suicide at the hands of a police officer.

Ask Participants: Why do you think that I mention "Suicide by Cop", how does that affect you?

Possible Response: Many P&P Officers are now armed and the offenders know this. They can manipulate the situation with you just as they would a police officer.

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Be careful that you aren't manipulated into allowing this to happen. However, you need to be prepared to protect yourself should this situation occur. Should the offender have a weapon first make sure you are safe and then you might consider talking them into putting it down.

Weapons - If you are in a situation where the offender has a weapon, do not try to get the weapon away from the offender. If at all possible, do not leave them alone, talk to them. You will find that offenders are usually very honest and willing to talk at this point. Remind them of the past times that they made it through successfully and focus on the things that are important.

Substance Abusers - This is an extremely dangerous situation. We must use all of our resourcefulness and skill in dealing with the individual who is under the influence of alcohol or drugs. If an offender under the influence of alcohol or drugs call and threatens suicide, get help immediately. Do not attempt to go to the offender and transport them. Try to keep them talking as long as possible and get as much information as you can. It is important to write down the information and have another officer contact the police with details, i.e., weapon information, any other persons in the home, substance abuse history of the offender. By keeping the offender engaged in conversation, you allow time for the police to arrive.

Imminent Harm - Again, remember that you will decide an offender's risk by "imminent harm". That means we assess the situation and decide what form of intervention is necessary. This applies whether the offender is on the telephone with you or in the office.

Post-Crisis Mental Health Intervention

When the acute crisis has passed, referral to a mental health professional is crucial for two reasons. **First**, the mental health professional will have to determine what treatment or other measures will be required. **Second**, specialized psychotherapeutic techniques may be applied, that involve a combination of emotional exploration, realistic confidence-building, and practical problem-solving approaches. Documentation will of course be required and even though we are accustomed to documenting all our activities with the offender, the need for careful documentation is magnified when intervening in a crisis situation with a mentally ill offender.

Documentation in a crisis situation

- Write down everything you do, everyone you notify.
- Note times. When dealing with duty to warn or suicide intervention, timing can be critical. We want to document the rapidity of our response by noting the time, particularly when we are notified of a situation requiring quick action.



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- Notify your superior in a crisis situation and document that notification.
- Follow policy and procedure with regard to incident reports and high profile notification if necessary.

If a crisis occurs that leads to an injury or death than a High Profile Event Notification (P7-1.19) should be completed as soon as possible or no more than 3 days past the original notification.

Documentation for civil commitment

- If you are to participate in a civil commitment, good documentation is vital.
- Document exactly what your offender says, using quotes if possible. Pay special attention to statements that indicate risk of harm to self or others.
- Demonstrate a pattern of behavior. If the present crisis is part of an ongoing pattern, not previous statements and behaviors with dates and times.
- Document behaviors that place your offender at risk. Things such as drug use, sexual promiscuity, risk taking, sleeplessness, agitation, anger, verbal disputes, delusional thinking, hallucinations, poor hygiene, or failure to care for self. Anything that may potentially demonstrate to the court that the offender is unable to care for themselves.

Okay we've covered a lot of information on suicide and homicide intervention and now I want to give you an opportunity to take this information and apply it to a situation.

GUIDED PRACTICE

Instructions: Individually you need to read the case study. Then as a group, answer the questions at the end. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Intervention Case Studies

Case Study #1

Instructions: Individually you need to read the case study that your group has been provided and answer the questions at the end. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Janet is Schizoaffective and has had multiple suicide attempts. She is also an anorexic and at one time she lost so much weight she nearly died, reaching 75 pounds. Janet is now about 105 pounds, extremely depressed, and has no will to live. Janet talks constantly about how much better off she would be if dead. When pressed she consistently denies any



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thought of suicide. Usually she indicates that she is not quite there yet. Janet always promises to tell you if it gets worse but says she wouldn't accept help.

About the only thing that matters to Janet is playing the guitar. One day Janet brings you a CD ROM which she says contains some of her music and that she wants you to have it. Recently she spoke proudly of some gifts she was able to give to her children. Janet's children are not in her custody and she has had little contact with them in the past.

Shortly thereafter you call Janet's home in response to a missed appointment. Clearly things are in crisis as Janet tells you that she is suicidal. Janet denies having started any suicide attempt but does tell you that she has all her medications ready and has started drinking in preparation. Janet tells you that she doesn't want any help and hangs up.

What do you do?

What provision should you have made to prepare for this?

How might you have predicted this?

What resources can you bring to bear?

Possible Responses:

What do you do?

- Call for emergency assistance, despite her claim that she does not want help, help is necessary.
- Give as much information as possible to the dispatcher regarding history of suicide attempts, possible means present in the home, any history of violence.
- Stay available. Stay by the phone to assist emergency services if they have any further questions for you.
- Document all actions, note times as well as date.
- Advise supervisor of the situation in case you need to respond to the home or to the hospital.
- Begin documenting specific statements made by client to support involuntary commitment if necessary.
- Prepare for quick follow up. Plan to see client at hospital if admitted. This is often the best time to make significant progress with the assistance of hospital staff.

What preparations should you have made to prepare for this?

- Keep address and emergency contact information current.
- Keep record of currently prescribed medicines in the event the client uses them for an overdose.
- Discuss thoughts of suicide and previous attempts before it becomes a problem again. Learn what client's preferred means was in previous attempt. Find out as much as you can about the circumstances surrounding previous decisions to attempt suicide.

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- Speak openly about these the subject of suicide, create an environment that builds trust in the client so that she will advise you if suicide is contemplated.

How might you have predicted this?

- In this case some significant gestures were made. Trying to give the PO something of personal significance, as well as the pride in giving gifts to her children. Look for things that are significant to the client, even if they are less so to you.
- Previous discussions indicating a move toward suicidal thinking.

What resources can you bring to bear?

- First and foremost emergency services. Client needs immediate intervention.
- Perhaps civil commitment through the probate court.
- Hospital resources. Hospital social work staff can assist with a range of issues prior to discharge.



Case Study #2

Instructions: Individually you need to read the case study that your group has been provided and answer the questions at the end. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

You are supervising a man named Chuck who suffers from severe depression. You are aware of two previous suicide attempts where Chuck took over twice the lethal dose of Phenobarbital, but survived. Chuck is compliant and drug free. Chuck has little family support and is constantly struggling to maintain housing. He had just moved in with an old friend. Chuck has spoken to you freely about his illness and sees you as a key person in his support.

One afternoon Chuck calls you, clearly crying and upset. When asked what is wrong he states that he is afraid he is in trouble. When you ask him why, he confides in you that his new roommate is a drug user. He begs you not to tell anyone as he doesn't want to get her into trouble. Chuck is terrified that her drug activity will lead to new legal problems for him. He is horrified by the thought of going to prison and has inferred that he might commit suicide rather than face incarceration.

You understand that Chuck's situation is not good, but his level of agitation seems much higher than warranted. You ask him if he is thinking of committing suicide. Chuck quietly says "Yes." You ask him if he has done anything yet. Chuck again quietly says, "Yes." When you ask him what he did he tells that you that he took an overdose of his medication. Chuck quickly adds, "Please don't call an ambulance, the police will come. There are drugs in the house."

What do you do?

What provision should you have made to prepare for this?

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How might you have predicted this?

What resources can you bring to bear?

Possible Responses:

What do you do?

- It will be necessary to disregard the client's request to not call for an ambulance.
- Having a client on the phone who is in the midst of an attempt presents further difficulties, there is the need to immediately call emergency services, but also the benefit of continued conversation with the client to gather important information, monitor condition, distract from further harmful action, and direct to assistance.
- In this situation, the help of another officer or supervisor would be extremely important. Attract someone's attention and indicate that you need assistance. Writing notes can be helpful.
- The person assisting you could call emergency services while you continue to collect information, or you could put the person assisting you on the line while you call for an ambulance.
- It is important to find out exactly what was used in the overdose, how much medication did the client take and when? What is going on with the client physically, are they vomiting, sleepy, or suffering no obvious effect?
- Attempt to calm and reassure the client about his concerns. Come up with a plan that addresses client's concerns, if possible.
- In this case, the PO advised the client to stay on the line with the PO until he heard the ambulance siren in front of the apartment building, then to step out and identify himself to emergency services. This defused the clients fear that the police may enter his home with paramedics and discover drugs belonging to his roommate.
- Remind client that the police usually respond on ambulance calls, reassure the client the police are there to help, not search their home.

What preparations should you have made to prepare for this?

- Keep address and emergency contact information current.
- Keep record of currently prescribed medicines current in the event the client uses them for an overdose.
- When working with potentially suicidal clients, it may be helpful to have a plan in place with co-workers, particularly those who sit nearby. Let them know that you may call upon them to talk to a client or to call an ambulance.



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- A regular field work partner can be invaluable. Even if they do not remember all your clients, the client will know them as the person who visits their home with you. This can go a long way towards setting the client at ease if you have to put another officer on the phone while you call an ambulance.
- Again, knowledge of circumstances of previous attempts is very important, the nature of the attempt, what led up to the attempt, and what intervention occurred.

How might you have predicted this?

- Suicide attempts are not always predictable.
- It is important to heighten scrutiny of clients with histories of suicide attempts anytime there is personal instability that may lead to suicidal ideations. In this case, unstable housing.

What resources can you bring to bear?

- First and foremost emergency services.
- Perhaps civil commitment through the probate court.
- Hospital resources. Hospital social work staff can assist with a range of issues prior to discharge. In this case it may be prudent to seek assistance with housing as the client has identified present housing as unsuitable.

Case Study #3

Instructions: Individually you need to read the case study that your group has been provided and answer the questions at the end. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Lee is a massive, kind hearted, docile man and has no major drug problems but does occasionally use Marijuana. The only problem is that when Lee, who suffers from Paranoid Schizophrenia, gets sick he becomes a loud, aggressive, menace. Lee is monstrous in size and capable of inflicting serious damage.

Lee is consumed with regret over what he perceives as a failed NFL career opportunity. He constantly tells you of his glory days as a lineman and how an injury robbed him of his chance to go pro. Lee tends to get sick around the beginning of football season. It is September and Lee is getting sick.

One day you get a call from his landlord. He tells you that Lee is up all hours of the night playing loud music. Two other tenants in the building have moved out due to Lee's behavior. One tenant was threatened by Lee when confronted about his behavior. The police have been to the apartment on multiple occasions. Lee will not answer the door. On one occasion the police went to the basement of the building and turned off the power to Lee's apartment. When he went to the basement to investigate, the police issued him a summons for Peace Disturbance. Clearly Lee is in crisis.

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Lee has a psychiatric case manager who is also aware of Lee's declining health and escalating behavior. Despite being ill, Lee is still reporting as directed. Lee shows up for his appointment and is clearly not doing well. He is not his usual polite, gentle, self; rather he is agitated, loud, and animated. When you ask Lee about his problems at the apartment he becomes angry, blaming the other residents and the landlord. Lee states "Come on man, you know the Steelers are coming into town and I have to get ready to party with them." Lee continues to rant about his problems with the landlord and other tenants, as his tirade intensifies he tells you "some blood is about to be spilled." When asked what he means by that statement, Lee makes no specific threats. Lee minimizes the comment and says he is not going to hurt anyone.

What do you do?

What provision should you have made to prepare for this?

How might you have predicted this?

What resources can you bring to bear?

Possible Responses:

What do you do?

- This situation presents a different challenge in that the client in crisis is sitting in front of you.
- First, extra caution should be taken as client is clearly agitated and perhaps actively psychotic. Remain calm. Mentally review your own safety plan. What will you do if client becomes aggressive with you?
- Attempt to calmly communicate with client. He has indicated that "some blood will be spilled", but has made no direct threat. It is very important to determine if client is focused on a particular problem or individual. Is this a genuine threat, or just venting?
- Ask questions. Ask him what he means by that statement. Ask if someone is threatening him or if he is concerned for his own safety. A great deal of fear accompanies Paranoid Schizophrenia. When someone is actively psychotic they may be perceiving threats that do not exist. Statements such as the one made by this client may indicate an underlying delusional belief of threat or danger. Proceed carefully but openly. It is important to determine if someone is in danger. Ask if there is someone specific that the client is in conflict with or wishing to harm.
- If a potential victim is named, record this information. Ask the client for full, legal name, phone number, and address. Determine the nature of the client's relationship with the potential victim. Ask if there has been previous violence in this relationship. Ask the client if he has a specific plan to harm this person. Be specific as to how, when, and where. Ask if anyone else is aware of this plan or if anyone has been enlisted to execute the plan.



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- Keep very careful notes. Record exact words of client in quotation marks. All of these statements may be useful if an involuntary commitment is sought.
- Call for help. In this case the client has a case manager. If the case manager did not accompany the client to the visit, call them in if possible. If they will arrive quickly, wait to question client until they arrive. Any statements made by the client may be useful for involuntary commitment and are best made in the presence of more than one reporter. If transportation is needed, the case manager has the ability to assist.
- In this case, immediate action is called for. It is most likely that the client's psychiatrist will assist in hospitalization. Perhaps an emergency appointment could be made and the doctor could do a direct admit to the hospital if the client will accept a voluntary admission. If the client will not be voluntarily admitted, an involuntary commitment by the probate court may be sought. It is usually best to win the client's compliance and go the route of voluntary commitment. If the client will sign himself in, and while at the hospital decides he wants to leave, the burden of involuntary commitment is shifted to the hospital staff, who are at greater advantage in getting an involuntary commitment.
- In this case, if the case manager transports the client to the hospital, the PO should follow behind. It may be necessary for you to be on site to direct client to comply with reasonable interventions. It is also advantageous to fill out an affidavit in the emergency room if involuntary commitment is pursued by the hospital. If you do decide to go to the ER, stay until the client is cleared from the emergency room if possible. Once the client is in a locked psychiatric ward, it will be much more difficult for them to leave.
- If client reluctantly agrees to hospitalization, consider given a written directive to remain until released. This can be worded, "Do not leave hospital against medical advice." In extreme cases where the client or community is at risk, this will give you the ability to issue a warrant if the client leaves the hospital.
- Use emergency services if warranted. It is not unreasonable to call an ambulance to the office if a client is in crisis and will not resist efforts to admit him to the hospital.

What preparations should you have made to prepare for this?

- In this case, there was a predictable cycle to the client's illness, giving the PO some advanced notice of possible instability.
- A good relationship with the case manager should have been developed prior to the crisis. Actively involving case managers in office visits and planning is very helpful. In the case of clients with a

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high likelihood of instability, advance emergency planning can also be helpful.

How might you have predicted this?

- Good knowledge of a client's psychiatric history can sometimes give clues about when to monitor more carefully. In this case it was unusually clear, the beginning of football season.
- Early reports from the client's landlord gave a clear indication that something was going seriously wrong. In supervising the mentally ill, minor law violations, such as noise ordinances need to be looked at especially carefully.

What resources can you bring to bear?

- The case manager is key in this case, as they have intimate knowledge of client and a working relationship with the psychiatrist.
- Hospital staff is an invaluable resource if involuntary commitment proceedings need to be initiated. Also in discharge planning. In this case it is likely the client may not be able to return to his apartment.
- Perhaps a residential facility placement is warranted in this case. If the client has demonstrated a consistent inability to maintain his own apartment due to a poorly managed mental illness, he may need a period of assisted living. The case manager and hospital are good resources in finding a suitable residential facility.
- The probate court may become involved if the client does not want to cooperate with intervention.



Case Study #4

Instructions: Individually you need to read the case study that your group has been provided and answer the questions at the end. Chart your answers. You have 15 minutes to complete this activity at the end of which your spokesperson will report out.

Antwon is a very ill man, suffering from Paranoid Schizophrenia with severe delusions and auditory hallucinations. Even though he is compliant with his medications, he does not experience full remission of his symptoms. Antwon is noticeably slow in speech and thought due to a developmental disability, as well as the effects of the high dosage of medications he takes. He always reports with his psychiatric case manager and has repeatedly remarked that he has difficulty riding the bus.

You are about to conclude an office visit with Antwon and his case manager. Nothing remarkable has happened during this visit. You have discussed compliance with psychiatric treatment and medications as well as addressed ongoing marijuana use. As you are about to conclude, you routinely ask, "Are you having any thoughts of harming yourself or others?" Surprisingly, Antwon responds, "Yeah." To which you respond, "Which?" "Which what?" Antwon replies, "Are you thinking of harming yourself, or someone else?" Antwon answers, "Someone else."

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You assess the situation; Antwon is calm and matter of fact. Hoping it is not you, you ask, "Who are you thinking of harming?" Antwon tells you a man's name. You ask Antwon why he wants to harm this man. The usually quiet Antwon, for the first time, becomes agitated and tells you a long story about trying to get his car repaired.

When the transmission on his car broke, a man he offered to fix his transmission but it wasn't fixed right. The car is now in the man's yard and man won't let him take it because he owes him \$300. Antwon thinks the man knew all along that the car wouldn't be fixed right and he did it to steal his car, and no one will help him, and he has no money..... When Antwon pauses for a moment, you ask him what he is thinking of doing. Antwon looks you straight in the eye and says "Killing him."

What do you do?

What provision should you have made to prepare for this?

How might you have predicted this?

What resources can you bring to bear?

Possible Responses:

What do you do?

- Mentally review your own safety plan. Assess the current situation in your office; is help nearby if you need it? This case manager is sitting next to the client; does he seem prepared to deal with this situation?
- Bring your supervisor into this situation as early as practical.
- Calm the client if you can. Assure him he has done the right thing in sharing his thoughts with you. Assure him you are going to act in a way that will help him.
- Collect as much information as you can about the potential victim. Get name, address and phone number if possible. Get work information as well. Determine client's relationship to victim. Does client have a firm plan to harm the victim? If so, when, where and how will this take place. Has the client collected the means to harm if a weapon is involved? If so, where is that weapon now? Does anyone else know about this plan, or has anyone else been enlisted to carry out this plan? If so, who are they and how can they be contacted?
- You or your supervisor should notify the victim of the threat. Do not communicate confidential information. The potential victim does not have the right to know about compliance with medications, drug use, arrests, or performance on supervision. Despite the presence of a threat, your client still has the right to have his privacy protected. Verify contact information with victim. Get additional phone numbers and emergency contact information should further warnings be needed. Consider resources that can be made available to the victim, such as NAMI. Give potential victim the number to the Probation and



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Parole Command Center. Advise potential victim to seek an order of protection.

- Find out if the potential victim has received and threats or unwanted contact with the client. If so, this can be a pivotal part of the involuntary commitment process. Find out if the potential victim has reported any threats or contact to the police.
- Document everything. Record exact quotes for possible involuntary commitment. Note action taken and time action was taken. Document contact with potential victim, note exactly what was communicated.
- Seek hospitalization. Work with case manager in obtaining a direct admission with the client's psychiatrist. Be prepared to go to the hospital with the client, following the case manager or ambulance. Submit an affidavit in the emergency room. Stay until the client is admitted.
- Use your power by issuing directives requiring the client to accept any medical help offered. Require client not to leave against medical advice.
- If client leaves the ER in against medical advice and in violation of your directive, follow up with additional call to the potential victim. Consider issuing your warrant in consultation with your supervisor.

What preparations should you have made to prepare for this?

- Establish a good working relationship with the case manager.
- If possible, have an emergency plan in place with the case manager.
- Make sure you have a clear plan in place to deal with potentially dangerous clients. Share this plan with your supervisor and those seated near you, advise them how they may assist you in such situations. At minimum you should have someone who would be willing to wait outside for an ambulance to guide paramedics to your area should the need arise.

How might you have predicted this?

- Some situations are completely unpredictable. This highlights the necessity of being aware of available interventions when the situation presents occurs.

What resources can you bring to bear?

- Case managers can be our strongest ally when a client is in crisis. The PO can also be of great assistance in helping the case manager meet his objectives as will.
- In crisis, the quickest and least painful means of getting help is with the assistance of the client's psychiatrist. If the client will cooperate

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with a direct admission, the instability can be addressed with a minimum of trauma and without the need of involving the court in an involuntary commitment.

- Emergency services may be called for in this case. The homicidal client may not be safe for a case manager to transport, even with you following behind. This may be a case where transport by ambulance is the best option.
- Once hospitalized, the PO can make great progress by visiting the client while admitted and working with the hospital staff and case manager to insure discharge to a stable environment.
- A residential facility may be called for. Any client manifesting homicidal ideations that are clear and credible, may need the constant monitoring that a residential facility can help provide. If the threat against the victim is serious and difficult to treat, a placement outside of the region may be called for. Accessing a residential facility elsewhere in the state is a powerful intervention.

Ask Participants: What did you learn from this activity?

Possible Response: That I need to prepare for these events prior to their occurrence; that there are red flags to watch for and that I need to respond to these flags and not wait until after the fact.

Ask Participants: How can you apply what you've learned to your office?

Possible Response: I can make create a list of red flags to watch for and review them periodically; I can create a list of resources that I can contact in case of an immediate need.

During this block of content we've touched on areas where you should think about your personal safety but now I want to expand on this subject and focus it on your personal safety when interacting with the mentally ill.

INSTRUCTIONAL INPUT

Before we discuss the issue of violence and the mentally ill, I reiterate that; *"Most people who are violent are not mentally ill, and most people who are mentally ill are not violent."* With this being said we need to explore the possibility that you will be faced with violent situation and discuss your possible options.

As you already know you always want to be observant when working with offenders but the possibility of a situation that poses a danger to your personal safety can increase if the offender is emotionally unstable.

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Note to Trainer: For example: “A person with a history of mental disorders threatened a U.S. probation officer with a loaded weapon in the Western District of Kentucky’s Owensboro office. The officer was able to press a panic button, which alerted the court security officer. The security officer, responding to the duress alarm, saw the probation officer being held at gunpoint by the offender. In the resulting struggle, the probation officer and the court security officer subdued the offender and took possession of the weapon. A shot was fired during the struggle, but no one was injured. Although the probation officer was authorized to carry a weapon, he had left it home that day because he planned to be in the office, where, like most officers, he thought he was safe.”



There is a tremendous amount of material on providing for your safety and I'm sure that you've heard most of it so I'm not going to waste your time on telling you about things that you already know. What I am going to do is give you an opportunity to share your experiences and how you have handled situations where you thought your safety may have been endangered. I also want to cover some key areas to watch. When you meet with an offender remember that safety should always be first. When dealing with any individual, you need to look at the following areas: The hands, the waist and the eyes.

Ask Participants: Why?

Desired Response: **Hands** are where a weapon will be held. Hands can offer information about a person's general anxiety level. Fist clenching, hand wringing, or nervous tapping of the fingers reveal clues about a person's mood. The **waist** is where a weapon may be carried. The **eyes** may indicate intention such as with a "target glance." A target glance occurs when an attacker looks at what he or she is going to strike or grab before doing so. Eyes may also indicate if a person is looking for witnesses or an escape route. Eyes may offer information about a person's mood and emotional state.

Approaching a mentally ill person requires more care than approaching a non-threatening person. If you encounter someone you suspect is suffering from a mental illness, remember to do the following:

- Offer more personal space, keeping a distance of 6 to 12 feet between you and the agitated or aggressive person.
- Call for assistance. Better yet work with another officer as a team. Have the officer remain off to the side and offer assistance when necessary. Be sure to designate a team leader who will be the one to talk to the mentally ill person.
- Use a soft approach.

The two major mistakes that occur with the mentally ill are moving too quickly and being too authoritative. Remember that a softer approach with the

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mentally ill is best. To use a “soft approach” you need to first and foremost remain calm, making sure that you do not over-react. You need to be aware of the rate, tone and volume of your speech and avoid confusing statements. Use short, clear phrases and repeat them as necessary. Regardless of the individuals mental status you need to treat the individuals with respect, addressing them as “Sir” or “Ma’am”.

When you’re interacting with the individuals you need to ease them into situations, always explain what is happening. If the person needs to be touched, notify him or her of this intent before it occurs. If the person must accompany you to another area or ride in a vehicle, advise the person of what needs to happen. **Don’t surprise them.** Reinforce and repeat that you are present to help, not harm the person. Be patient. Slow down and ask simple, open-ended questions. Remember all the training you’ve had in communication skills and safety training. Be prepared.

Many of the offenders feel like they are under a tremendous amount of pressure to perform and unexpected or aggressive actions simply agitate the situation, increasing everyone’s stress level. Stress for the offender and stress for you. Manifestations of stress are numerous and varied but they generally fall into four categories (this is only a partial list of most common symptoms):

- **Physical:** fatigue, headache, insomnia, muscle aches/stiffness (especially neck, shoulders and low back), heart palpitations, chest pains, abdominal cramps, nausea, trembling, cold extremities, flushing or sweating and frequent colds.
- **Mental:** decrease in concentration and memory, indecisiveness, mind racing or going blank, confusion, loss of sense of humor.
- **Emotional:** anxiety, nervousness, depression, anger, frustration, worry, fear, irritability, impatience, short temper.
- **Behavioral:** pacing, fidgeting, nervous habits (nail-biting, foot-tapping), increased eating, smoking, drinking, crying, yelling, swearing, blaming and even throwing things or hitting.

Offenders with mental health issues may have a combination of several if these symptoms and pressuring the offender during an interview will only increase their instability. Stress can be a big factor in how they react and actually this is true for all people. Stress added to any situation can make it more problematic and if you don’t know how to deal with stress it can continue to affect you long after the incident that perpetuated it. There are a several things that you can do to help in dealing with stress but first let’s address the offenders stress level. If you think the offender is going through a high stress situation pass your concerns along to the mental health care professional so that they can address the issue. This ensures that the individual receives the appropriate directives that are parallel with their



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mental health treatment.

Regardless of who you are the more stress free you are the better you are going to be at your job. Did you realize that stress is the most common cause of ill health in our society, probably underlying as many as 70% of all visits to family doctors? It's no wonder that offenders who have mental health issues are stressed but remember that you're in a stressful position and need to reduce pressure too.

Ask Participants: So how can you decrease your stress level?

Possible Responses: Attend stress training, reduce your work load, exercise, eat better, quit my job, etc...

There are many ways to reduce stress from going for a walk to quitting your job. However, here are 10 practical strategies that range from simple and can be implemented quickly to others which are a bit more involved. All are feasible and beneficial. These will work for you, for your family and friends and for the offenders you supervise.

Note to Trainer: The following was based on information from Dr. David B. Posen Lifestyle Counselor and Psychomental health professional, and Author of "Always Change a Losing Game" Oakville, Ontario. Presented at Tri-University Winter Medical Symposium St. Petersburg, Florida March 11,1995.

1. Decrease or Discontinue Caffeine

In terms of "bang for the buck," it is hard to beat this simple intervention. Most people do not realize that caffeine (coffee, tea, chocolate and cola) is a drug, a strong stimulant that actually generates a stress reaction in the body. The best way to observe the effect of caffeine is to get it out of the system long enough to see if there is a difference in how you feel. After 3 weeks you should feel more relaxed, less jittery or nervous, sleep better, have more energy (a paradox, since you are removing a stimulant), less heartburn and fewer muscle aches. Many people feel dramatically better and cannot believe the difference.

2. Regular Exercise

As a way of draining off stress energy, nothing beats aerobic exercise. To understand why, we need to review what stress is. People often think of stress as pressure at work, a demanding boss, a sick child or rush-hour traffic. All these may be triggers but stress is actually the body's reaction to factors such as these. Stress is the fight-or-flight response in the body, mediated by adrenaline and other stress hormones, and comprised of such physiologic changes as increased heart rate and blood pressure, faster



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breathing, muscle tension, dilated pupils, dry mouth and increased blood sugar. In other words, stress is the state of increased arousal necessary for an organism to defend itself at a time of danger.

The stress reaction is in us, not "out there." It provides us with the strength and energy to either fight or run away from danger and is therefore self-protective. There is only one problem: unlike a caveman being attacked by a wild animal or warring tribesman, fighting and running away are rarely appropriate responses to stressful situations in the modern world. The result is that our bodies go into a state of high energy but there is usually no place for that energy to go; therefore, our bodies can stay in a state of arousal for hours at a time.

Exercise is the most logical way to dissipate this excess energy. It is what our bodies are trying to do when we pace around or tap our legs and fingers. It is much better to channel it into a more complete form of exercise like a brisk walk, a run, a bike ride or a game of basketball. During times of high stress, we could benefit from an immediate physical outlet - but this often is not possible. However, regular exercise can drain off ongoing stress and keep things under control. Recommendations for physical activity vary from every day or two to at the very least, exercising three times per week for a minimum of 30 minutes each time. Aerobic activities like walking, jogging, swimming, bicycling, racquet sports, skiing, aerobics classes and dancing are suitable. Choose things you like or they will feel like a chore and you will begin to avoid them. It is also beneficial to have a variety of exercise outlets. For chronic or acute stress, exercise is an essential ingredient in any stress reduction program.

3. Relaxation/Meditation

Another way to reduce stress in the body is through certain disciplines which fall under the heading of relaxation techniques. Just as we are all capable of mounting and sustaining a stress reaction, we have also inherited the ability to put our bodies into a state of deep relaxation which Dr. Herbert Benson of Harvard University has named "the relaxation response." In this state, all the physiologic events in the stress reaction are reversed: pulse slows, blood pressure falls, breathing slows and muscles relax.

Where the stress reaction is automatic, however, the relaxation response needs to be brought forth by intention. Fortunately, there are many ways of doing this. Sitting quietly by a lake or fireplace, gently petting the family cat, lying on a hammock and other restful activities can generate this state. There also are specific skills that can be learned which are efficient and beneficial. A state of deep relaxation achieved through meditation or self-hypnosis is actually more physiologically restful than sleep. These techniques are best learned through formal training courses which are taught in a variety of



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places. Books and relaxation tapes can be used when courses are not available. On days when exercise is not possible, relaxation techniques are an excellent way to bring down the body's stress level. Whereas exercise dissipates stress energy, relaxation techniques neutralize it, producing a calming effect. As little as 20 minutes once or twice per day confers significant benefit.

4. Sleep

As mundane as it sounds, sleep is an important way of reducing stress. The chronically stressed almost all suffer from fatigue (in some cases resulting from stress-induced insomnia), and people who are tired do not cope well with stressful situations. These dynamics can create a vicious cycle. When distressed people get more sleep, they feel better and are more resilient and adaptable in dealing with day-to-day events. Most people know what their usual sleep requirement is (the range is five to 10 hours per night; the average being seven to eight), but a surprisingly large percentage of the population is chronically sleep deprived. To determine if you are getting enough sleep you should go to bed 30 to 60 minutes earlier and monitor the results for a few days or a week. If you are still tired, consider a suggested bedtime of 30 minutes earlier than this. Eventually, you'll find what works for you. The three criteria of success are waking refreshed, good daytime energy and waking naturally before the alarm goes off in the morning.

Sleeping-in is fine but if you sleep too long, it throws off your body rhythms during the following day. It is better to go to bed earlier. Daytime naps are an interesting phenomenon. They can be valuable if they are short and timed properly (i.e., not in the evening). The "power nap" or catnap is a short sleep (five to 20 minutes) that can be rejuvenating. A nap lasting more than 30 minutes can make you feel groggy. People with insomnia should be discouraged from daytime naps. Beyond these cautionary notes, sleep can be the key in reducing stress and helping you cope and function better.

5. Time-outs and Leisure

No one would expect a hockey player to play an entire game without taking breaks. Surprisingly though, many otherwise rational people think nothing of working from dawn to dusk without taking intermissions, and then wonder why they become distressed. The two major issues are **pacing** and **work/leisure balance**.

Pacing has two components:

- monitoring your stress and energy level, and
- then pace yourself accordingly.



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It is about awareness and vigilance; knowing when to extend yourself and when to ease up. It is also about acting on the information your body gives you. Increased stress produces increased performance, initially. Once you pass a certain point (the hump), any more stress results in decreased performance. Trying harder at this point is unproductive or even counterproductive. The only sensible move is to take a break. We need a certain amount of stress to function well (healthy tension) - this is called "eustress" (good stress). However, stress becomes harmful (distress) when there is too much, when it lasts too long or when it occurs too often. One of the first symptoms of distress is fatigue, which we tend to ignore.

The other key to pacing is taking periodic time-outs. Too many people go far too long without breaks. **The 20-Minute Break**, written by Dr. Ernest L. Rossian, praises the virtues of a short recess every couple of hours throughout the day. Just as we all have cycles of deep sleep and dream sleep throughout the night (at roughly 90 to 120-minute intervals), we also have cycles through the day (peaks of energy and concentration interspersed with troughs of low energy and inefficiency). These cycles are called "*ultradian rhythms*" because they happen many times per day. The basic idea is that every hour and a half or so you need to take a rest break - if you don't you may be well on your way to the "*Ultradian Stress Syndrome*": you get tired and lose your mental focus, you tend to make mistakes, get irritable and have accidents - If you continue to ignore your need to take a break you can experience more and more stress until you actually get sick.

It is not always convenient for people to take time-outs when nature tells us to but we can all become better at this. A mid-morning break, lunch, a mid-afternoon break and supper divide the day into roughly two hour segments. These time-outs can include power naps, meditation, daydreaming, a social interlude, a short walk, a refreshment break, a change to low-concentration tasks or listening to music. Like the catnap, it is simply a good investment of time that pays itself back quickly in increased productivity and reduced stress.

Work-leisure balance - Despite all our labor-saving devices, leisure is still an elusive commodity for most people. Statistics show that the average American is working an extra three hours per week compared with 20 years ago. That translates into an extra month of work each year. Add to that the phenomenon of the two career family (which makes family and leisure time even more scarce) and you start to get a picture of society on an accelerating treadmill.

Leisure time and levels of distress are inversely proportional - the less leisure, the more stress. We all require time to meet our own needs (self-care, self-nurturing, etc.) and when that is neglected, trouble usually follows.



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Self directed activities can include exercise or recreation, relaxation, socializing, entertainment and hobbies. The word leisure is derived from the Latin word "*licere*" which means "permission." The main reason so many people do not have enough leisure is that they are not giving themselves permission to make the time to enjoy it.

Leisure is one of the most pleasant stress relievers ever invented. It is strange that people resist it so much (e.g., feeling selfish, guilty). However, once they experience a payoff, the benefits will reinforce the behavior. After that, they are usually able to give themselves permission.

6. Realistic Expectations

A common source of stress is unrealistic expectations. People often become upset about something, not because it is innately stressful, but because it does not concur with what they expected. This can be especially true for offenders and doubly so for those with a mental health issue. Take, for example, the experience of driving in slow-moving traffic. If it happens at rush hour, you may not like it but it will not surprise or upset you. However, if it occurs on a Sunday afternoon, especially if it makes you late for something, you are more likely to be stressed by it.

When expectations are realistic, life feels more predictable and therefore more manageable. There is an increased feeling of control because you can plan and prepare yourself (physically and psychologically). For example, if you know in advance when you have to work overtime or stay late, you will take it more in stride than when it is dropped on you at the last minute. There is much we can do to help offenders by letting them know when their expectations (of themselves and others) are unrealistic.

7. Reframing

An extremely powerful and creative stress reducer, reframing is a technique used to change the way you look at things in order to feel better about them. We all do this inadvertently at times. For example, many people viewed the baseball strike as a personal disaster whereas others immediately realized they were going to save a lot of time and money by not hotfooting it down to the ballpark whenever the Cardinals were in town.

The key to reframing is to recognize that there are many ways to interpret the same situation. It is like the age-old question: Is the glass half empty or half full? The answer of course is that it is both or either, depending on your point of view. As Dr. Joel Goodman put it at The Power of Laughter and Play Conference, Toronto, 1986: "There is more than one meaning to the same reality." However, if you see the glass as half full, it will feel different than seeing it as half empty because the way we feel almost always results from



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the way we think. The message of reframing, then, is that there are many ways of seeing the same thing - so you might as well pick the one you like. One of the things we can do with offenders is help them reframe stressful situations. This most often involves helping them see positives in a negative situation and assisting them in understanding the behavior of other people. It is best to get the offender to provide the input first (to which you can add later) by asking certain questions. The information is more meaningful when it comes from them.

For example, suppose you have an offender who loses her job because of a chronic, though not life-threatening illness and you asked if anything positive had come out of this experience. She came up with several things, including "It will make me a stronger person," "I never liked the work I was doing before." "This gives me the chance to do what I really want to do," "It has made my marriage stronger," "It has brought me closer to my family," and "I have learned to watch my money and spend more carefully, which I never had to do before." You then asked her to focus on what is there (what she can still do) rather than what is missing (due to the restrictions of her illness). She replied, "Most things - my hobbies, watch television, go to the cottage, socialize, go out; although some things are still (physically) uncomfortable." By asking her to think about her illness from a different perspective, she was encouraged to reframe the situation and she felt better emotionally as a result.

In terms of reframing the behavior of other people, ask them why they think someone did what they did. For example, a woman's boss was acting critical and domineering towards her. You can ask, "Assuming your boss is not just evil or malicious, why do you think she might be acting like this?" The answers will probably include, "She is probably insecure," "She is under a lot of pressure," and "She is having personal problems." Performing this exercise helps the offender step outside herself and look at other possible interpretations of her boss's behavior.

Note that reframing does not change the external reality but simply helps people view things differently (and less stressfully). It should be done with a bit of preamble to explain the premise (e.g., using the glass half empty as an illustration) and only after you have acknowledged the validity of the offender's initial (stressful) interpretation. You are not trying to disrespect their point of view but only to suggest there are other, less stressful ways of looking at the same thing.

8. Belief Systems

A lot of stress results from our beliefs. We have literally thousands of premises and assumptions about all kinds of things that we hold to be the truth - everything from, "You can't fight City Hall" and "The customer is



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always right," to "Men shouldn't show their emotions" and "Children should make their beds." We have beliefs about how things are, how people should behave and about ourselves ("I can never remember people's names"). Most of our beliefs are held unconsciously so we are unaware of them. This gives them more power over us and allows them to run our lives.

Beliefs cause stress in two ways. The first is the behavior that results from them. For example, if you believe that work should come before pleasure, you are likely to work harder and have less leisure time than you would otherwise. If you believe that people should meet the needs of others before they meet their own, you are likely to neglect yourself to some extent. If you're the type of person that believes, "If you want something done right, you have to do it yourself." Then you probably do not delegate well and tend to get overloaded.

In the above three cases, the beliefs are expressions of people's philosophy or value system, but all lead to increased effort and decreased relaxation - a formula for stress. There is no objective truth to begin with. These are really just opinions but they lead to stressful behavior. Uncover the unconscious assumptions behind your actions can be helpful in change.

The second way beliefs cause stress is when they are in conflict with those of other people. Recently my wife had a fight with our son because the child wore the same clothes several days in a row. When I asked why it bothered her she replied, "Because you should change your clothes every day." I asked her where this idea originated: "Well, my mother taught me that. Everyone knows you should change your clothes every day." I told her that this was not "the truth," but merely her opinion based on the way she was raised. In many cultures people do not change clothes often and nothing bad happens to them. This helped her see that this was a premise she held but one which was not shared by her son. The argument was not over the clothes themselves but merely about a difference of opinion. Once she recognized his belief was not "true," her anger diminished. (She was mad at me however for questioning her.)

We can do much for offenders by getting them to articulate their beliefs and then to label them as such. Next, we need to help them acknowledge that their assumptions are not truth but rather opinions and, therefore, they can be challenged. Lastly, we can help them revise their beliefs or at least admit that the beliefs held by the other person may be just as valid as their own. This is a mind-opening exercise and usually diminishes the anger the person was experiencing.

9. Ventilation/Support System

We have all had times when we have been upset and those of us that are



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lucky enough to have a friend who will listen allows us to talk incessantly about a problem, and we will feel better when we are finished. We have told our story, cried or made some admission, and the act of doing so has been therapeutic. They often do not have to say much. They just have to be there, listen attentively and show their concern and caring. On other occasions they might offer validation, encouragement or advice. But the combination of being able to ventilate and their offering support can be profoundly beneficial.

There is an old saying that "a problem shared is a problem halved." People who keep things to themselves carry a considerable and unnecessary burden. Friends who allow us to ventilate or encouraging us to do so seldom realize the benefit of their actions. Consider recommending to the offenders on your case load to develop a support system (a few trusted relatives, co-workers or friends to talk to when they are upset or worried).

Another form of ventilation that is helpful is writing, for example in a private journal at home. Former tennis star Guillermo Vilas once said: "When my life is going well, I live it. When it's not going well, I write it." These letters are not for sending; they should be destroyed once they are written - unread. The value is in expressing the feelings and getting them out. Rereading the letter just reinforces the "upset" and fans the flames of anger all over again.

10. Humor

Toddlers laugh 400 times a day while adults laugh only 15 times a day. It appears that we took those haunting words, "Wipe that smile off your face, do you want people to think you are stupid?" or "You are not being serious," to heart.

Humor is a wonderful stress-reducer and antidote to upsets. It is clinically proven to be effective in combating stress, although the exact mechanism is not known. Experts say a good laugh relaxes tense muscles, speeds more oxygen into your system and lowers your blood pressure. So tune into your favorite sitcom on television. Read a funny book. Call a friend and chuckle for a few minutes. It even helps to force a laugh once in a while. You'll find your stress melting away almost instantly. Americans were attracted to humor from the stories of Norman Cousins, who had successfully overcome cancer by watching comedy shows on television. These days, there are organized humor meetings even in places like India where laughing in public is not considered good manner.

Dr. Lee Berk and his associates at Loma Linda University in California have been studying the effects of laughter on the immune system. Laughter has been shown to lower blood pressure, reduce stress hormones, increase muscle flexion, and boost immunity. Laughter can also trigger the release of endorphins, the body's natural painkillers (The Laughter-Immune Connection: New



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Discoveries, Lee S. Berk, DPH, Humor and Health Journal, vol. 5, no. 5, 1996).

A study from the University of Maryland Medical Center (2005) has shown that laughter is good for your heart. This study showed how laughter can literally help blood vessels function better. Researchers found that people with heart disease were 40 percent less likely to laugh in a variety of situations compared to people of the same age without heart disease.

We enter the world with an inborn ability to laugh, smile, play, have fun and make light of life. We spend most of our adulthood being humor impaired. Have you experienced watching a comedian or being caught up in situation with friend where you laughing so hard it hurt? Then, afterwards, felt so good! Just remembering the event brings a smile back to your face.

Ways to Use Humor to De-Stress

1. Take moment and take deep breathe and think about something funny you have experienced. Go ahead---laugh out loud!
2. Need outside stimulus? Buy one of those tickle me toys, when you squeeze the stuffed animal it giggles and shakes all over. Go ahead and laugh, its contagious!
3. Since self-humor can never get you in a situation where someone accuses you of making fun of them, think about how your stressful day must look to the outside world, As you were running around getting the kids ready, search for the car keys, running into the store changing lanes at the grocery store check out three times to find the fastest one, then sprinting through the parking lot. Would your day make a great cartoon?
4. Tell a funny story even if it is the same one you have told many times before, getting others to laugh will get you to laugh too.
5. Buy a joke book and keep it handy to read if you are feeling really stressed. Read a few jokes. Humor can help free the mind so you can free the body of stress. Truly giggle your tension away.

Humor is an individual thing - what is funny to one individual may be hurtful to another. Care should be taken if you are attempting to reduce another person's stress through humor. To reduce your stress you need to read a funny book, see a funny movie or go to a comedy club. Laughter really is the best medicine.

Okay, now that we've covered this last bit of information I want to give you an opportunity to consider all the things we've discussed and how you can apply this information back on the job.

GUIDED PRACTICE



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Instructions: For the next 10 minutes I want you to review the information that we've discussed and write down three things that you are going to use from this program when you return to work. You need to be specific and not just say "I'm going to be as stressed." or "I'm going to be more observant when working with a MH offender."

Note to Trainer: Allow 10 minutes for the participants to complete their action plan and then have the participants' pair up to discuss their ideas. Give them 5 minutes to talk about their ideas before you discuss them with the entire class. Once this is complete ask for volunteers to discuss what they are going to do to implement subjects covered in this training program.

Ask Participants: What do you see as the biggest challenge when implementing your action plan?

Possible Response: Time constraints, office arrangements, deciding how and best to approach the offender.

Ask Participants: If you see an MH offender who is obviously under stress, how do you intend to handle it?

Possible Response: Refer them to a MH professional or contact their MH Counselor and advise them of what you observed, recommend that they begin exercising, stop drinking coffee, read a funny book or go see a funny movie.

EVALUATION AND CLOSURE

This has been a full training program and we covered a lot of different topics. While there is a lot of additional information available on mental health and the criminal justice system that hasn't been covered, however, what has been discussed in this workshop will provide you with a better understanding of the offender population who has mental health issues. There are a lot of important things to remember when interacting with an individual who has a mental illness. First and foremost you need to get beyond the stigma that follows mental illness, the offenders that you work with need your help to be successful and this is especially true for those that have mental health issues. Consider how you interact with the offender; remaining on your side of the professional boundary, being patient, listening carefully, and being understanding. This doesn't mean that you ignore accountability; it simply means that you need to be aware of the challenges that these offenders face and consider it when you interact.

I also think that it's important to remember that *"Most people who are violent are not mentally ill, and most people who are mentally ill are not violent."* This is often part of the stigma that is associated with the mentally ill, that



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they are prone to violence and while this can occur, however the reality is that this occurs only a low percentage of the time especially when compared to acts of violence committed by those without a mental health issue.

In this training program we were guided by two separate paths, the first path and most important is your expectation of what you desired to get from this program. As we moved through this program we've followed your expectation and hopefully we've been able to meet them all.

Note to Trainer: If there are unmet expectations you may need to address them with the class or meet with the participant after the program ends.

The second path we followed which led us to this point were the performance objectives which were:

At the conclusion of this lesson, participants will:

1. Given information on mental health signs and symptoms, compare and contrast this against personal mental health concepts.
2. Through a role play, conduct an interview and identify possible mental health signs or symptoms according to the provided material.
3. Given drug and mental health profiles, specify differences and determine how to address each, according to the information provided.
4. Using information on personal safety and stress mgt, create a personal action plan identifying three ways to apply this to your job.

Your role in the offender's life is critical especially for those who are challenged by mental illness. They look to you for answers and depend on you to help them succeed. Use the information from your action plan to help them.

