A BASIC GUIDE TO MENTAL HEALTH SERVICES IN JAILS: THE WORKBOOK

PREPARED BY

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FORWARD

Mental health issues concerning incarcerated inmates raise serious questions and concern for the correctional administration. With the deinstitutionalization of the nation's state psychiatric facilities, many former patients now end up as inmates in the local jails and prisons around the country. These correctional facilities are becoming the psychiatric centers of the 1980's.

The need for a trainer's training workbook was recognized by the National Institute of Corrections. The course MENTAL HEALTH IN JAILS for correctional supervisors had been the institute's primary training mechanism to provide mental health training and resources. In March 1986, the course was discontinued due to fiscal budgetary adjustments. As a result, A BASIC GUIDE TO MENTAL HEALTH SERVICES IN JAILS: THE WORKBOOK was developed to fill the void by providing mental health information to correctional professionals nationwide. This workbook will provide:

- -the most updated material on mental health in jails
- -an overview of mental health issues and concerns
- -a total mental health package and
- -additional resource information

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It is our primary concern that this mental health guide will be valuable by providing pertinent jail mental health resource information to correctional professionals nationwide.

ABOUT THE AUTHOR

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INTRODUCTION

This workbook is designed to provide correctional professionals with an overview of information to assist them with mental health problems and issues in their jails. It is a sixteen hour training course with additional reading materials and resource information available. A BASIC GUIDE TO MENTAL HEALTH SERVICES IN JAILS is designed for correctional professionals which include officers, mental health staff, social workers, counselors, nurses, intake and classification workers, and significant others who deal with these problems. The course can be used as supplemental training to present training programs, added to basic training for certified officers, for policy formations and the development of special projects.

The primary intentions of this guide is to assist in policy-making decisions, educate staff on the basic issues of mental health, identify signs and symptoms of mental illness, learn appropriate solutions to dea with special population inmates and provide assistance in understanding the reponsibilities and liabilities involved in providing protection and care for the mentally ill offender. Therefore, possible benefits of thi course to administration and staff are limitless!

NOTE TO THE TRAINER

This program is a sixteen hour course designed to inform and educate correctional workers on mental health issues and problems. It is extremely complex material explained in simplistic terms and should be taught by competent professionals to eliminate student confusion. The intention is not to make the correctional staff doctors but rather to inform and assist them on how to handle the various inmate populations the jail setting.

It is advised that the trainer coordinate the course schedule and activities with the mental health staff. The course will be most effective when there is full cooperation from Mental Health. In addition, it is designed to encourage team building for custody and treatment staff. For systems without mental health representation, it is recommended that county or state mental health staff be utilized who are familiar with the issues and problems of the jail system. Since mos of the material is of a highly technical nature, it is important to adhere to the strong recommendations of the author for the efficacy of the course. For example, it is recommended that the lesson plans Legal Issues and Liability are taught by a county attorney and Psychotropic Medications is taught by a psychiatrist!

For systems that are developing and/or improving existing mental health programs, it is important to remember that mental health programs shoulc be designed, implemented, and operated by trained mental health professionals and not by custody staff. Although it is not for custody to run the mental health program, it is essential that custody be an intricate part of the team approach to mental health!

It is advised that the trainer have a strong mental health background, however, an updated, highly recommended general psychology textbook will be sufficient preparation for the training task. Carefully go through the material and become familiar with it. Encourage trainers to share their own appropriate experiences which will enhance the power of the written material. Prepare student workbooks with Lesson Plan Objectives course handouts and the additional resource materials that are included with the training package. At the end of the first day, you should strongly recommend that students read the action plan material and other resource material that accompany this course.

Most importantly, encourage strong participation from the students. In selecting the students, select workers from various areas of the jail that would benefit from this specialized training, whether it is direct inmate services, classification, research or policy formation.

Assessment of student performance will be evaluated by classroom participation and job performance. No testing instrument has been designed for this course. An instructor and course evaluation is provided at the end of the training.

GOOD TRAINING!

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COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
TIME ALLOCATED	Sixteen Hours
SPACE REQUIREMENTS	Large Classroom for all participants
COURSE OBJECTIVES	1. To share with participants information that will assist them in improving the quality of care for mentally ill inmates. 2. To identify the role of concerned staff with regards to the delivery of mental health care and services, and identify their relationship with the clinical staff. 3. To share with participants the minimum standards of mental health care. 4. Introduce participant strategies for the development of resources and support for mental health programs in local jails.
METHOD OF PRESENTATION	Lecture, brainstorming, question and answering, and role-playing.
STUDENT MATERIALS	Notebook, Pens, Pencils and Handouts
INSTRUCTOR MATERIALS & EQUIPMENT	1. Two flip charts or blackboard, writing materials and pens. 2. Podium or front table 3. Back table for presenters 4. Tape, scissors, name tags, etc. 5. Suggested film 6. Student Handouts 7. 3 by 5 cards 8. Lecture notes
METHODS AND SEQUENCES	Follow each lesson plan outline.

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Welcome/Introduction/Program Overview and Expectations
TIME ALLOCATED	One Half Hour
SPACE REQUIREMENTS	Large classroom to comfortably seat all participants
LESSON OBJECTIVES	Each student will: 1. Know the purpose of the course 2. Know the administrative requirements, schedule, methods to be used, and instructors.
TRAINING STAFF	SENIOR RANKING SECURITY AND MENTAL HEALTH OFFICIAL (e.g., Sheriff, Jail Administrator, Psychiatrist, Psychologist, Counselor, Nurse)
STUDENT MATERIALS	1. Agenda 2. Course objectives 3. Student workbooks 4. Pens and pencils
INSTRUCTOR MATERIALS & EQUIPMENT	1. Lesson plans 2. Flip charts or blackboards and marking pens
METHOD OF PRESENTATION & SEQUENCE	This session is designed to introduce the purpose of the course, explain and complete all administrative requirements, introduce instructors and course materials.

INSTRUCTIONS	DISCUSSION
WELCOME	Welcome to "A Basic Guide to Mental Health Services". This course is designed to be resourceful, creative and innovative by providing you with information which will assist you in developing and enhancing your mental health programs. My name is:_________and I will be your facilitator for the next two days.
	Now, I want you to look in your notebooks that I have prepared and you will find the agenda for the course. Take a few minutes to look over the schedule, instructor's names, and other specifics.
INSTRUCTOR	(Explain the agenda that you have prepared).
	As you can see, the class has been divided into sixteen hour blocks. Before we go further, let us go over the administrative details of the course.
INSTRUCTOR	(In this section inform the students about the schedule, starting and ending times, meeting rooms, breaks, smoking policies, classroom maintenance, meals, hotels, flight schedules and rental car accommodations, messages, telephones, entertainment and what to do in case of an emergency).
	This course was designed by the National Institute of Corrections as a sixteen hour training course to provide an overview with answers to the many issues, concerns and problems that you face daily as a correctional professional. This course can be used as supplemental traini or it can be presented individually. Additional resource information is provided for continued readings. The course is composed of lectures, discussions, a workbook with handouts,

a suggested film, if available, role playing and other exercises to enhance th learning process. It is designed to provide basic principles of mental health stimulate ideas, allow for problem-solvin and the development of policy formations.

We want you to participate in the variety of exercises and experiences we have planned. Our expectations are high and we expect learning to occur as a result of instructors and students sharing and exchanging information.

An evaluation procedure has been developed for your comments and assessment of the course. Feedback is important in the design because we plan to continuously improve and modify th course. We will continue to provide you with verbal feedback on your ideas and progress.

Although there are no testing procedures for this course, a student information and evaluation sheet handout has been develope to record student demographic data and monitor class participation.

Look in your notebook for this handout and fill out all information down to the dotte line. When you are finished, give the handout to your instructor.

INTRODUCTION OF SENIOR STAFF

At this time, I would like to introduce you to __________ he/she is and the (title of position).

INSTRUCTOR

(Give brief background information on this individual. This person could be your Senior Ranking Officer, your Sheriff, Jail Administrator, and/or Chief of Mental Health Services. Let him/her provide some history of the mental health program. If one does not exist, give reasons why there is a need for a program and how this cours fits into the current or future proposed mental health program).

HANDOUT

Student Information and Evaluation Sheet
for the Class
Detention Officers in Mental Health

Name: ______________________, ________________, ______
Last First MI

Age: __________ Years experience in Corrections: ____

Years experience in Mental Health: __________

Education Level in Years: circle

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Please list all formal training you have received in Corrections and/or Mental Health (subject and length of courses).

____
____
____
____
____

Continue on Back

- -

Test A Score: _________ Test B Score: ________

Class Participation: ____
____
____
____
____
____

Counseling skills observed: ____________________________
____
____
____
____

STRENGTHS: ____________ WEAKNESSES: ________________
______________________ ___________________________
______________ ___________________________
______________________ ___________________________
______________________ ___________________________
______________________ ___________________________

NOTES:

SEMINAR TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Introduction of students
TIME ALLOCATED	One Half Hour
SPACE REQUIREMENTS	Large classroom to comfortably seat all participants
LESSON OBJECTIVES	Each student will: 1. Be familiar with other students' names, titles, what year they started in corrections, what they remember mental health services were then, and what personal views regarding mental health services have changed since their first year in corrections.
STUDENT MATERIALS	None
INSTRUCTOR MATERIALS & EQUIPMENT	Two flip charts with markers of different colors.
METHOD OF PRESENTATION & SEQUENCES	The instructor will list in chronological order by decades what services were provided, on one flip chart, and will list the changing views, on another flip chart.

INSTRUCTION	DISCUSSION
	Now that we have introduced the course and our training staff, let us do an introduction exercise so that we can acquaint ourselves.
INSTRUCTOR	(If staff are available encourage them to participate).
	The instructions for this exercise are to arrange yourself around the room in a horseshoe position according to how long you have been in corrections.
	(Allow students time to position themselves in their seats).
QUESTIONS	Who has been in corrections the longest? What is the earliest year?
	Now, I want each of you to: (1) introduce yourself (2) tell what year you started in corrections (3) what do you recall mental health services were during your first year on the job? (4) have your own personal views about mental health changed since then?
INSTRUCTOR	(Have each student answer the three questions, monitor your time so that you can finish the exercise in one hour).
	BREAK!

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	History of Mental Health in Jails
TIME ALLOCATED	One Hour
SPACE REQUIREMENTS	Large classroom for all participants
LESSON OBJECTIVES	Each student will: 1. Understand the development and change of mental health issues in jails from the 1950's to the 1980's. 2. Understand how the Civil Rights Act of 1962 affected the Mental Health Movement.
TRAINING STAFF	This session should be taught by someone with an understanding of mental health history.
STUDENT MATERIALS	A handout on what other classes have listed as "services provided" and "changing views" of correctional professionals.
INSTRUCTOR MATERIALS & EQUIPMENT	Flip charts and marking pens
METHODS AND SEQUENCES	Lecture, question and answers

INTRODUCTION

DISCUSSION

This hour will be used to brainstorm about what kinds of mental health services and changing views have occurred historically. At the end of the hour, I will give you handouts of responses from another class who discussed this topic. It should be interesting to compare responses.

Let us start with the 1950's.

INSTRUCTOR

(On the flip chart to your left write down "1950's").

1950's

The 1950's was a quiet time for mental health issues in the jails. Mental health was never an important issue in the 50's. It was a time of progressive construction of jails and the acceleration of federal dollars spent on training programs for psychiatrists, psychologists and social workers. There was unlimited opportunity to learn and for clinicians to be adventurous because mental health in corrections was a new area. Let's brainstorm and come up with other trends of the 50's.

INSTRUCTOR

(List student comments on the 50's on the flip chart).

QUESTION

Can you think of anything else that you would like to contribute?

1960's

The theme of the 1960's was a time when we felt we had the DUTY to treat everyone. President John F. Kennedy played an important role in the development and passing of the Mental Health Act of 1962. He was highly motivated to provide mental health services; probably a contributing factor was due to the psychiatric condition of his sister.

The 1960's was the beginning of the Civil Rights Movement. This movement insisted that mental health professionals place emphasis on mental health problems and issues. It was believed that mentall ill people had the right to live in the community. There was an emphasis to get them out of hospitals and back into the community. This was the beginning of the deinstitutionalization movement.

It was felt that society had the duty to treat everyone who needed it. There was "psychological awareness". People began reading books, participating in a variety of therapies and young professionals abandoned the state hospitals and went to community mental health centers to work with many of the past residents of the state psychiatric hospitals. One of the most important occurrences was the arriva of psychotropic medications. They became valuable resource and management tool of the mental health staff. The 60's produced the growth of Alcoholic Anonymou and its treatment aspects. By the end of the decade, drug treatment for addicts ha become a reality. This was a time of experimentation. Therapies were experimental, demanding and frustrating. We learned that people similar to us went to jail and prison. It was a time of violen prison unrest and, in turn, tougher law enforcement.

1970's

The Mental Health Movement of the 70's was depicted as the death of optimism for the rehabilitation of the 60's. This was an era of substantial court involvement. The majority of the cases occurred in the mid 1970's. There was an incentive to sue organizations regarding mental health issues. Great emphasis was placed on training law enforcement professionals. Social services learned a lot from law enforcement. This was a time of court ordered decrees.

QUESTIONS

Does anyone here have a court ordered decree? What are the specifics of the decree? Does it require particular kinds of staff members, for example, officer

patient ratios, specific kinds of treatmer and care that the jail must provide for inmates?

Three important issues were with us at the close of the 70's that affected mental health issues:

1. Overcrowding issues of jails and prisons.

2. A dwindling of government resources.

3. Significant changes in the DSM II to DSM III. (DSM III is currently being debated and will probably be changed in the near future).

QUESTION

What can you contribute to this list?

1980's

The theme of the 1980's is "The Well Managed Jail". Community mental health systems are deteriorating. The states wil probably have to run them. There appears to be a working blend of cooperation between mental health and other correctional professionals. With the continuatic of Reagonomics, there is high demand, low resources, and budget cuts. There are overcrowded facilities and limited service provided. Special problem areas appear ir this decade, for example, drugs, alcohol, family violence, and child molestation.

QUESTION

What can you add to the list for the 1980's?

HANDOUT

SERVICES PROVIDED HISTORICALLY IN CORRECTIONS
(STUDENT RESPONSES)

1950's

- Mental health services were not an identification issue
- The attitude then was leave them alone, if possible

1960's

- There were limited mental health services in corrections
- No attention was given to mental health needs because it was considered the family's responsibility
- There was the separation of responsibility and services between corrections and mental health

1970's

- Diagnose and classify <u>everyone</u>
- Court-ordered diagnostic work and separate housing for inmates
- Mental health problems were seen as discipline problems
- Diagnostic/counseling services for juveniles developed
- Crisis intervention procedures appeared
- Emphasis on control via medications and restraints
- Ship the violent offender out to a different facility for stabilization
- Strong mental health programs for jail inmates
- Response to individual inmate, jail staff and community needs

1980's

- Bring them in and get them out
- The extraordinary event (media event) emphasized health services
- There was an awareness of the needed mental health services for inmates
- Out of sight, out of mind - take them across the county line
- Overcrowded facilities and too few services provided
- Concerned correctional officers wanted appropriate services for inmates
- Large numbers of special problem areas appeared: alcohol, substance abuse, family violence, child molestation, etc.
- HIGH DEMAND, LOW RESOURCES.

HANDOUT

CHANGING VIEWS

-A need for progressive special services

-There is a solution to problems (crisis intervention)

-Medicate ASAP -we are a jail!

-Use available resources when needed

-Require vigilance services at every point in the system

-Service delivery systems now appear more open and responsive

-There appears to be respect for "free will, individual responsibility, etc"

-Mental health services are now a critical management tool

-Deinstitutionalization stinks

-A need to coordinate and use local services in the jail facility

-Locking an inmate down does not appear to be treatment

-Rehabilitation can work for <u>some</u> inmates

-There is now system consultation

-There is a focus on external resources

-We need to address prevention strategies

-Our own problems are 98% attitudinal

-There is a need to provide broader human needs (recreation, education, medical, etc.)

-A need for in-house mental health services

-An acknowledgement of the current mental health problems in corrections

-The unchanged view is that we still have a clear responsibilit

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Perceptions of Custody vs. Treatment
TIME ALLOCATED	One Hour
SPACE REQUIREMENTS	Two classrooms to seat each small working group.
LESSON OBJECTIVES	Each student will be able to: 1. Clarify his/her role in the jail, job policies, and what state regulations dictate. 2. Voice dissatisfaction with the attitudes, values, opinions, and views of correctional staff, be it custody or treatment. 3. Vicariously change sides to understand the many issues and problems of the other side (custody or treatment).
TRAINING STAFF	Two additional instructors are needed for the two small working groups; one instructor per group.
STUDENT MATERIALS	Two 3x5 cards per student and writing materials.
INSTRUCTOR MATERIALS & EQUIPMENT	Two flip charts and marking pens, one chart per small group.
METHODS AND SEQUENCES	The instructor divides students into two separate groups of custody and treatment. Each group is sent to a small working group with an instructor who will assist them in

clarifying job roles, policies, and what their state regulations dictate. Once the role clarification is completed, the instructor will assist the participants by listing their perceptions of dissatification for the opposite group. After the completion of the list, the participants will reconvene to the large group for the groups' presentation. The facilitator will keep track of group reactions, comments, and may close by asking each side to suggest solution strategies for the identified problems.

INSTRUCTIONS	DISCUSSION
NOTE TO THE INSTRUCTOR	(Clearly, the most important problem facing facilitators during this segment is to get everyone involved and encourage participants to talk about how they view the other group. This is merely an exercise, but it assists in developing a variety of thoughts. It is designed for the consideration of better service delivery, greater cooperative efforts between the two service professions, and certainly a better understanding of these services).
INSTRUCTOR	(The facilitator will introduce the instructions for the next two hours).

In the next two hours, we will deal with the perceptions of custody vs. treatment. We are concerned with the dissatisfactions of each group toward the opposite group, be it custody or treatment We will identify the values of each group toward their own perceived objectives.

Each group will have forty-five minutes to create and prioritize a list of their perceptions about the other group which interfers with the jail's mission of maintaining public safety and meeting inmate needs.

THE PROCESS

Treatment Staff will remain in one room and the Custody Staff will go to the other room. Each group will then voice their dissatisfactions with their opposite in terms of how they interfer with the operation of their separate functions. (The Custody facilitator should currently be working in Custody and the Treatment facilitator should currently be working in Treatment).

Once the clarification has been completed, you will be supplied with two 3x5 cards to place three to five dissatisfactions, silently and independently, for about three minutes. Upon completion, you will be asked to express, in the order of your priorities, the "most dissatisfications", which will be placed on the flip chart. After everyone is finished with this task, and three or more flip chart sheets have been taped on the wall, the the group will be asked to consider the list and prioritize all of the information onto a single sheet of flip chart paper, with no more than five statements regarding the dissatisfactions in the order of their relative importance. This last sheet of five prioritized dissatisfactions will be returned to the large group for the entire class to analyze and consider. One representative from each group will give the group's perceptions to the whole class. The primary facilitator will organize the group's perceptions and join the entire class in the discussion.

Are there any questions?

QUESTIONS

Some important questions to ask following the listings:

-Do you understand the problems of the other side?

-What do you want from them?

-What can you provide for them?

EXAMPLES FOR INSTRUCTOR

Here are a few examples of how Custody and Treatment have expressed their dissatisfactions.

Custody's dissatisfactions with Treatment:

1. Treatment staff appear to be afraid of the inmates.
2. They do not understand the mission.
3. No operational sensitivity, no knowledge of the laws by which we must operate.
4. A needed, timely delivery of services.
5. No protocol in place.
6. Undecided treatment plans.
7. No appreciation for the physical plant limitations.
8. Treatment staff are gullible and easil "conned bleeding hearts".
9. There should to be a dress code for treatment workers.
10. No concern for the types of inmate charges.
11. "A better than thou" attitude.
12. Talking down to correctional officers.

Treatment's dissatisfaction with Custody:

1. They are too authoritarian.
2. They are arbitrary and impulsive decision-makers.
3. Mental health is one of the jail's defenses against liability.
4. Custody identifies problems but are not part of the solutions.
5. There is a strong mistrust for Treatmen professionals.
6. There is a failure to share information (e.g. shift changes).
7. There is a failure to follow through.
8. Their attitude is "guilty until proven innocent".
9. Custody is punative, confrontational, primitive, depressive, dumb, and frustrated.
10. There is failure to follow specific suicide prevention policies.
11. They are buck passers.
12. There is resistance to change.
13. They are not team players.

HANDOUT

FOR SMALL GROUP FACILITATORS

I. Assist students in clarification by asking the following questions:

1. What is your role in the jail?

2. What do your policies dictate?

3. What are your state regulations regarding your role and work in the jail?

Collect this information and list it on the flip chart. You are now ready to proceed to the next part of the exercise.

II. 1. List 3 to 5 dissatisfactions you have with your opposite cohorts. List attitudes, values, opinions, and points of view

2. Collect, prioritize, and rank.

3. Return with the flip chart page, listing the top 5 dissatisfactions.

**Note Encourage strong participation from the students for a successful exercise.

SEMINAR TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Introduction to Psychology
TIME ALLOCATED	Two Hours
SPACE REQUIREMENTS	Large classroom for all participants
LESSON OBJECTIVES	Each student will: 1. Be aware of the basic concepts of psychology. 2. Be aware of the conflicts between the common use of psychological terms and the formal diagnosis.
TRAINING STAFF	An instructor with a good understanding of basic psychology.
STUDENT MATERIALS	Writing materials
INSTRUCTOR MATERIALS & EQUIPMENT	Lecture notes
METHODS AND SEQUENCES	Lecture, question and answers.

INSTRUCTIONS	DISCUSSION
INSTRUCTOR	This afternoon is your introduction to psychology, and psychiatry (the medical aspect of psychology). We will cover the major types of mental illness, aspects of personality, psycho-tropic medications, substance abuse and suicide. The task here is not to make doctors out of you, but to give you a soli foundation for understanding the technical aspects of mental illness. Let us begin with a general introduction.
	There are a variety of major areas of psychology. They are abnormal, clinical, educational, social, personality, etc. We will concentrate on the areas of clinical and abnormal since these are the most relevent to your job tasks.
QUESTIONS	When someone says an inmate is crazy because he is acting "a little weird", is he really crazy? (Wait for a response) Is the seventeen year old who abuses drugs crazy? Is the con artist who can talk you out of everything from your checkbook to your virginity crazy? What about the mass murder who kills others for gratification? Is the pedophile who molests and harms helpless children crazy?
	(Wait for a response). You will be able to answer these questions by the end of this course.
DEFINITION	To begin with, let us define psychology. Psychology is the study of behavior. Many would like to define it as just the study of human behavior but the psychologist can study a variety of plants, animals, an environments.
	Now, let us look at psychology from a historical perspective. When we talk about the history of psychology, Sigmund Freud and his psychoanalytic theor comes to mind. First, it is a system of psychology derived from Freud which stresses particularly the role of the unconscious and dynamic forces in psychic functioning. It is a comprehensive personality theory as well as a therapeuti

method. Its primary components are free association, transference and resistance. Let me explain transference, countertrans- ference and resistance to you.

Transference is the unconscious identification with the therapist by the patient with someone in the patient's past e.g., mother, father, lover, etc.

Countertransference is just the opposite. It is based on the therapist's repressed feelings, symbolic of libidinal (sexual) relationships and other unconsious feelings projected onto the patient.

Resistence is the maintenance of symptoms and the unconscious opposition of treatment to uncover repressed material.

The most exciting part of his theory is that the instincts are contained in a subsystem of the personality. The id is presented at birth and knows nothing of reality or morality. It seeks only to gratify drives and to enjoy the pleasure that results when tension aroused by the body is discharged, e.g., a baby sucking. The id is the pleasure principle.

The next component is the ego. It develops to deal effectively with reality. The ego is said to obey the reality principle. It is the balancing element of the id and the superego.

The last subsystem is the superego. It develops from the social learning or the introjection of values from society. As the individual matures, the superego is influenced by the individual's critical examination of his values. It is the conscience. It is concerned with morality, with the principles of right and wrong. It is the element that causes feelings of guilt.

A good way to remember these components is to think about the primary characters of the television program Star Trek. Captain Kirk, represents the ego (the balancing of both Spock and McCoy). Dr. McCoy represents the id (emotionality, representing many times the antithesis of

logic), and Mr. Spock (logic, the conscience, the right and wrong element of the ENTERPRISE). When the id breaks through the controls of the ego, the self will be punished by the superego. This occurs when the individual even contemplates doing something that arouses feelings of guilt or anxiety.

Anxiety is defined as coming from dangers or threats from the external environment. It warns of impending danger, and drives the individual to some kind of action. Usually the individual can handle the anxiety with rational action but when this does not work the ego is forced to use irrational measures. These measures are defense mechanisms which help the individual by use of denial or distortion of reality. These mechanisms operate at a unconscious level so that the person is nc aware of what is happening.

INSTRUCTOR

(Although time does not permit the coverir of the defense mechanisms, you should be familiar with these mechanisms to answer students' questions).

Here is a list of some defense mechanisms:

Repression, denial, fantasy, rationalization, projection, reaction formation, undoing, regression, identification, introjection, compensation, displacement, emotional insulation, isolation and sublimation.

QUESTION

Now let us get back to our original question, what is CRAZY? Although DSM II (Diagnostic and Statistical Manual of Mental Disorders) basically eliminated the category of the neuroses, it is still important for you to understand how the psychologist (Ph.D.) and psychiatrist (M.D were trained to view neuroses. For this reason, we will operate on the past definition of DSM II and include neuroses in this discussion. One of my professors said that an individual suffering a neuroses is one who dreams about the fictitious house that he would like to liv in, however, the individual suffering a

DEFINITION

psychosis lives in the house. Therefore, the definition of a neuroses is a mild personality decompensation. The person is in contact with reality but there may be impairment of social functioning. For example, this might be the compulsive personality that continues to wash his hands, or continues to go back home to mak sure she locked the door, or constantly counts his money. This individual many times has some insight into nature of his behavior, rarely is injurious or dangerous to self or society, and usually does not require institutional care. On the other hand, the definition of a psychosis is a severe personality decompensation where there is a marked loss of reality and incapacitated social functioning. There can be a wide range of delusions, severe deviant behavior, hallucinations, emotiona blunting, behavior that is injurious or dangerous to self and society, and usually there is a need for institutional care. For example, this might be the paranoid schizophrenic who is out of touch with reality and feels that everyone wants to kill him. He is protective of himself thu dangerous to anyone who comes in contact with him. In sum, the neurotic can function and the psychotic is completely out of touch with reality and cannot function in society.

DEFINITION

In terms of causes of mental illness, ther are two basic categorical causes of mental illness, organic and functional disorders. An organic disorder is diagnosed when ther is specific organic cause for the disease or disorder.

Examples of organic disorders are syphilis head injury, substance abuse, aging, etc.

DEFINITION

A functional disorder is one where there i no specific physical damage but there are unexplained problems. For example, hysterical blindness and psychosomatic disorders.

What is a delusion? It is when an individual is convinced of a situation whe in actuality it does not exist, but the individual believes and may be completely

logical about the situation. An individual can suffer delusions of grandeur (thinking he is Jesus Christ or that she is the Virgin Mary) and delusions of persecution (bloodsucking machines and evil spaceships are after him).

What is an illusion? It is a false perception or belief about something that exists (mistaking a man for a tree in the back yard).

QUESTIONS

What is a hallucination? It is a perception in which there is no external stimulus. It is a false sensory perception. Can you give me some examples?

(Wait for responses)

There are auditory, visual, tactual, taste, and olfactory hallucinations).

Auditory hallucinations are the most common type (hearing voices).

Now that you understand the basics, we will discuss in detail the DSM III and how it works. This is the standardized system which helps doctors diagnose patients. We will cover this in the next session of Major Types of Mental Disorders.

BREAK!

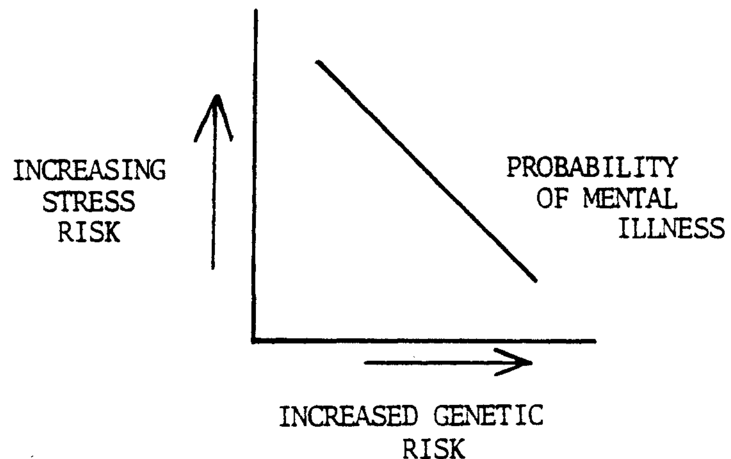
SEMINAR TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Major Types of Mental Disorders
TIME ALLOCATED	One Hour
SPACE REQUIREMENTS	Large classroom for all participants
LESSON OBJECTIVES	Each student will: 1. Be familiar with the use of DSM III. 2. Know the three major types of mental illness. 3. Understand the relationship of genetics and stress as a risk factor of mental illness.
TRAINING STAFF	This session should be taught by a psychologist, psychiatrist or psychiatric social worker.
STUDENT MATERIALS	Writing materials and the DSM III handouts.
INSTRUCTOR MATERIALS & EQUIPMENT	Lecture notes, DSM III reference manual and DSM III handout.
METHODS AND SEQUENCES	Lecture, discuss, questions and answers.

INSTRUCTIONS	DISCUSSION

INSTRUCTOR

(If at all possible, this section should be taught by a mental health professional).

During this hour we will investigate the Major Types of Mental Disorders that are based on the diagnostic process outlined in the DSM III. There is a DSM III handout that has been prepared for you in your notebook. Please take it out now and look at it. The five step evaluation process was developed to insure reliability, consistency and uniformity. We will spend most of our time on Axis I and Axis II. The disorders of Axis I are the primary subject of this hour. This Axis represents the major types of mental disorders. The major psychiatric disorder are the classifications we used for the "real sick", the mentally incompetent, and the "big time crazies". When you hear the doctor say this person is "crazy", he/she normally means the individual is suffering one of the major disorders. Before defining the types of major disorders, let us take a little time and discuss the risk probability of acquiring a mental disorder. There are two factors of most concern, genetics and stress. Most scientists now agree there is a genetic factor in most mental disorders, and we ar beginning to be successful in identifying these factors. As you will see in great detail later, stress levels clearly are related to the possibility of acquiring a mental disorder. If we chart these two factors, we get a graph that looks like this:



INSTRUCTOR

(Draw the graph on the board or flip chart)

If either risk factors are too high, there is a strong probability of mental illness. If the two combined are high, the odds in favor of mental illness occurring are practically guaranteed.

The three Major Types of Mental Disorders are Schizophrenia, Affective Disorders and Organic Brain Syndrome. Let us examine each of these areas in detail beginning with schizophrenia.

DEFINITION

Schizophrenia is a thought disorder, a major mental illness, has a high genetic load factor, characterized by loose association, incoherency, flat affect, a lack of enjoyment, inappropriate responses to the social environment, social withdrawal, ambivalent feelings (experiencing conflicting emotions at the same time), delusions of grandeur or persecution, hallucinations and a complete loss of reality. It is prevalence in the United States and is 1% of cases in the general population. It can occur in early childhood and first admittance to the psychiatric hospital occurs in adulthood between the ages of 20 to 40 years of age. The course of the illness, the future prognosis is a continuous downhill battle. Unlike some illnesses that tend to improve as time goes on, the schizophrenic illness continues to deteriorate.

Many scientists believe schizophrenia to be a biological illness. The theory is that due to excessive quantities of the neuro-transmitter, dopamine, the transmission of impulses are rapid and random which makes attentional control increasingly difficult for the schizophrenic.

The next disorder is the Affective Disorders. These are the mood disturbances characterized by mania, major depression, the bipolar episodes which manic-depressive episodes alternate or exist simultaneously. There is a high genetic load factor with the typically occurrence beginning prior to age 30. One out of 7 will die if

untreated because of exposure to the elements and/or suicide. Unlike schizophrenia, the affective disorders' prognosis is good. As the illness progresses, the prognosis is better. A patient can go into remission and not have an incident for ten years!

It is believed by Weiss, et al. (1970, 1976) that there is a biological explanation for affective disorders. These researchers have developed the "catecholamine theory" which says that neurotransmitter catecholamine (norephinephrine) is responsible for mania and depression. The believe that with low norepinephrine, the experience is depression and with high norepinephrine, the experience is mania. In depression, MAO inhibitors, antidepressants tend to balance the mood swings by providing a higher level of norepinephrine to the brain.

The last area of concern is the Organic Brain Syndromes. The cause of these syndromes is due to a nonspecific identifiable damage to the brain produced by drugs, tumors, age deterioration, stroke, metabolic disturbances and injury. Since the syndromes affect the brain, many biological factors appear to be psychological in nature. The DSM III categorize several areas of Organic Brain Syndromes; four of these are:

1. Presenile and Senile Dementia (Alzheimer's Disease), caused by a gradual deterioration and decreasing brain size.

2. General Paresis (prolonged syphilitic condition).

3. Epilepsy.

4. Huntington's Chorea (hereditary, uncontrollable tremors, poor balance and involuntary movements).

QUESTION	HOW IS THE PSYCHOSIS RELATED TO THE MAJOR TYPES OF MENTAL DISORDERS?
	A psychosis is not a major type of disorder. It should be looked at as one of the primary ingredients in the "broken brain". Psychosis is a term used to describe the behavior of an individual. It is a severe illness characterized by the complete loss of reality which can include hallucinations and delusions. An individual who is psychotic cannot function socially and usually requires hospitalization. All schizophrenics are psychotic without medication. However, not all psychotics are schizophrenic. Psychosis can be identified throughout the three major types of mental disorders. For example, an individual in the manic phase can be psychotic, but only in the hyper-manic phase. Psychosis can occur in certain organic brain syndromes.
QUESTION	Can anyone tell me in which of the above four areas can a psychosis occur?
ANSWER	Presenile and senile dementia, general paresis, not usually epilespy.
	In the next hour we will talk about the treatment of mental disorders. For now, it is important to recognize that with most mental disorders we cannot see the actual "broken" mechanism as we can see a broken bone on an X-ray. As a result, we observe the symptomatic behavior of the individual.
	Are there any questions? If there are no further questions we will stop at this point and later take a closer look at a number of other disorders in the DSM III.

HANDOUT

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

DSM-III

A multiaxial approach to diagnosing mental disorders that provides a common language, precise descriptions, and uniformity of diagnosis. The five axis are:

Axis I	- Clinical Syndromes - Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment (V. Codes)
Axis II	- Personality Disorders - Specific Developmental Disorders
Axis III	- Physical Disorders and Conditions
Axis IV	- Severity of Psychosocial Stressors
Axis V	- Highest Level of Adaptive Functioning Past Year

An Example of a DSM-III Multiaxial Evaluation

Axis I:	296.23	Major Depression, Single Episode with Melancholia
	303.23	Alcohol Dependence, in Remission
Axis II:	301.60	Dependent Personality Disorder (Provisional,rule out Borderline Personality Disorder)
Axis III:	Alcoholic cirrhosis of liver	
Axis IV:	Psychosocial stressors: anticipated retirement and change of residence with loss of contact with friends Severity: 4 - Moderate	
Axis V:	Highest level of adaptive functioning past year: 3 - Good	

IRDERS THAT USUALLY FIRST IFEST THEMSELVES IN INFANCY, .DHOOD OR ADOLESCENCE

ntal retardation
e a 1 in the fifth digit to indicate other :hiatric symptoms (requiring attention or tment that are not part of another irder). Otherwise code 0.

0x Mild mental retardation
0x Moderate mental retardation
.1x Severe mental retardation
.2x Profound mental retardation
.0x Unspecified mental retardation

ntion deficit disorders
.01 with hyperactivity
.00 without hyperactivity
.80 residual type

luct disorders
Aggressive conduct disorder
.00 Undersocialized type
.23 Socialized type*
Nonaggressive conduct disorder
.10 Undersocialized type
.21 Socialized type*
.90 Atypical conduct disorder

iety disorders of childhood or lescence
.21 Separation anxiety disorder
.21 Avoidant disorder of childhood or adolescence*
.00 Overanxious disorder

er disorders of infancy, childhood idolescence
.49 Attachment disorder of infancy*
.22 Schizoid disorder of childhood or adolescence*
.23 Elective mutism
.81 Oppositional disorder
.22 Identity disorder

ting disorders
7.10 Anorexia nervosa
7.51 Bulimia
7.52 Pica
7.53 Rumination disorder of infancy
7.59 Atypical eating disorder

reotyped movement disorders
7.21 Transient tic disorder
7.22 Chronic motor tic disorder
7.23 Tourette's disorder
7.20 Atypical tic disorder
7.30 Atypical stereotyped movement disorder

her disorders with physical nifestations
17.00 Stuttering
17.60 Functional enuresis
17.70 Functional encopresis
17.46 Somnambulism
17.46 Pavor nocturnus*

rvasive developmental disorders
ide in fifth digit, 0 = full syndrome esent, 1 = residual state.
9.0x Infantile autism
9.8x Childhood onset pervasive developmental disorder*
9.9x Atypical

ecific developmental disorders
te: These are coded on Axis II.
5.00 Developmental reading disorder*
5.10 Developmental arithmetic disorder*
5.31 Developmental language disorder
5.39 Developmental articulation disorder
5.50 Mixed specific developmental disorder
5.80 Atypical specific developmental disorder

ORGANIC MENTAL DISORDERS

Section 1. Organic mental disorders in which the etiology or pathogenesis is listed below (taken from the mental disorders section of ICD-9-CM).

Senile and presenile dementias
Code phenomenology in fifth digit as 0 = uncomplicated, 1 = with delirium, 2 = with delusional features, 3 = with depressive features.
290.0x Senile dementia
290.1x Presenile dementia
290.4x Multi-infarct dementia

Substance-induced
Alcohol
303.00 intoxication
291.40 idiosyncratic intoxication (*Pathological intoxication*)
291.80 withdrawal
291.00 withdrawal delirium
291.30 hallucinosis
291.10 amnestic syndrome (*Korsakoff syndrome*)
Indicate severity of dementia as 1 = mild, 2 = moderate, 3 = severe, 0 = unspecified.
291.2x Dementia associated with alcoholism
Barbiturate or similarly acting sedative or hypnotic
327.00 intoxication (305.4)
327.01 withdrawal (292.0)
372.02 withdrawal delirium (292.0)
327.04 amnestic disorder (292.83)
Opioid
327.10 intoxication (305.5)
327.11 withdrawal (292.0)
Cocaine
327.20 intoxication (305.6)
Amphetamine or similarly acting sympathomimetic
327.30 intoxication (305.7)
327.32 delirium (292.81)
327.35 delusional disorder (292.11)
327.31 withdrawal (292.0)
Phencyclidine or similarly acting arylcycloalkylamine
327.40 intoxication (305.9)
327.42 delirium (292.81)
327.49 mixed organic mental disorder (292.9)
Hallucinogen
327.56 hallucinosis (305.3)
327.55 delusional disorder (292.11)
327.57 affective syndrome (292.84)
Cannabis
327.60 intoxication (305.2)
327.55 delusional disorder (292.11)
Tobacco
327.71 withdrawal (292.0)
Caffeine
327.80 intoxication (Caffeinism) (305.9)
Other or unspecified substance
327.90 intoxication (305.9)
327.91 withdrawal (292.0)
327.92 delirium (292.81)
327.93 dementia (292.82)
327.94 amnestic disorder (292.83)
327.95 delusional disorder (292.11)
327.96 hallucinosis (292.12)
327.97 affective disorder (292.84)
327.98 personality disorder (292.89)
327.99 atypical or mixed organic mental disorder (292.9)

Section 2. Organic brain syndromes in which the etiology or pathogenesis is either noted as an additional diagnosis from outside of the mental disorders section of ICD-9-CM or is unknown.
293.00 Delirium
294.10 Dementia
294.00 Amnestic syndrome
293.81 Organic delusional syndrome
293.82 Organic hallucinosis
293.83 Organic affective syndrome
310.10 Organic personality syndrome
294.80 Atypical or mixed organic brain syndrome

SUBSTANCE USE DISORDERS
Code course of illness in fifth digit as 1 = continuous, 2 = episodic, 3 = in remission, 0 = unspecified.
305.0x Alcohol abuse
303.9x Alcohol dependence (Alcoholism)
305.4x Barbiturate or similarly acting sedative or hypnotic abuse
304.1x Barbiturate or similarly acting sedative or hypnotic dependence
305.5x Opioid abuse
304.0x Opioid dependence
305.6x Cocaine abuse
304.2x Cocaine dependence
305.7x Amphetamine or similarly acting sympathomimetic abuse
304.4x Amphetamine or similarly acting sympathomimetic dependence
328.4x Phencyclidine or similarly acting arylcycloalkylamine abuse (305.9)
305.3x Hallucinogen abuse
305.2x Cannabis abuse
305.1x Tobacco dependence
305.9x Other, mixed or unspecified substance abuse
304.6x Other specified substance dependence
304.9x Unspecified substance dependence
304.7x Dependence on combination of opioid and other non-alcoholic substance
304.8x Dependence on combination of substances, excluding opioids and alcohol

SCHIZOPHRENIC DISORDERS
Code course of illness in fifth digit as 1 = subchronic, 2 = chronic, 3 = subchronic with acute exacerbation, 4 = chronic with acute exacerbation, 5 = in remission, 0 = unspecified.
295.1x Disorganized (Hebephrenic)
295.2x Catatonic
295.3x Paranoid
295.9x Undifferentiated
295.6x Residual

PARANOID DISORDERS
297.10 Paranoia
297.30 Shared paranoid disorder
297.90 Paranoid state

AFFECTIVE DISORDERS
Major affective disorders
Code severity of episode in fifth digit as 1 = mild, 2 = moderate, 3 = severe but not psychotic, 4 = mood-congruent psychotic, 7 = mood-incongruent psychotic, 5 = in partial remission, 6 = in full remission, 0 = unspecified.
Manic disorder
296.0x single episode
296.1x recurrent
Major depressive disorder
296.2x single episode
296.3x recurrent
Bipolar affective disorder
296.4x manic
296.5x depressed
296.6x mixed

Chronic minor affective disorders
301.11 Chronic hypomanic disorder
301.12 Chronic depressive disorder
301.13 Cyclothymia

Atypical affective disorders
296.81 Atypical manic disorder
296.82 Atypical depressive disorder
296.70 Atypical bipolar disorder

PSYCHOSES NOT ELSEWHERE CLASSIFIED
295.40 Schizophreniform disorder
298.80 Brief reactive psychosis
295.73 Schizoaffective disorder
298.90 Atypical psychosis

ANXIETY DISORDERS
Phobic disorders
300.21 Agoraphobia with panic attacks
300.22 Agoraphobia without panic attacks
300.23 Social phobia
300.29 Simple phobia
300.01 Panic disorder
300.30 Obsessive compulsive disorder
Post-traumatic stress disorder
308.30 acute
309.81 chronic
300.02 Generalized anxiety disorder
300.00 Atypical anxiety disorder

FACTITIOUS DISORDERS
300.16 Factitious illness with psychological symptoms
301.51 Chronic factitious illness with physical symptoms (Munchausen syndrome)
300.19 Atypical factitious illness with physical symptoms

SOMATOFORM DISORDERS
300.81 Somatization disorder
300.11 Conversion disorder
307.80 Psychogenic pain disorder
300.70 Hypochondriasis
300.71 Atypical somatoform disorder

DISSOCIATIVE DISORDERS
300.12 Psychogenic amnesia
300.13 Psychogenic fugue
300.14 Multiple personality
300.60 Depersonalization disorder
300.15 Atypical dissociative disorder

PSYCHOSEXUAL DISORDERS
Gender identity disorders
Indicate sexual history in the fifth digit Transsexualism code as 1 = asexual, 2 homosexual, 3 = heterosexual, 4 = mixed, 0 = unspecified.
302.5x Transsexualism
302.60 Gender identity disorder of childhood
302.85 Atypical gender identity disord of adolescence or adult life

Paraphilias
302.81 Fetishism
302.30 Transvestism
302.10 Zoophilia
302.20 Pedophilia
302.40 Exhibitionism
302.82 Voyeurism
302.83 Sexual masochism
302.84 Sexual sadism
302.89 Atypical paraphilia

Psychosexual dysfunctions
302.71 Inhibited sexual desire
302.72 Inhibited sexual excitement
302.73 Inhibited female orgasm
302.74 Inhibited male orgasm
302.75 Premature ejaculation
302.76 Functional dyspareunia
306.51 Functional vaginismus
302.79 Atypical psychosexual dysfunct

Other psychosexual disorders
302.01 Ego-dystonic homosexuality
302.90 Psychosexual disorder not else where classified

DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED
312.31 Pathological gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent explosive disorde
312.35 Isolated explosive disorder
312.39 Atypical impulse control disor

ADJUSTMENT DISORDERS
309.00 with depressed mood
309.24 with anxious mood
309.28 with mixed emotional features
309.30 with disturbance of conduct
309.40 with mixed disturbance of emo tions and conduct
309.23 with work (or academic) inhibition
309.83 with withdrawal
309.90 with atypical features

OTHER CONDITIONS
300.90 Unspecified mental disorder (non-psychotic)
Specify physical disorder on Axis III.
316.10 Psychological factor probably affecting physical disorder
316.20 Psychological factor definitely affecting physical disorder

PERSONALITY DISORDERS
Note: These are coded on Axis II.
301.00 Paranoid
301.21 Schizoid
301.22 Schizotypal
301.50 Histrionic
301.81 Narcissistic
301.70 Antisocial
301.83 Borderline
301.82 Avoidant
301.60 Dependent
301.40 Compulsive
301.84 Passive-Aggressive
301.89 Atypical, mixed or other personality disorder

V CODES FOR CONDITIONS NOT ATTRIBUTABLE TO A MENTAL DISORDER THAT ARE A FOCUS OF ATTENTION (AXIS I)
V65.20 Malingering
V62.88 Borderline intellectual functi ing* (V62.89)
V71.01 Adult antisocial behavior
V71.02 Childhood or adolescent antisocial behavior
V61.10 Marital problem
V61.20 Parent-child problem
V62.81 Other interpersonal problem
V62.30 Academic problem*
V62.20 Occupational problem
V62.82 Uncomplicated bereavement
V15.81 Noncompliance with medical treatment
V62.89 Phase of life problem or other life circumstance problem

ADDITIONAL CODES
V71.09 No Axis I diagnosis (or condit
799.91 Axis I diagnosis of condition deferred
V71.09 No Axis II diagnosis
799.92 Axis II diagnosis deferred

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Psychotropic Medications
TIME ALLOCATED	Two Hours
SPACE REQUIREMENTS	Large classroom to seat participants
LESSON OBJECTIVES	Each student will: 1. Know appropriate and inappropriate use of medication. 2. Know the four basic groups of medications used in psychiatry. 3. Be aware of positive and negative effects of medication on specific illnesses.
'RAINING STAFF	Instructor should be a psychiatrist or a mental health professional.
TUDENT MATERIALS	Handout and writing materials
NSTRUCTOR ATERIALS & QUIPMENT	Instructor should have knowledge of the jail program. A copy of the Physicians Desk Reference 1986, would be appropriate for students to review.
ETHODS AND EQUENCES	Lecture and discussion

INSTRUCTIONS	DISCUSSION
INSTRUCTOR	(This lesson plan is composed of highly technical drug information. The followin list of words have been selected for you review and to prepare you to explain, in simplistic terms, the following terms):
KNOW TERMS	

1. Neurotransmitter
2. Korsakoff's syndrome
3. Anxiolytics
4. Anticholinergic effects
5. Cardiotoxia
6. Neuroleptics
7. Antipsychotics
8. Agoraphobia
9. Norepinephrine
10. Extrapyramidal symptoms

INSTRUCTOR

Each of you have observed the remarkable changes that occur when certain medications are given to inmates. On many occasions, I am sure you have wished the doctor would give the problem inmate a shot to "knock hi out" and to make your job easier. This nex hour will be spent on explaining medications, the whens and whys of their use, and when it is inappropriate to use them.

In the jail, we are primarily concerned with drugs that disrupt the normal operations of the jail and the prevalence of their use. Only a few fit this pattern. They are PCP, alcohol and amphetamines (speed).

)EFINITION

PCP (Phencyclidine) Angel Dust

PCP is a powerful anesthetic which possesses dangerous hallucinogenic and psychomimetic characteristics. Due to its adverse side effects which elicit psychotic behavior, insensitivity to pain and supernormal strength, its anesthetic properities cannot be utilized. It is believed that PCP may disrupt the neurotransmitter catecholomines, serotinin, and acetylcholine.

PCP is fat soluable which means that the substance is stored for a longer period of time in the fatty tissue of the body. An episode can last from two to eight hours and can stay in the body up to approximately six months! A pleasant experience this week can result in a terrifying, uncontrollable experience next month from the same dosage. PCP may induce a variety of psychological symptoms which include: extreme irrational violence, spatial disorientation, confusion, paranoia, mania, depersonalization, hallucinations and agitation. The superhuman strength and insensitivity to pain makes the PCP victim extremely dangerous. They are almost impossible to stop, tossing police off of them as if the were rag dolls and being combative even after suffering a gunshot wound. With chronic use, PCP can produce irreversible brain damage and toxic psychosis. PCP can be found in marijuana and recently it was found mixed with cocaine. It causes Organi Brain Syndrome and victims feel disassociation, that is, the brain feels separated from the body. Most importantly the victim becomes dangerous, unpredictabl and disorganized.

EFINITION

Ethanol (Ethyl Alcohol)

Alcohol is usually not thought of as a drug. It is the "wet" drug. Behaviorally and psychologically, alcohol produces similar effects as the barbiturates. It i a central nervous system depressant. Tolerance can occur with excessive use. The brain learns to adjust and function with higher levels of alcohol in the body.

Alcoholism is a disease of chronic alcohol abusers. Life revolves around drinking ar drinking alcohol is essential to the alcoholic. The victim is physically and psychologically dependent on alcohol and withdrawal can be a frightening and dangerous experience. Death can occur as result of alcohol withdrawal if not properly handled. It is much more dangerous than the opiates withdrawal. Wit delirium tremens (DTs) there can be seizures, hallucinations and paranoid delusions. Alcohol use can produce toxic psychosis, liver and extensive brain damage.

Korsakoff's syndrome is an organic brain disease caused by chronic alcohol use. It produces toxic psychosis, brain lesions in the hippocampus,(an important center for memory), aphasia (speech problems), ataxia (muscle problems) and amnesia.

In pregnancy, women who drink alcohol pass the same alcohol to their unborn fetuses through the placenta. Babies born to thes mothers may be addicted to alcohol, and ca be mentally and physically retarded, a disorder known as fetal alcohol syndrome.

Alcoholism has a high genetic load factor and tends to run in families. Alcoholics usually have dependent personalities, are demanding, suspicious and display hostile and disruptive behavior.

)EFINITION

Amphetamines (speed)

Amphetamines act as stimulants by increasing arousal, alertness, militates against fatigue, and is a psychic energizer. It produces an awakening effect, is an appetite suppressant, and provides a feeling of euphoria (a rush). The awakening effect does not habitutate, therefore, the victim does not need to increase the dosage to acquire the same effect. However, the "rush" does habituat(and the victim increases the dosage to regain the euphoria. Withdrawal brings with it terrifying miserable "crashes". The victim may sleep for days, awake hungry and extremely depressed. With

chronic use it can produce toxic psychosis, irreversible brain damage, and is <u>indistinguishable from paranoid schizophrenia.</u> Behaviorally, the personality becomes aggressive and paranoid.

Amphetamines arouse the central nervous system by releasing the neurotransmitter, norepinephrine, faster than the body can replace it which produces depletion of norepinephrine. It is this depletion that causes severe depression. To remain balanced the victim becomes caught in a vicious cycle of drug abuse. Amphetamines are <u>legitimately</u> for the treatment of narcolepsy (a sleep disorder).

Now let us look at the psychotropic drugs. There are four classes of psychotropic medications.

1. <u>Anxiolytics</u> - They are minor tranquilizers and are effective in reducing anxiety, psychosomatic disorders and tension. Although they are not recommended for chronic psychotic conditions, they have been used for psychomotor agitation with acute psychosis, phobic disorders, epilepsy and alcholism. These drugs serve as muscle relaxants and reduce excitability because they depress the central nervous system. When there is muscle tension, there is anxiety. The greater the tension, the great the anxiety. The anxiolytics have a tendency to break this cycle.

   There are many side effects which include:

   addiction, tolerance, physical and psychological dependency, ataxia, headaces, drowsiness, and the anticholinergic effects (dry mouth, constipation, and blurred vision).

   With withdrawal comes tremors, muscle cramping, diarrhea, seizures, vomiting motor difficulties, terror and sometimes death. Withdrawal from the anxiolytics are worse than from the opiates.

2. <u>Mood Stabilizers</u>

Mood stabilizers are helpful in stabilizing the affect. The most commonly used is lithium carbonate for acute manic episodes. It is a preventive medication for manic-depressive illnesses. It reduces the severity of the mood swings and does not have sedative side effects which most patients appreciate. Since it usually takes some time for the drug action to occur, neuroleptics are used to alleviate insomnia and agitation.

A list of side effects are as follows:

fatigue, confusion, muscle weakness, tremors, increased thirst, nausea, vomiting, frequent urination, and diarrhea.

Blood levels are measured periodically because lithium can be toxic. Patients with renal impairment, dietary restrictions of salt and thyroid disease should not take lithium. It is believed that lithium interacts with the cell membrane of the neuron. The manic-depressive tends to have an unstable cell membrane which makes the neuron more irritable. Lithium stabilizes the membrane.

It can be used for Premenstrual Syndrome (PMS) and episodic alcoholism. Some people do not respond to lithium and must be treated with an antiseizure medication like Tegretol.

3. <u>Antidepressants</u>

Antidepressants are known as mood elevators and are used for affective disorders, unipolar and bipolor depression. There are two categories of depression: reactive and endogenous depression. Reactive depression is caused by external stressors whereas endogenous depression is severe and is caused by internal stressors or events. In the

1950's and 1960's Electroconvulsive Shock Therapy (ECT) was used for endogenous depression. Although less safe and effective, chemotherapy has replaced ECT's use. Antidepressants can be used for the treatment of agoraphobia, (fear of open space or being away from home). They appear to be the drug of choice compared to anxiolytics for agoraphobia.

Monoamine Oxidase Inhibitors (MAOI's)

The MAOI's are antidepressants which are considered dangerous and sometimes fatal because of the interaction with the amino acid, tyramine, which is in common foods such as cheese and beer. If used the patient must follow a strict restrictive diet. Tricyclics are used more frequently than MAOIs.

MAOIs were discovered by accident when iponiazid, a drug used to treat tuberculosis was found to produce euphoria in patients. MAOI side effects include liver damage, stroke, mania and anticholenergic effects.

Tricyclic Antidepressants

These drugs are mood elevators that were discovered by accident when scientists were experimenting, looking for a drug that would eliminate schizophrenic symptoms. Although the drug did not alleviate the symptoms of schizophrenia, it did produce euphoria. 65-80% of the patients taking these drugs have a positive response.

All antidepressants require three to four weeks before they are effective. They are long-acting drugs and require a transition period to alleviate suffering and mental anguish. Psychomotor symptoms are alleviated before mental suffering. During this period, aggression on others and suicide may occur. Tricyclics are extremely toxic and a one week supply, taken at once, can kill a patient. They are prescribed with caution for suicidal patients. Sinequan, the liquid, may be

used to eliminate hoarding. There are a variety of tricyclics. A few include Elavil, Tofranil and Norpramine.

As noted earlier, depression is caused by insufficient amounts of the neurotransmitter, norepinephrine. Antidepressants (MAOIs and tricyclics) tend to balance and stabilize the levels of the neurotransmitter. The tricyclics may produce cardiotoxia which is not reversible but the following side effects do tend to wear off:

-extreme anticholinergic effects
-excessive perspiration
-weakness and numbness of the arms and legs
-fatigue
-tremors
-impotence
-insomnia
-seizures

4. <u>Neuroleptics</u>

Neuroleptics are antipsychotic medications which are major tranquilizers. Basically, these drugs greatly alleviated the need for filled beds in the psychiatric hospital. Neuroleptics opened a new era for the treatment of mental illnesses. The antipsychotics alleviate the symptoms of schizophrenia which include:

-destructive behavior
-hallucinations
-delusions
-paranoia
-delirium
-confusion
-mania
-agitation
-thought disorders

Neuroleptics tend to reverse thought disorders and restore positive contact with reality. These antipsychotics tend to work in two ways:

1. They sedate the psychotic patient.

2. They alleviate hallucinatory and delusional symptoms.

The phenothiazines (Thorazine) tend to be more effective than butyrophenones (Halidol). These drugs produce major adverse side effects which include:

-anticholinergic effects more common with the phenothiazines than haloperidal.

-extrapyramidal symptoms

-tardive dyskinesia

These drugs should not be used with alcohol, narcotics or barbiturates nor should they be taken with other anticholinergic drugs.

There are an unusually high number of dopamine receptors in the brain of the schizophrenic. The neuroleptics tend to block many of these receptors so the patient can channel into his environment b positively responding. The more constructive the antipsychotics are as blockers, the more stable will be the schizophrenic patient.

In sum, these medications can be used as chemical restraints, but it is not medically wise or legal to do so. The doctor is liable. Medication is for treatment not for punishment. It is the law!

HANDOUT

PSYCHOTROPIC MEDICATIONS

The following is a list of the major psychotropic medications you are likely to encounter and their main indications. The medications in each category are listed in order of "popularity" and may be indicative of the frequency that you hear them.

NEUROLEPTICS/ANTIPSYCHOTICS

- Thorazine
- Haldol
- Mellaril
- Prolixin
- Prolixin D
- Navane
- Stelazine
- Triavil
- Serentil
- Loxitane
- Trilafon
- Moban
- Etrafon
- Permitil

ANTIPARKINSON (TREAT SIDE EFFECTS OF NEUROLEPTICS)

- Cogentin
- Artane
- Benadryl
- Symmetrel

MOOD STABILIZERS

- Lithium (Lithobid, Eskalith)
- Tegretol

ANTIANXIETY/BENZODIAZEPINES

Valium	Dalmane
Librium	Centrax
Tranxene	Restoril
Serax	Paxipam

ANTIDEPRESSANTS

Elavil	Vivactil
Tofranil (Imipramine)	Endep
Sinequan	Pamelor
Norpramin	Surmontil
Asendin	Nardil
Ludiomil	Parnate
Desyrel	Marplan
Adapin	

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Questions Review
TIME ALLOCATED	One Hour
SPACE REQUIREMENTS	Large classroom for all participants
LESSON OBJECTIVES	Each student will: 1. Be able to answer questions from the first day.
TRAINING STAFF	Course facilitator.
STUDENT MATERIALS	Writing materials
INSTRUCTOR MATERIALS & EQUIPMENT	Flip charts and marking pens
METHODS AND SEQUENCES	Questions and answers

INSTRUCTIONS	DISCUSSION
INSTRUCTOR	(Basically the method of instruction will be questions and answers. Questions shoul be directed to students. If the students are unsure of the answers, the instructor will provide them. This review is the introduction to day two).
	This hour is designed to review material covered in day one.
	Are there any questions before we start th review? (instructor answer questions).
	If everyone thoroughly understands what happened in the first day, let's answer some review questions that I have prepared
INSTRUCTOR	(Ask the following questions and others that you feel are appropriate to this review session).

REVIEW QUESTIONS

1. In addition to the changes of the DSM II to DSM III, what two important mental health issues effect the jai environment and operation?

   ANSWER:

   1. Overcrowding of jails and prisons.

   2. Dwindling of government resources and funds.

2. What is psychology?

   ANSWER:

   Psychology is the study of behavior.

3. What is transference and counterference?

ANSWER:

Transference is the unconscious identification with the therapist by the patient with someone in the patient's past. Countertransference is based on the therapist's repressed feelings, symbolic of sexual relationships and other unconscious feelings projected onto the patient.

4. In Freud's psychoanalytic theory, what are the three components of the subsystem of the personality?

ANSWER:

The id, ego and superego.

5. What is the id?

ANSWER:

It is the pleasure principle. It is present at birth and knows no sense of reality or morality.

6. What is the ego?

ANSWER:

It is the reality principle. It is the balancing agent between the id and the superego, e.g., Captain Kirk.

7. What is the superego?

ANSWER:

It is the conscience. It is responsible for feelings of guilt and is concerned with morality, logic, and the principles of right and wrong.

8. What is anxiety?

ANSWER:

It comes from dangers or threats in the external environment. It drives the individual to some kind of rational action.

9. Can anyone tell me what the difference is in a neurosi compared to a psychosis?

ANSWER:

A neurosis is a mild personality decompensation. Ther is an apparent impairment of social functioning, however, the individual is in contact with reality and does not need hospitalization. On the other hand, a psychosis is a severe personality decompensation with marked loss of reality and incapacitated social functioning. This individual usually requires hospitalization and medication.

10. What is a delusion?

ANSWER:

A delusion is when an individual is convinced of a situation that does not exist; the individual believes and may be completely logical about the situation. E.g., believing that she is the Virgin Mary or he is Jesus Christ.

11. What is an illusion?

ANSWER:

A misinterpretation of a real stimulus situation. For example, a woman perceives a man in the corner, when ir actuality it is the American Flag.

12. What is a functional disorder?

ANSWER:

A functional disorder is where there is no specific physical damage but there are unexplained complications, e.g., some forms of epilepsy, and conversion reactions (unexplained blindness with no apparent physical cause).

13. What is a hallucination?

ANSWER:

A sensory perception in which the sensory organs perceive without the reality of external stimulation. The experience is an internal stimulation, e.g., hearing voices and seeing spaceships.

14. What is the most common type of hallucination?

ANSWER:

The most common type of hallucination is an auditory experience.

15. What is schizophrenia?

ANSWER:

Schizophrenia is a major type of mental disorder. It is a thought disorder with psychotic overtones. The prognosis for individuals with this disorder is poor.

16. What is a manic-depressive disorder?

ANSWER:

It is an affective disorder which effects the mood of individuals who suffer it. The prognosis for this disorder is usually very good.

17. What is the drug of choice for the manic-depressive illness, in addition to the antipsychotic medication that is given?

ANSWER:

Lithium

18. What drug with chronic use produces irreversible brain damage and is indistinguishable from paranoid schizophrenia?

ANSWER:

Amphetamines

19. What is the DSM III?

ANSWER:

It is the Diagnostic and Statistical Manual that explains the current psychiatric classification system.

20. When we talk about the genetic risk factor of a mental disorder, what exactly does this mean?

ANSWER:

Researchers have found that genetic's play a significant role in psychiatric disorders and substanc abuse disorders. Schizophrenia and depression tend to run in families. If there is a high genetic risk factor compounded by stress, there is a strong predisposition of acquiring a disease or a disorder.

21. Neuroleptics are antipsychotic medications. They reverse thought disorders and restore positive contact with reality. What kinds of patients are given neuroleptics?

ANSWER:

Schizophrenics and other disorders which include psychosis because they sedate and alleviate hallucinatory and delusional symptoms of the psychotic inmate.

22. What are the most serious side effect of neuroleptics/ antipsychotics?

ANSWER:

The most serious side effects:

1. anticholinergic effects
2. extrapyramidal symptoms
3. tardive dyskinesia

23. Chemically, the biological theory of schizophrenia proposes that excessive quantities of a neuro-transmisser make attentional control increasingly difficult for the schizophrenic. What is the neurotransmitter?

ANSWER:

Dopamine

24. Should medication be used as a chemical restraint?

ANSWER:

It is not medically wise or legal to use chemical restraints. The doctor is liable because medication is for treatment not for punishment.

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Personality Disorders
TIME ALLOCATED	One Hour
SPACE REQUIREMENTS	Large classroom for all participants
LESSON OBJECTIVES	Each student will be able: 1. To know the definition of a personalit disorder. 2. To understand the basic characteristic of the following personality disorders -Antisocial -Compulsive -Paranoid -Narcissitic -Histrionic
TRAINING STAFF	Instructor with advanced knowledge of personality disorders.
STUDENT MATERIALS	Four handouts and writing materials
INSTRUCTOR MATERIALS & EQUIPMENT	Instructor notes, flip charts, marking pens, four handouts, David Shapiro's "Neurotic Styles", if available, and a copy of DSM III.
METHODS AND SEQUENCES	Lecture, question and answers

INSTRUCTIONS	DISCUSSION
INSTRUCTOR	In the next two hours, we will talk about personality disorders. In the DSM III, personality disorders can be found in the 301 to 301.89 category. The definition o: a personality disorder according to the D: III is:

"Inflexible and maladaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress" (APA, 1980).

In your notebook you will find two handouts on the DSM III, and one lists the twelve different personality disorders. Look at the sheet that is filled with all of the DSM III categories. Look for Personality Disorders. Now look at your next sheet that explains the multiaxial categories. Personality diisorders are coded on Axis II. Look at your personalit handouts now. Due to time limitiations, w will discuss five of these personality disorders. The five areas consist of the antisocial, compulsive, paranoid, narcissitic and histrionic. Before we describe each area, let me give you some background information.

In the DSM II, many of the classifications under personality disorders were classifie as a Neurosis. They are now personality disorders. With the coming of the new nomenclature, DSM III, there was the omission of the diagnostic category of Neurosis which is a matter of great concer to many in the psychiatric profession.

David Shapiro's book titled "Neurotic Styles" is a classic and appropriate for our discussion. When he talked about the style, basically it is the particular way in which one cognitively functions and/or behaves defined by specific acts. For example, style is like a "mental cap", tha is worn by people with a particular personality disorder. This cap is a cognitive style. The histrionic style has a different "cap" than the antisocial personality disorder. This "cap" dictates how the individual will act. What is

important for you to remember is that all of us have elements or components of thes disorders. For example, in order to beco a doctor, the tendency to be compulsive i important in the acquisition of knowledge All of us have personality traits that he us perceive and deal with our environment Only when these traits are maladaptive an inflexible does the individual experience difficulties. In other words, personalit disorders consist of cognitive modes or ways of thinking that give the inmate difficulties.

THE ANTISOCIAL PERSONALITY DISORDER

This category is extremely important because of the prevalence of inmates who have antisocial personalities. It is estimated that their numbers are over 5 million. 40% of all criminals are antisocial, committing 80% to 90% of all crimes. The terms sociopath, psychopath and antisocial are interchangeable terms. These people are sane, not psychotic, not out of touch with reality. They suffer from no major mental illness. They are "normal" with inflexible ways of perceivi the world.

The most significant characteristic of th antisocial personality disorder is the history of continuous abuse of the rights of others and the disorder occurs before 15 years of age. There is reluctance and failure to accept social norms. Therefor the inmate antisocial is unsocialized and is in constant conflict with society. If you notice, I said the inmate antisocial. Antisocials are found in all occupations. For example, we have antisocial lawyers, bankers, doctors, etc.

These people are cold, callous, selfish ar impulsive. Their superego is almost non-existent because it is difficult for them to feel guilt. Their tolerance for frustration is low, they rationalize thei difficulties. They form no allegiances tc others because they are incapable of showing loyality to country, social values groups or individuals. Since they are self-centered, it is understandable why tl suicide potential for these individuals is

relatively low. 85% are male and 15% are female. They hate authority, jails, prisons, and hospitals. Their IQs tend tc be above average and they possess high verbal skills.

The cause for the disorder has been linkec to everything. As of recently, no apparer causal relationship has been established. Some say the antisocial was developed as a result of child abuse. Either the parents were brutal or overly indulgent and the child blocked them out. Many times the blocking occurs to the point of homocide.

Antisocials are calm when others are highl emotional because there is a deficiency ir emotional arousal which reduces fear in stressful situations. However, they do respond emotionally and physiologically tc

1. Ego threats

2. Ego stimulation

These individuals are extremely defensive when you attack or threaten their egos. A show of force may make them protract, that is, drag out the situation. It is important to allow them to "save face".

The lack of stimulation and activity increases the stress level. The stimulation and activity of the crime, itself, is reinforcing to the antisocial and any financial gains are secondary. When they are bored and silent, they can b extremely dangerous because they need ego stimulation desperately. The following is an example of the lack of conscience in an antisocial.

EXAMPLE

A correctional psychologist working in a federal prison was approached by a young antisocial male of approximately 25 years of age. He told her that he was stupid. He said that he could have escaped prison had he killed the mother and child who recognized him robbing the bank. Realizin the lack of guilt or a strong superego, what do you think the doctor might have said to him to reinforce his decision of not killing the mother and child?

QUESTION

If you were the psychologist what would y say to him?

(Encourage participation).

ANSWER

The doctor appealed to his fear of prison She said that he had done the right thing by not killing them because law enforceme officials search hard and long for baby killers. She convinced him that he would have gotten more time for the crime. If you notice, she understood that talking about right and wrong was like asking an egg to jump. She appealed to his fears.

EXAMPLE

I was once asked who I would rather meet i a dark alley, a paranoid schizophrenic, wh is completely out of touch with reality or an antisocial personality disorder?

Which one would you choose?

(Encourage strong participation).

ANSWER

The rationale is that you know what a paranoid schizophrenic is capable of doing but with an antisocial, he could smile at you and kill you all in the same breath. Many times murder occurs for mere stimulation. These individuals can be extremely dangerous.

Examples of antisocials include Ted Bundy. He killed college women. Remember the movie, "The Deliberate Stranger"? Charles Manson of the Sharon Tate murders and Ed Kemper who confessed to killing 35 women, including his grandmother and grandfather because he was upset with his mother.

'ILM

(Instructor if "50 Weeks of Planned Killing" is available, insert it here. Th film takes approximately an hour. Find time to schedule it after class hours. Analyze the film and ask the participants their feelings and impressions afterward).

Are there any questions on the antisocial personality disorder?

THE COMPULSIVE PERSONALITY DISORDER

Shapiro describes the Compulsive (Obsessi\ Compulsive) Personality Disorder as a "living machine" primarily interested in work. He exerts tremendous pressure by taxing the self through laborious effort. This person is internally driven. He drives himself to the point of exhaustion. Psychologically, there is an intense, shar focus which makes him appear to be constantly concentrating.

However, his focus is marked and limited i mobility and range. It is restrictive attention with limited flexibility and volitional (free-will) direction. Just as there is psychological rigidity, there is the physical rigidity of the body. Remember, where there is muscle tension, there is anxiety.

Being called single-minded is no insult tc him; he appears to be proud of this characteristic. He is not impressionistic rarely gets hunches, misses the flavor in life, affective experience is extremely limited, and it is difficult to have fun because fun must have aim, purpose and effort. Can you imagine going on vacation with someone like this?

I once went to a Xmas party of a compulsiv personality. He had everything planned right down to the one hamburger to four nuts that the guests would eat and all activity was planned. This compulsive was working hard at having fun.

Freud would say the compulsive's superego is unusually harsh because of the severe punishing of the self. He understand rule and acts on them. There is a fear of goin crazy and losing control. Psychologically he stands guard over the self by expending tremendous amounts of energy, e.g., laughing too hard with out a happy affect.

Remembering that he has an overbearing superego, would you see a compulsive in th jail setting?

(Encourage participation).

Considering the characteristics of hard work, sharp focus, one would expect the compulsive personality to accomplish a great deal. Initially this does happen because success and compulsivity are compatible. What happens is the compulsiv personality disorder gets caught in a vicious cycle, e.g., physically and mentally counting his money all day which interfers with other activities, washing his hands everytime he touches something because he is afraid of germs (Howard Hughes exhibited similar characteristics), returning home to check if the doors are locked and continuously going over and ove: financial records looking for mistakes.

Since he does not get hunches, you could plan his surprise birthday party, right in front of him, and he would never suspect it. This individual requires psychotherapy immediately because severe forms of the compulsive personality disorder decompensates into the paranoid type, the most severe form.

Are there questions?

THE PARANOID PERSONALITY DISORDER

This individual is suspicious and continously searches for clues to confirm his suspicions. Unlike the **compulsive,** he is not surprised by the birthday party because he anticipated it. He lives in anticipation, dreads surprises because the unexpected is threatening, and is unusually sensitive to his environment. He distorts reality and is preoccupied with suspicious expectations. No attention is paid to new facts that could eliminate his suspicions. The paranoid is psychologically rigid, has intentional control over the self, is not spontaneous, and does not know how to have fun. Like the compulsive, rarely does he laugh but merely imitates the behavior. He is not romantic or interested in art or aesthetics. The paranoid personality disorder is the most severe form.

UESTIONS

Can you see how the compulsive style can decompensate into the paranoid personality disorder?

What are the similarities between the both of them?

What is the difference in the paranoid personality disorder and the paranoid schizophrenic?

How would the paranoid personality handle his wife or girlfriend?

Are there any question before we move on?

THE NARCISSITIC PERSONALITY DISORDER

This inmate has a grandiose sense of importance. There is a strong preoccupation for admiration, constant attention and fantasies of unlimited success, beauty, power, wealth and brilliance. The ego is weak and the individual constantly militates against threats to the ego and self-esteem. He exploits others because he has feelings of entitlement, that is, he believes he has a natural right to exploit. Empathy of others is non-existent and there are frequent feelings of ambivalence. He can adore and despise an individual all at the same time. It is more important for him tc be seen with the right people, at the right places with the right things (yuppy toys - expensive cars, clothes, car phones, watches, etc.) than developing lasting substantial relationships. I am sure you see inmates like this all of the time. What kinds of inmates have you seen that fit this description?

NSTRUCTOR

Good examples are:

1. Pimps
2. Drug pushers
3. Inadequate personalities

Ending with the narcissitic style, are there any questions before we go on to the next category? Do you have a full understanding of the Narcissitic Personality Disorder?

NSTRUCTOR

(Encourage questions and participation.)

The final category is the Histrionic (Hysterical Neuroses in DSM II) Personalit} Disorder.

HISTRIONIC (HYSTERICAL) PERSONALITY DISORDER

Shapiro does an excellent job describing this disorder. Histrionic is a word that defines a theatrical person, that is, one who acts. This individual is cognitively (mentally) insufficiently organized, too quick in decision-making, represses information, thus not having the factual information for a logical analysis.

EXAMPLE

A man tells his histrionic wife, "I want you to pay the telephone bill today. I forgot to pay it earlier. Here is a $100.00 bill because I don't have any smaller bills. If you don't pay it today, the telephone company will cut it off. Thanks darling, I love you. Got to get to work". Later on that evening, the husband picks up the telephone and it is "dead". He confronts his wife. She becomes hysterical saying that he never gave her any money and never told her to pay the telephone bill.

He goes to her purse, finds the $100 bill and she swears that he "set her up". This woman is not lying! According to her style, she completely repressed everything that happened regarding the situation. This husband is in "BIG TROUBLE".

There is a lacking in intellectual curiosity, inability to concentrate and lack of a sharp focus. These individuals are rarely scientists, accountants, researchers, etc. Basically they are ruled by affect and are highly emotional. Psychologically they are easily captured, surprised, highly suggestible, distractible, impressionistic, and are "struck" by people, places and things. Histrionic personalities are extremely romantic, believing in a Cinderella romance and

feeling afraid of losing the "things that really count" in life. You will find them to be overly flamboyant, wearing lots of jewelry, make-up, "done up" hairstyles and loud clothes. These elaborations can be clues to the possible indication of this personality style, but be careful not to generalize these characteristics to the general inmate population. There are just as many male histrionics as there are females.

INSTRUCTOR

Are there any questions?

(Encourage participation).

BREAK!

HANDOUT

THE ANTISOCIAL PERSONALITY DISORDER

'he following characteristics are indicative of the antisocial ›ersonality disorder:

- -super intelligent
- -good verbal skills
- -inadequate conscience development
- -no internalized ethical or moral values
- -tolerance for frustration is low
- -does not learn from difficulties or experiences
- -violent and callous unconcern
- -disregard for social obligations
- -calm when others are anxious, worried and stressed
- -will "act out" tensions by being hostile and aggressive
- -irresponsible
- -manipulates and uses people for own use
- -chronic liar
- -cannot trust him
- -will not accept the blame for actions
- -blames others for difficulties
- -self-centered and egocentric
- -is an actor with practiced social skills for all emotional responses
- -hates authority
- -resents punishment
- -does not like jails or hospitals
- -incapable of loving others
- -good prisoners
- -excellent police informants

HANDOUT

THE COMPULSIVE PERSONALITY DISORDER

The following characteristics are indicative of the compulsive (obsessive-compulsive) personality disorder:

- nuisance offenders
- ritualistic thought and behavior (exhibitionism, kleptomania, pyromania, voyeurism, fetishism, and obscene phone calls)
- sexual inadequacy
- living machines
- cognitive and physically rigidity
- restrictive attention
- inflexible with limited volition (will power)
- intense sharp focus
- marked attention in mobility and range
- always concentrating
- rarely gets hunches
- misses life's flavor
- proud of single-mindedness
- not impressionistic
- shrunk affect
- interest is working
- taxes himself
- acts on and follows rules
- harsh superego
- works at having fun
- activities must have aim, purpose, and effort
- afraid of going crazy
- decomposes into paranoid personality disorder

Referenced from "Neurotic Style", David Shapiro.

HANDOUT

THE PARANOID PERSONALITY DISORDER

The following characteristics are indicative of the paranoid personality disorder:

-extremely suspicious
-rigid
-fixed, preoccupied expectations
-searches for confirmation of suspicions
-does not attune to new facts
-never surprised, anticipates
-searches for clues
-sensitive to change or unexpected events
-the unexpected is threatening
-distorts reality by suspicions
-constantly ready for an emergency
-intentional control over self
-not playful, rarely laughs
-imitates behavior
-not romantic
-considers feelings, weak and effeminate
-not interested in art or aesthetics
-extremely jealous
-the most severe form of personality disorder

Referenced from "Neurotic Styles", David Shapiro.

HANDOUT

THE HISTRIONIC PERSONALITY DISORDER

The following characteristics are indicative of the histrionic (hysterical) personality disorder:

- -repression of memory content
- -lack of sharp focus
- -impressionistic
- -factual information not important
- -distractible
- -hunches are final
- -incapable of intellectual persistence, curiosity, and concentration
- -as many men as there are women but men appear to mask their histrionic behavior better
- -highly suggestible
- -easily captured
- -easily surprised
- -rarely scientists and researchers
- -may wear a lot of jewelry
- -are struck by things
- -theatrical
- -Cinderella romance love affairs
- -ruled affectively
- -highly emotional
- -cognitively insufficiently organized
- -quick when making decision without factual information

ndividual with histrionic personality disorders commit crimes of passior nd emotions. Many male homosexual-love affair type crimes are ommitted by the histrionic individual. These crimes tend to be xtremely violent inflicting severe body mutilations.

nformation referenced from "Neurotic Styles", David Shapiro.

:OURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
.ESSON TITLE	Suicide Awareness/Prevention
:IME ALLOCATED	One Hour
;PACE REQUIREMENTS	Large classroom for all participants
.ESSON)BJECTIVES	Each student will: 1. Be able to understand the correlates of suicidal behavior. 2. Be able to identify high risk suicide symptoms, situations and inmates. 3. Be able to take appropriate steps to minimize and prevent high risk situations. 4. Be aware of the impact of inmate suicide on correctional staff.
'RAINING STAFF	The instructor should have knowledge of jail related suicide procedures and legal responsibilities. Invited instructors are appropriate here, e.g., county attorney, psychiatrist, etc.
'TUDENT MATERIALS	Four handouts and writing materials
NSTRUCTOR :ATERIALS & QUIPMENT	Lecture notes, flip chart, and marking pens.
ETHODS AND EQUENCES	Lecture, discussion, and question and answers.

INSTRUCTIONS	DISCUSSION
INSTRUCTOR	One of the most frustrating situations you will face as a correctional worker is an inmate threatening suicide. This inmate presents a variety of legal, moral and humanistic issues for the correctional administration. It is a difficult and stressful situation when an inmate commits suicide. For the next hour, we will address suicidal behavior.

Out of all the Major Types of Mental Disorders, there is a high number of suicides associated with Affective Disorders than any other. Suicide is the tenth leading cause of death in the United States. Some 20,000 to 30,000 Americans commit suicide annually, killing themselves on Friday, "blue" Monday and Sunday, respectively. Most suicides occur in the evening. The evening provides privacy, solitude and feelings of loneliness are more apt to occur. Suicide rates increase around Christmas and early Spring (April and May). Christmas is a time when family and friends come together, supposedly, in happiness and cheer. Television throughout the holidays reinforces the concept of family and togetherness. This may produce feelings of sadness, depression and despondency for people who feel less fortunate and deprived as they watch Hollywood theatrics depict happiness, well being and holiday cheer. While springtime symbolizes for many "new life" and a starting over period, for others who feel less fortunate, it symbolizes the reality of the "old life" and the continuous burden of hopelessness and unhappiness.

Looking over the data on successful suicide, the history of previous suicidal attempts appears to be the best successful indicator of future suicide. Also, demographic data appears to be a contributing factor (marital status, age, race, and sex).

People who are separated, divorced or widowed, commit suicide at an alarmingly higher rate than married people.

The highest rate of suicide occurs between the ages of 55-65 years of age. There is a tremendous risk for teenagers 15-19 years old. This is the second leading cause of death for this age group. Ages 24-44 are the

highest rates of attempted suicides. The rate for college students is particularly high, som 50 percent higher than for their non-academic cohorts.

Although 90 percent of the individuals committing suicide are white, urban Black male tend to have a higher suicide rate proportionately. The minorities' suicide rate is on the increase.

Statistics indicate future sexual equality in the suicide rates. At present, women attempt suicide more often than men, but men are more successful at it than women. Men commit suicide by hanging themselves or by gunshot. The childhood socialization process tends to teach male children how to be aggressive and violent which probably explains their methods of suicide. On the other hand, women appear more vain and, as a rule, do not shoot or stab themselves. They are interested in their aesthetic appearance even after death. Their method of suicide is usually poison, overdose or hanging. Those who commit suicide appear t(have a low tolerance for coping with stress an(appear to be somewhat mentally rigid.

UESTION

Do you have any idea why these groups have a tendency to be suicidal?

(Encourage participation)

NSTRUCTOR

(Write this information on your flip charts or blackboard)

Beck (1979) has identified factors relating to suicide risk:

1. Suicide ideations
2. Lethality of the method
3. Availability of the method
4. Detection of suicidal intent
5. Medical intervention by a concerned individual
6. Strong social support systems to diffuse the intensity of the wish

The jail is a high risk environment. Suicidal behavior is a significant problem for correctional workers because you are legally an morally responsible for preventing inmate suicides.

)UESTION

What inmates are high risk?

:NSTRUCTOR

(Write this information on the flip chart).

Every inmate should be viewed as a potential suicide risk. However, there are a variety of factors that selectively indicate high risk; they are as follows:

1. First time offenders who are extremely frightened and unsure of the jail and legal procedures are at high risk. This is a critical time because suicide tends to occur within the first 24 hours of incarceration.

2. Young (male) rape victims encountering thei) first homosexual experience in the jail are at high risk.

3. Inmates placed in isolation increases the probably they will commit suicide.

4. Inmates facing a crisis situation, whether it is receiving a major sentence, the loss of a loved one by death or divorce, persona] illness (e.g., the manic-depressive, depression, terminal illness, surgery, etc), and heavy drug abusers are at high risk.

   Drug abusers should be watched carefully because withdrawal or depression may be viewed as an escape from abstinence. For example, when an incarcerated cocaine abuser experiences severe depression as a result of the lack of cocaine, he is at high risk for suicide because the inmate could view suicide as an escape from the aftereffects of cocaine. Inmates in this category shoulc be referred to the mental health staff immediately.

5. Severely depressed inmates are at high risk and should also be referred to the mental health staff.

   Depression indicators which may warn the correctional staff an inmate is in "psychological danger" are an overall depressed appearance which includes walking slowly, a lack of sufficient energy fatigue, loss of appetite, and weight loss. In addition to these problems, there are sleep difficulties. The sleeping pattern is irregular, there is insomnia but ironically also early morning awakening.

   The depressed inmate appears to psychologically "crawl into himself". He i apathetic, despondent, feels hopelessness and dependent. There is withdrawal from staff and inmates, crying spontaneously for no legitimate reason, self-pity, giving personal possession away, talking of previous attempts, if any, may work on a suicide note (only a small amount of people committing suicide leave notes), and talk of suicide.

6. Inmates appearing to improve from the depression cycle are at high risk.

   They appear to be changing, changing lifestyle, habits, interest, sleeping, eating, and sexual patterns is indicative of considerable high risk. These inmates frequently develop order to their lives. They may settle debts, clean their rooms, wash their clothes, shave, bath, and give away personal property.

7. Inmates incarcerated for long periods of time and are tired of their life pattern, criminal history and long incarceration are at high risk.

   They view suicide as a way to eliminate future failures. Due to their adverse behavior, staff find it difficult to be empathetic with these inmates.

8. Inmates who are impulsive are at high risk. Impulsivity is an essential ingredient in the suicide production. Alcohol and drug abuse contribute to impulsivity. For

example, the impulsiveness of the late Freddie Prince television actor of "Chico and the Man". In an argument, he impulsively picked up a gun and shot himself.

9. Inmates charged with crimes of violence and passion are at high risk.

NSTRUCTOR

Alert Intake and Booking officers are a valuable resource in identifying suicidal risk. This is the first encounter with the inmate and this officer has the opportunity to observe the initial behavior and communications. If an inmate has a history of suicidal ideations, appears anxious, makes comments like "life is worthless", "nobody cares about me", or "I'd be better off dead", and exhibits symptoms of high risk, it is important that the correctional worker respond to the appropriate symptoms and not encourage or provoke an inmate to kill himself. DO NOT IGNORE THE INMATE. To do this could push him "over the edge" which you are morally and legally responsible for the end result!

Inmates exhibiting any of the symptoms that we have discussed will require special housing for their safety and protection.

JESTION

(What kind of housing is appropriate for the suicidal inmate?)

<u>EXAMPLES</u>

-Frequent, <u>randomly</u> <u>checked,</u> controlled living areas

-Clean rooms, no sharp instruments, nothing to assist in a hanging situation, and no electrical outlets

The Jail Suicide Prevention Seminar, 1985 cites a study that NCIA conducted in 1979 on suicide in jails. From a population of 344 inmates, a profile on the victim of suicide was developed.

The study found that 97% of the inmates who commit suicide are males. 67% are white and 22% are Black. 75% of the population were

under 32 years of age, with the average age being 28. 89% of the population was intoxicated and committed suicide within 24 hours of incarceration. 50% of these were dead within 3 hours. 96% of the suicides were hangings. Peak hours for committing suicide were between 12:00 A.M. to 3:00 A.M but the hours of 9:00 P.M. to 6:00 A.M. are considered critical times!

The environmental setting of the jail is conducive to suicidal behavior. Jails are:

1. Authoritarian, providing the inmate with little or no control over his life situation.

2. Confining and isolating.

3. Frightening, particularly for the first offender.

4. Dehumanizing.

5. Producers of shame and guilt. Although this appears to be an important factor in eliminating future criminal activities for convicted inmates, for many who are innocent or guilty, the superego is severe and the inmate's moral image may be enough to "push them over the edge".

UESTIONS

Why are these symptoms seen more in jails than in prison?

(Encourage class participation).

ANSWER

Prison inmates have passed through the jail system and have learned coping mechanisms which have helped them to adjust and survive. As a result, these inmates are more experienced than first-time offenders or inmates who have never been in prison.

There are many inmates who threaten suicide merely to manipulate staff. They are maladjusted and should be referred to the mental health staff. Every threat should be handled as a serious event because, unfortunately, many manipulative inmates accidently kill themselves.

The self-mutilators and borderline personality disorders tend to injure, damage and punish themselves to relieve guilt for something they have done. These acts are beneficial for the continuation o living. This is usually not a suicidal gesture, however, the mental health team should be alerted immediately. The office can be instrumental in talking with the inmate to find positive reasons for living Most importantly, it is the responsibility of the officer to inform mental health about the signs and symptoms of this kind of inmate, and the suicidal inmate. The officer must verbally inform and notify th officers on the next shift about the inmate's behavior. Since a large percentage of suicides occur on the midnight-early morning shift, these officers must continue to be alert and watchful.

SUICIDE IMPACT ON STAFF

Suicide affects not only the suicide victim but family, friends, and correctional staff. Staff members can experience many of the same kind of problems that family and friends of the suicide victim experiences. Feelings of shame, guilt, uncertainty must be addressed. The ventilation of feelings is important, the interpretation of the suicide situation supported by factual information and support from others will emotionally assist the staff. What is often forgotten is that other inmates may experience similar kinds of feelings. Talking with them about their feelings wil assist them emotionally. When an inmate commits suicide, it is difficult on the many who shared his environment!

UESTION

WHAT DO YOU DO IF YOU FIND A POTENTIAL SUICIDE?

ANSWER

The majority of suicides in the jail are the result of hangings. Hanging attempts are extremely damaging to the neck structures because they may effect the major blood vessels supplying blood to the brain, damage the delicate spinal cord structures and damage air passages.

If you find a hanging victim, you should regard the incident as a medical emergency It is essential that you remember that a suicide victim is alive, until the proper medical authority pronounces him/her dead, regardless of appearances or physical symptoms! If you find a hanging victim, you should regard the incident as a medical emergency and do the following:

a. call for medical assistance

b. take special consideration of the head and neck areas, cut the inmate down carefully!

c. not moving the head or neck, carefully provide artifical respiration and circulation if the inmate is not breathing. Do this until the medical team arrives.

For more specific details take out your handout called HANGING ATTEMPTS. This was taken from Suicide in Jails, Library Information Specialists, Inc. December, 1983. This is an excellent handout that will assist you in how to handle a hanging attempt.

NSTRUCTOR

(If you have time go over the handout and discuss your department's policy on handling suicides).

HANDOUT

FACTS AND FABLES ABOUT SUICIDE

his handout was adapted from the Jail Officer's Training Manual, taken irectly from Suicide in Jails, NIC, Library Information Specialists, nc., December 1983.

FABLE: People who talk about suicide don't commit suicide.
FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

FABLE: Suicide happens without warning.
FACT: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions.

FABLE: Suicidal people are intent on dying.
FACT: Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling.

FABLE: Once a person is suicidal, he is suicidal forever.
FACT: Individuals who wish to kill themselves are "suicidal" only for a limited period of time.

FABLE: Suicide is inherited or "runs in the family."
FACT: Suicide does not run in families. It is an individual pattern.

FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily psychotic (out of touch with reality).

HANDOUT

INTERVENTION STRATEGIES

This handout was adapted from Bruce L. Danto and Jeffrey Eubank, Suicid in Jails and Its Prevention. Colorado: National Institute of Correctio Jail Center, 1980, taken directly from Suicide in Jails, 1983.

Once an officer has noted suicidal tendencies in an inmate, it is important that he/she establish lines of communication with the inmate. The following suggestions may be helpful:

1. If he is crying, let him know that it's good he can show his feelings.

2. Encourage the inmate to verbalize his suicide plans. If you can us the word "suicide," he will know you are comfortable about discussing it with him. Questions to be asked are:

    a. How do you plan to take your life?
    b. Where do you plan to do this?
    c. When do you plan to do this?
    d. Do you have the means to accomplish this? Where do you plan on obtaining them if you haven't already?

   Keep in mind that the more le[illegible]al the intended means of suicide, th greater its availability and [illegible]e [illegible]ore specific the plan, the greate the risk of a successful suicide.

3. Be attentive to what the person is saying. Ask clarifying questions; ask the person to continue; indicate by facial body cues that you are listening to him. Let him know that you're pleased that he is sharing his feelings with you.

. Give honest responses. Don't lie to the inmate about the consequences of his actions or your feelings about what he is doing. Don't be afraid to tell him that you don't have all the answers, but that you are willing to help him find answers to his problems by referring him to the mental health team.

. Try to understand the person's view. This does not mean you agree with his view, but rather that you understand how he is viewing the events that have happened to him. This understanding gives him an ally.

6. Don't give advice. The suicidal person has probably been "talked at for months. People love to help others by telling them what to do and why. However, this is rarely helpful to the emotionally trouble person. He usually knows what he should do, but, emotionally, is blocked from doing it. Telling him what to do may increase his feelings of failure and inadequacy and heighten his suicidal intent

7. Don't belittle his actions or humiliate him for being human. Occasionally, when individuals attempt to assist a suicidal person, they make misguided attempts to "shock" the person back to reality. They do so by "calling his bluff" or by minimizing his attempt. For example, a response to a person's unsuccessful wrist cutting could be, "You really botched it; next time you should cut deeper." Unfortunately, the person may act on this misguided advice. Also, don't minimize the person's problems. What may appear to be insignificant to you may be overwhelming to him. If you indicate that you feel his problems are minor issues, you lose your opportunity to understand what really is occurring in the situation

8. Don't be judgmental. Most people contemplating suicide are victims of a very harsh internal judge, and this judge may have already passed sentence. A suicidal person will not respond positively to having another judge enter the scene.

9. Create rapport with the individual. Indicate legitimate agreements between yourself and the inmate in as many areas (particularly non-emotional ones) as possible. Again, this serves to ally the office with the inmate and helps to develop the relationship between them, allowing the inmate to feel that the officer can understand him since they have some similar background.

10. Let him know that his family needs him around to love them and that this alone is an important reason for staying alive.

11. Keep his sense of the future positive. Tell him about prison if he has been convicted and assure him that this might be his chance to learn a trade or obtain some education.

12. Take all threats seriously. Taking threats lightly many increase the individual's feelings of hopelessness and increase his desire to die. Explain to the inmate that social workers can help him with some of his worries, and make an immediate referral to the mental health team.

HANDOUT

HANGING ATTEMPT

A hanging attempt may affect any or all of the structures in the neck. These include the structures of the airway, spinal cord, and the major blood vessels, which bring the blood supply to the head. All of these must be considered in caring for the hanging victim.

DISPOSITION FOLLOWING A HANGING ATTEMPT

1. Extricate victim, protecting head and neck as much as possible.
2. Have someone call an ambulance immediately.
3. Give basic first aid.

FIRST AID

1. Monitor and maintain open airway.

   a. Look, listen and feel for breathing if he/she is unconscious

   b. Maintain airway, if necessary, using the modified jaw thrust technique. DO NOT tilt the head back.

      1) Place your fingers behind the angles of lower jaw.

      2) Forcefully bring jaw forward.

      3) Use your thumbs to [illegible] lower lip down to allow breathing through [illegible] e [illegible] uth as well as the nose.

   c. Give artificial respiration, if necessary, while continuing maintenance of airway through jaw lift.

2. If there is no pulse, give cardiopulmonary resuscitation.

3. Assume that he has spinal cord injury, and treat appropriately.

   a. Place victim flat on floor with head held stable.

   b. Do not let victim or anyone else lift or twist victim's head.

   c. Do not give the victim anything to eat or drink, or any medication.

4. If there is swelling or discoloration, apply an ice bag to the area.

5. Do not leave the victim alone.

*From Suicide in Jails, Library Information Specialist, Inc., 1983.

:OURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
,ESSON TITLE	Mental Health Needs of Special Populations
'IME ALLOCATED	One Hour
:PACE .EQUIREMENTS	Large room for all participants
ESSON BJECTIVES	Each student will: 1. Understand the inmates' specific mental health needs. 2. Understand how to manage the violent offender. 3. Understand the needs of the mentally retarded inmate.
RAINING STAFF	Trainers should be mental health staff who have worked with these special populations.
TUDENT MATERIALS	Writing materials
NSTRUCTOR ATERIALS & QUIPMENT	Lecture notes, flip charts, and marking pens
ETHODS AND EQUENCES	Lecture, question and answers

INSTRUCTIONS

DISCUSSION

INSTRUCTOR

For the next hour, we will examine the mental health needs of special jail populations.

Proper management of special population inmates maintains order and disruptions, allows the jail administration better control over the facility and additional budgetary expenditures which would be needed to maintain control. Tangentially, the issues of increased professional services come at a time when jails must deal with issues of overcrowding. This makes it difficult to develop better service and treatment programs, programs for people that society would like to forget.

In jail environments, staff and inmates are uncomfortable with the mentally ill and other special population inmates because they upset the equilibrium of the jail setting. The "healthy" inmate has a right to be isolated from the seriously disturbed mentally ill inmate who, if violent could, theoretical, jeopardize the safety of the jail's general population. In addition, segregated units are essential because the strong inmates tend to prey upon the weak. It is the responsibility of the jail administration to protect inmates from victimization by segregating them from the general population.

The "least restrictive" environment applies to segregation of the mentally ill inmate. When separating them from the general population, the correctional administration must have documented justification for removing the inmate and it must be a reason other than punishment.

UESTION

Can anyone describe some of these special populations?

EXAMPLES

The mentally ill, the juvenile offender, the violent offender, the homosexual offender, the female offender, the mentally retarded and or physically handicapped, religious groups, gang members, "protective custody" inmates and drunk drivers..

NSTRUCTOR

Yes, there are a variety of populations in the jail that require special attention. For our purposes, we will discuss three populations, the mentally ill, violent offenders and the mentally retarded. The major mental disorders, Schizophrenia, Affective Disorders and Organic Brain Syndrome, require attentive care because these inmates have specific needs which may include segregrated housing, selective medications and monitoring procedures and/or special diets. For example, the manic-depressive inmate may require antipsychotics medications and lithium as well as monitoring of the blood levels to regulate the lithium dosage. Earlier we discussed the major mental disorders in detail. Special attention and care should be given to this population because of the moral and legal obligations required for their care and safety.

Many times a mentally ill individual may be stabilized in the general jail population. After a few days, weeks or months in this environment, an officer may witness a "stable" inmate who suddenly becomes disordered, unusual and exhibiting inappropriate behavior. The officer must answer the following questions:

1. Why the sudden change in the inmate?

2. What is wrong?

3. Is the inmate psychotic, that is, is he in touch with reality?

4. If this behavior continues what are the possible outcomes?

5. Is the inmate in need of psychological treatment? Should I notify the mental health team?

Psychotic disorders are thought disorders associated with inappropriate perceptions, distortions and emotions. These inmates operate in "another world". They perceive a reality far different than ours. Since their systems of perceptions are distorted and maladjusted, information that is given them are interpreted based on their distorted, malfunctioned psychological systems. The stresses and [illegible]s of the jail environment usually [illegible] not cause psychotic behavior, usually the inmate has a history of such episodes. Such behavior has a way of "running its course" in spite of the jail environment. The request for a mental health consultation should be made. If hospitalization is inappropriate for this inmate, special care should be given to provide ongoing psychological treatment and management strategies.

A psychotic inmate may be a danger to himself and others. In many states, psychotic individuals may be hospitalized involuntarily. You will find that city and district attorneys may drop minor charges if the individual voluntarily commits himself. The unfortunate aspects are the individual is quickly released and finds his way back to the legal system creating the vicious cycle of the chronically mentally ill.

Unusual behavior can be viewed on a behavior continuum from normal to psychotic. Inmates with "normal" behavior may periodically act-out as well as psychotic inmates. We must understand that the inmate may be responding out of fear, anxiety, confusion, uncertainty, isolation and discomfort. Many of the feelings that the inmate is experiencing, may be evoked in you just by observing the inmate's behavior. This is all right; it is considered a normal reaction. As a result of these feelings, inmates may become violent as a way to relieve their stresses and strains.

THE VIOLENT OFFENDER

The identification of predictive diagnostic clues of violent thought and behavior are essential for correctional workers in the jail environment. Many times by understanding and observing clues of violence, you can effectively predict and circumvent violent behavior before it occurs.

Certain kinds of inmates give clues which many indicate their predisposition for violence. They are the psychotic inmate, organic brain syndrome inmates, drug and alcohol intoxications and withdrawals, and some personality disorders. Let us discuss some of these areas.

Although we are more suspicious of the schizophrenic inmate because of his thought disorder and bizarre behavior, it is the manic-depressive inmate who is more likely to be a problem for the correctional worker due to violence. Manic inmates can be extremely violent no matter how "good natured" and amusing they may appear.

The organic brain syndrome inmate should be referred to mental health immediately. Although they appear "crazy" they may be suffering from life threatening disorders.

Violence at the point of entry into the jail maybe a significant indicator of drug related activity. Inmates intoxicated due to drugs and alcohol present a major problem to the successful operation of the jail because they are often frustrated, belligerent, and uncooperative. In addition, they are easily provoked. Like the manic inmate, amphetamine induced inmates may show extreme agitation and violence. Also PCP, phencyclidine, is highly related to violent, combative behavior. The drug produces superhuman strength where victims have been known to throw officers around like tossing baby dolls. Also PCP appears to disassociate the body from its pain centers making an offender difficult to stop.

The alcohol induced inmate may cause problems for the correctional staff. They may be explosive, unmanageable, and destructive as they progress through the withdrawal phases. Inmates with [illegible]ium tremens (DTs) and barb[illegible] withdrawal have a high potential for violence.

Some personality disorders can be violent upon entering the jail. The paranoid inmate may suspicously scan the jail environment and find that the normal interviewing procedures are overwhelming and intolerable. The questions produce tension and anxiety assisting in the eruption of violence. The antisocial and borderline inmates become violent when there is drug or alcohol intoxication.

INSTRUCTOR

(Write the following predictors on the flip chart)

Behavioral Predictors of Violent Behavior

Three excellent predictors of violent behavior are:

1. diagnosis of the patient,
2. past history of violence and
3. behavioral clues such as motor activity, muscular tension and speech.

QUESTIONS

The most essential noticeable clues of violence is the motor behavior of the inmate. If he is sitting, observe how he is sitting in the chair. Is he tense and rigid or is he relaxed and calm? If he is standing, is he standing rigidly or pacing?

Pacing behavior is indicative of anxiety and tension. If he is pacing away from you and quickly turns and walks towards you, you should leave immediately because you are probably in physical danger. This pacing is called appoach avoidance behavior and the inmate can be extremely dangerous.

When an inmate appears to be potentially violent, you should be aware of your environmental position. That is, you should always try to be between the inmate and the door. Physical distance can send the paranoid schizophrenic into a panic. You should keep a good distance from this inmate. Generally, you should stand an arms length away from the inmate and NEVER turn your back on the potentially violent inmate.

Talking to the inmate is one of the best procedures that can be used! Introduce yourself and convey to him that you intend to help him. Treat

him like a normal person with dignity and respect. Support the inmate as much as possible. Offering the inmate food is symbolic of caring and concern.

In the jail, there are general guidelines which are useful for handling violently aggressive behavior. Most importantly, when an inmate is upset, remember to remain calm, cool and collected. Try to alleviate disturbing environmental stimuli. Do not order the inmate to be calm rather state behavioral objectives and limits in a calm controlled voice and inform him of your intentions. Do not allow the inmate to verbally provoke you; this is an intended trap. Handle yourself in a manner that allows both you and the inmate the ability to maintain self-dignity. It should be noted that some inmates become violent and aggressive to maintain or regain their perceived threatened self-dignity.

If these approaches are unsuccessful and the violence and aggression contin[illegible] you must leave no doubt in the [illegible]'s mind that he will not win this [illegible]nc[illegible]nter. It may be necessary to us[illegible] f[illegible]ce (e.g. four pointing to capture his attention). At this point, restraints will be necessary. It is recommended that five people be available to restrain the inmate, one for each limb and one to pay close attention to the head area. It has been found that having a female available is very beneficial and calming to the inmate because five male officers may symbolically represent overwhelming control which many of these inmates, especially the psychotic ones, are afraid of losing self-control. Once he is restrained, observe the inmate on a frequent, irregular basis. Work toward getting the inmate out of restraints as soon as possible.

THE MENTALLY RETARDED INMATE

Mental retardation is diagnosed as a subaverage intelligence with an IQ below 70. Only 2.3% of the population possesses an IQ below 70. 89% of retarded individuals are mildly retarded. Their IQ is 55-69. In late adolescence and early adulthood the primary difficulties that yo will see are problems with social and vocational skills. This difficulty with social skills may be a contributing factor of incarceration. It is important for the jail service team to adapt a clear policy definition for the mentally retarde that will be followed by everyone. There are dangers associated with weak policy definitions. Establish clear policy procedures for diagnosis and decision-making.

Three aspects which are helpful in the policy definition are:

1. Low IQ scores (below 70)

2. Poor adaptive skills

3. Evidence of special education services during school years.

Neurological damage may produce a lowering of the IQ, for example, Korsakaff's syndrome, Temporal lob epilepsy, Alzheimer's disease and other forms of Organic Brain Syndrome. Although these disorders may or may not lower the IQ, they make jail confinement extremely problematic for the inmate and jail adminstration.

If the retarded offender is destined to stay in the jail setting:

1. Establish a highly structured environment for him.

2. Provide one to one assistance on a daily basis.

3. Anticipate what parts of daily

activities will be difficult for the inmate, e.g., personal hygiene, meals, recreation, night hours, etc.

NSTRUCTOR

(Encourage participants to interact and share examples of the retarded inmates that were in their facilities).

Some helpful mechanisms that the jail administration may use for coping with the problems of the retarded offender include:

1. Weighing the seriousness of the crime.

2. Using the responsiveness of state agencies for retarded adults.

3. Using local support groups that are advocates of the retarded. If the inmate is convicted of the crime, asking for continued support of the agency to insure that services do not end as a result of incarceration.

4. M[illegible] rtain that the judge u[illegible]er[illegible]ands the special risks t[illegible]e jail administration faces with the retarded inmate.

NSTRUCTOR

(Involve the participants).

What are these special problems?

:OURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
,ESSON TITLE	The Rights of Inmates
IME ALLOCATED	One Hour
PACE EQUIREMENTS	Large classroom for all participants
ESSON BJECTIVES	Each student will: 1. Understand the moral and legal rights of the inmate. 2. Understand what legal rights are alleviated due to incarceration. 3. Understand the rights of treatment and care.
RAINING STAFF	An instruc-or who is familiar with the legal .ssues and rights of inmates. A county attorney or mental health administrator would be ideal for this session.
TUDENT MATERIALS	Writing materials
NSTRUCTOR ATERIALS & QUIPMENT	Flip charts and marking pens
ETHODS AND EQUENCES	Lecture, question and answers

NSTRUCTIONS

DISCUSSION

NSTRUCTOR

Each of you because of your affiliation with the correctional administration has legal and moral obligations to the jail an its inmates. Even though these people hav been accused and possibly convicted of a particular crime, as "patients" they have legal rights that affect how you must deal with them. Confidentiality, refusal of medication and other issues must be addressed periodically by you.

Our moral obligation is to treat the inmat with honesty, dignity, respect and fairness. This behavior produces better results. Inmates treated humanely have a greater probability of behaving in an acceptable manner. Your behavior directly effects the behavior of the inmates. Destructive and harmful behavior is totall unacceptable and will not be tolerated!

<u>LEGAL PROCEDURES</u>

What is most important to remember is that the i[illegible] has the right to treatment and to b[illegible]ed by qualified professional staf[illegible] inmates are dependent on the jail [illegible]istration for their primary need[illegible] which a[illegible] food, water, shelter, clothing and medical care which includes physical and psychological care.

The inmate has the constitutional right of timely professional treatment and care by personnel bound to, and operating under, the same professional and legal stipulations as their civilian counterparts. He also has the right of informed consent, unless the court has granted an administrative sanction, with specific type of treatment and risk factors involved.

Confidentiality between inmate and mental health is kept to the extent that the inmate does not present a danger to self and others. Beyond this, it is difficult to keep confidentiality because many jail units requires lots of information during the booking process.

Isolation of the mentally ill inmate must have documented justification specifying the reasons for the isolation. Isolation may push the suicidal patient to kill himself, produce panic attacks, may psychological devastate the paranoid schizophrenic but tangentially, may produc calming effects for a few inmates. When considering isolation, the environmental and psychological conditions of confinemen and the specific needs of the inmate must be considered! A trained clinician must approve the segregation and restraints.

Remember, isolation and force should not b used for punishment! Force should never b excessive and weapons and chemical restraints are not the usual procedure. When using restraints you must follow rules on:

1. Authorization

2. Monitoring

3. Duration

The limited use of isolation by the administration is more effective and humane than dependency on psychotropic medications and physical restraints. The main tools of correctional staff should be strong interpersonal communications and teamwork. Carefully established policies and procedures as well as patient medical records must be maintained.

Just as mentally ill inmates should not be isolated, restrained or medicated for punishment, taking "good time" from these patients for their disruptive behavior is unacceptable!

The Eighth Amendment dictates that the needless infliction of pain and suffering will not be tolerated. There is consensus among mental health and security staff that the incident of mentally ill inmates have increased dramatically in recent years and the jail is obligated to identify, diagnose, and treat these inmates. Two possible explanations for the increased mental pathology are:

1. The deinstitutionalization of former psychiatric residents of mental hospitals have created the criminal justice revolving door phenomenon of the chronically mentally ill. These patients are released from the psychiatri hospitals, they commit crimes and are admitted to the local jails and prisons Correctional institutions are indeed th psychiatric facilities of the 1980's.

2. Overcrowding has been named as the culprit for increased mental illness by producing tension in prisons and causing mental illness. Cruel and unusual punishment is unacceptable as interpreted by the Eighth Amendment. Delibrate indifference to the psychological and medical needs of inmates is illegal. For inmates who are booked, detained but not convicted, they are protected by the Due Process Clause of the Fourteenth Amendment which dictates the right to care for jail inmates.

   The jail alleviates many of the legal r[illegible] of inmates. Inmates lose the r[illegible] to:

   1. Free movement

   2. Live with one's mate, unless that mate is incarcerated in the same jail

   3. Freedom of association and privacy

   4. Freedom from punishment

   5. Freedom of expression without it being scrutinized

   Inmates do, however, maintain the right to:

   1. Legal and court procedures

   2. Religious freedom

   3. Not receive cruel and unusual punishment

   4. Treatment

In the case of Estelle v. Gamble, the Eighth Amendment clarified the inmate's right to medical treatment and Bowring v. Godwin clarified that medical and psychological treatment should be indistinguishable.

THE RIGHT OF INFORMED CONSENT

The right of informed consent specifies that within a patient's ability, they have the right to know what kind of treatment they are receiving, the risks, benefits an alternatives to treatment. The inmate mus have:

1. Sufficient information
2. No coersion
3. Legal competency

THE RIGHT TO REFUSE MEDICATION

The patient has the right to refuse medication unless:

1. He is under court order for treatment.
2. Under orders of two doctors on the staff for particular medication that i. essential to the well-being of the inmate and jail environment.
3. He is in immediate risk to self or others.

THE RIGHT OF PRIVILEGED COMMUNICATIONS

At this time, it must be assumed that the correctional worker has no right to withhold information gained during conversation or the therapeutic process with an inmate. Recent incidents imply that such a right does not exist for inmates. Since you will be developing inmate relationships and information will be discussed which may be harmful to inmates and the general public you must:

1. Be prepared to let inmates know what you can and cannot hold as confidential information.

2. Be prepared not to let personal feelings interfer when serious crimes and dangerous situations become known to you.

As a result of the controversy over punishment vs. treatment of inmates in correctional organizations, the high costs of rehabilitation for the criminally deviant of society, the difficulty acquiring qualified staff, there is a strong schism regarding professional care and treatment of inmates.

THE MENTALLY RETARDED INMATE

There is agreement by interviewed mental health professionals that jail is probably worse for the mentally retarded inmate than for the mentally ill inmate. Jails do not cause retardation, but the unbearable stress may produce the regre[illegible] of acquired skills and their vune[illegible]y to the penal environment incr[illegible]es

They require constant individualized attention which is a difficult resource in a jail setting. There is a large percentage of mentally retarded offenders in the jail, but most of them are trainable.

Researchers Santamour and West, 1979 describes the mentally retarded inmate as:

1. Obtaining harsh legal treatment, being often denied parole and serving larger sentences than other inmates.

2. Targets for sexual harrassment and comical humiliation.

3. Experiencing difficulties understanding essential rules and regulation which raises basic questions of fairness, emotional parity, and the need for training.

4. Proned to body injury which appears to be job related.

5. Viewing rehabilitation as an admittanc that they have problems which they do not want emphasized.

As noted earlier, Estelle v. Gamble is the legal basis of the right to treatment for mental disorder. Since mental retardation is a learning disability rather than a mental illness, the mentally retarded _currently_ does not fall in the auspicies o the right to treatment. There is still the debate over this problem, the matter has not been resolved. Judiciously, it is the standard practice that severely retarded offenders have not been subject t prosecution or incarceration. To do so is deemed highly inappropriate, morally and legally.

Currently, judicial concerns for the mentally retarded include:

1. Indentification of the mentally retarded.

2. Appropriate psychological, educational and vocational testing.

3. Classification systems which support the needed housing and other special needs of the mentally retarded.

In closing, handling the mentally retarded has moral and legal implications. My appeal is to your moral decency, good judgment and common sense that you provide the mentally retarded offender with the appropriate care and attention.

NSTRUCTOR

(If time permits, ask the following questions).

(Encourage strong participation).

UESTIONS

1. Researchers have found that there is a high percentage of mentally retarded inmates in correctional facilities (approximately three times the number in the general population!). What is the reason for these alarming high numbers?

2. What kind of program would you develop to deter mentally retarded inmates away from the correctional institutions?

3. Should the mentally retarded (emphasizing degrees of mental retardation) be exempt from criminal responsibility like the criminally insane inmate? Under what conditions?

COURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
LESSON TITLE	Liability and Negligence
TIME ALLOCATED	One Hour
SPACE REQUIREMENTS	Large classroom for all participants
LESSON OBJECTIVES	Each student will: 1. Understand the concepts of negligence and civil rights liability issues as they relate to corrections. 2. Understand legal issues regarding suicide.
TRAINING STAFF	This session must be taught by a lawyer! An ideal candidate would be the county attorney charged with representing the jail in legal matters.
STUDENT MATERIALS	Writing materials
INSTRUCTOR MATERIALS & EQUIPMENT	Flip charts and marking pens
METHODS AND SEQUENCES	Lecture, question and answers

INSTRUCTIONS | DISCUSSION

INSTRUCTOR

(It is strongly recommended that the coun attorney who represents the jail in legal matters teach this session. As a result, this lesson plan will be more of a detail outline because of the different legal issues and concerns for each jail system. The attorney in your region should use hi discretion on emphasizing what will be important to your jail system. The following outline is generic legal material which should be covered and will be beneficial to the correctional worker)

OUTLINE

I. Purpose and kinds of litigation

1. Forms of litigation
2. Effects upon the jail system

II. Historical Legal Perspective

1. Burbaum
2. Ennis

III. I theories and constitutional basi

rt explanation/negligence
. .iability and damages
3. State statutes, regulations, codes policies and procedures

IV. A-alysis of the Constitutional Standar

1. Ruiz v. Estel_e
2. Ramos v. Lamb

V. Specific Legal Issues of Mental Health Factors

1. Suicide
2. Medication - psychotropic
3. Classification
4. Procedures - documentation
5. Observation
6. Training
7. Right to treatment
8. Right to refuse treatment
9. Doctor-patient privilege issues
10. Transfers

HOW THE LAW WILL VIEW YOUR BEHAVIOR

The law says that the jail administration has the DUTY and responsibility for the health, welfare, care and security of inmates in its custody. Your DUTY is contingent upon your correctional occupation. Once you are aware of particular knowledge about an inmate, you must exercise reasonable care, concern and security. If you make life or death decisions, e.g., saying a suicidal inmate is dead and not following proper procedures, you will be legally judged as a doctor and will be found liable because yo are not a doctor. Correctional workers must not make these kinds of decisions.

An important question which will be asked is, does the jail have standard policies and procedures of operation to handle situations and problems of inmates? What are these rules? It is extremely importar to document information on occurrence in the jail. The legal system says that if i is not documented, it did not happen.

When responding to a lawsuit, discuss the matter with the county attorney. State th facts and remember not to place blame on other staff members because the private attorney will benefit by placing correctional workers against each other!

SUPERVISOR LIABILITY

If the supervisor is away from the jail when an incident occurs, this does not mea that the supervisor was not responsible. Were there rules for correctional staff to follow? If there was information about a particular inmate and that information was not relayed or processed, the supervisor may be liable.

NEGLIGENT ENTRUSTMENT

If a supervisor knows that an employee is not a responsible individual, entrusting a inmate with that individual is a basis of separate liability against the supervisor. As a supervisor, you are legally responsible, in part, for your employees.

NEGLIGENT RETENTION

If the supervisor keeps an employee on the job who is incompetent for one reason or another, and an incident occurs, the supervisor is liable. Cases like this are representative of the "good old boy syndrome". Many times supervisors keep such employees because they are close to their retirement date. Remember there are legal issues involved.

INSTRUCTOR

(Students from other classes have asked the following questions. Be prepared to ask these questions to the student and provide the answers if necessary. Can you think of other questions that are appropriate for this session?)

QUESTIONS

1. Exactly who is the authority on the use of restraints on inmates (The doctor, psychiatrist, the administration)?

2. Wha[illegible] e liability when a correctional off[illegible] ves out medication?

3. Is there any liability concerning nurses who [illegible] out medication without a standing orde[illegible]o medicate from the doctor?

4. What are the legal issues regarding involuntary medication of violent inmates?

5. Can inmates be place in "mental health" isolation areas legally against their will

6. Can an inmate dispute being placed in a high risk area after he was assaulted in that area?

7. Can you identify decisions specifically based upon the failure to provide appropriate/adequate mental health care in the jails or prisons?

8. Can you explain the issues of confidentiality of the inmate's psychiatric and medical information regarding correctional staff?

9. When is it appropriate to inform correctional officers about the psychiatric and/or medical diagnosis?

10. Have these decisions included community mental health agencies as having vicarious liability? If so, please identify.

11. Has a department of corrections been found liable for not providing adequate mental health care? If so, please identify.

12. Who is responsible for the medical cost of inmate care (medicare, insurance)?

:OURSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
,ESSON TITLE	Organizational Health
:IME ALLOCATED	One Hour
;PACE :EQUIREMENTS	Large classroom for all participants
,ESSON 'BJECTIVES	Each student will: 1. Understand the work related, family and personal indexes of job stress. 2. U[illegible]stand how to diagnosis mental [illegible] problems and issues of the [illegible]zation, develop strategies and ac[illegible]n plan statements to solve these problems.
RAINING STAFF	Faci[illegible]ator or other instructor who under[illegible]nds organizational theories.
TUDENT MATERIALS	Handouts and writing materials
NSTRUCTOR ATERIALS & QUIPMENT	Flip charts and marking pens
ETHODS AND EQUENCES	Lecture, question and answers

INSTRUCTIONS	DISCUSSION
NSTRUCTOR	For this session, when we talk about the organizational health of a correctional agency, basically we are referring to the overall mental health of the organization which includes the policy and procedures used in the organization. Staff behavior provides a natural index of the level of stress in the organization.
IST INFORMATION	Some indications are:

I. WORK RELATED INDICES:

a. Absenteeism

b. Monday and Friday sick days or beginning and end of the shift change

c. The number of overtime hours worked as a double shift

d. Staff against staff assaults

e. Grievances, and staff turnover, etc.

II. FAMILY AND PERSONAL RELATED INDICES:

a. The number of divorces and separations

b. Child and spouse abuse

c. Substance abuse, e.g., alcohol and drug abuse

d. Stress related physical disorders

JESTION	Can you think of additional examples to add to this list?

There are particular kinds of stress which are common to all jails. To combat stress, it should first be identified:

1. Overcrowding of inmates and understaffing.

2. Correctional staff many times feel responsible for the failures of the general inmate populations. Often

these expectations are unrealistic because it usually took a lifetime for the inmate to acquire his criminal tendencies. It is unheard of, to expect to change behavior in such a short period of time. Of all felons, 80% of them are released from the jail in four or five days. Of all convicte misdemeanors, 60% of them are recidivists within 18 months after release from the jail.

3. The physical conditions of employment in the jail directly increase the impact of stress upon the employee. These include the pleasantness of the physical environment, noise level, light levels, poor supervision, presence of threat, etc.

4. Usually the correctional employee is i corrections as a result of a second, third or fourth career choice, never was it the first choice.

5. The containment and supervision of disrespectful, aggressive, pressing i[illegible]es increase the stress levels of [illegible]tional staff.

6. T[illegible] [illegible]ack of positive feedback in addition to the para-military environment with constant policy and pr[illegible]edural changes tends to aggrevate c[illegible]rectional workers and increase t[illegible] stress levels.

7. Since correctional workers are often underpaid, many officers work two jobs to provide for their families and others worry continuously about financial responsibilities that they cannot pay.

There are steps that correctional staff can use to combat these problems. These steps can be used with the organization, the family and the individual.

1. Diagnose the problem

2. Create a treatment plan

3. Implement the treatment plan

A diagnosis is done to access the current situation, to address the problem and to prepare for anticipated change.

Correctional workers must consider alternative strategies, consider and weight how strategies might fail, and think of ways to respond to that failure. The key to success is choosing a variety of strategies. An organizational strategy should include:

1. The mission (purpose)

2. Goals (hopes to achieve)

3. Strategic moves (plans to make things happen)

The strategy summarizes how the organization wants to adapt to, interact with its environment. It provides the overall direction of the organization's mission and basic goals to be achieved. It identifies the broad direction and basic strategic moves it must perform to progress. The strategy does not provide a detailed step-by-step plan regarding how the organization is to achieve its goal, since this is the purpose of the action plan. Therefore, strategic plans must be translated into the specific actions (action plan) the organization must take to achieve its objectives.

Action planning involves the basic planning process of setting objectives, making forecasts, analyzing alternative plans and choosing a plan.

NSTRUCTOR

(At this point, have the students look at the Action Planning Handout. This will assist them in the following exercise).

JESTION

What exactly is an action plan?

It is a process which allows you to examine strategies and a method to plan jointly for changes in your jail. There are some general assumptions of action planning:

1. People support what they help to create in the organization.

2. Brainstorming leads to creativity and a nonjudgmental amosphere.

3. Ask what, how to, and when, but not necessarily why.

4. It builds toward "able to do" goals.

NSTRUCTOR

I want you to break up into small working groups and for the next twenty minutes identify mental health problems you experience in your organization. This exercise is designed to allow you to work on organizational problems and brainstorm the obstacles you face and the resources you have to solve the problem. Write a complete solution statement. One student should report back to the large group the results of the action planning.

ANDOUT STUDENTS
ILL USE

1. List the problems you face in or with the mental health program.

2. P[illegible]ize and select a problem you c[illegible]sonably solve in the next four mo[illegible].

3. Des[illegible]ibe the problem in detail to u[illegible]stand the complications and [illegible]nsity of the problem.

4. [illegible]ibe what you believe to be the ideal solution.

Here are some helpful mechanisms which may be beneficial to your exercise:

Not: We need an in-house Mental Health Service Team.

But: Mentally ill inmates do not receive appropriate care.

Not: We should train C.O.s to better monitor inmate behavior.

But: Too many mentally ill inmates (50%) are not identified during their first 14 days in the jail.

Above all, you as correctional custody staff should avoid:

- We need to create a Mental Health program for inmates.
- We will develop Mental Health policy and procedures in written form for our jail. We need to hire...

QUESTIONS

Can anyone explain the differences between the Nots and Buts? What are these differences?

INSTRUCTOR

Reconvene small groups into the large group and briefly have each group member discuss their problems and their action agenda.

What is expected from this exercise is a product, the action agenda, that details the steps towards your goal. It is a process that builds responsibility and ownership, and a starting point for even the toughest problems.

HANDOUT

ACTION PLANNING EXERCISE

1. List the problems you face in or with the mental health program.

2. Prioritize and select a problem you can reasonably solve in the next four months.

3. Describe the problem in detail to understand the complications and intensity of the problem.

4. Describe what you believe to be the ideal solution.

HANDOUT

ACTION PLANNING WORKBOOK

NAME________________________________

CLASS_______________________________

DATE________________________________

This workbook will serve at least three important functions:

1. This action planning workbook will assist you in problem solving and developing strategies.
2. It allows you to brainstorm and come up with positive solutions.
3. It serves as a concrete guide for the implementation of your action plan.

ACTION PLANNING

An Overview

AT IS IT?

--a process to develop strategies for change

--a method of collaborative or individual planning that allows people to have an influence on the outcome of decisions

AT ARE THE UNDERLYING ASSUMPTIONS?

--PEOPLE HELP SUPPORT WHAT THEY CREATE

--people involved in change should have a part in making those plans and decisions

--there are no preconceived ways to reach the goal

--steps utilizing brainstorming stimulate creativity of thought and provide a nonjudgmental atmosphere for generating ideas

--working in groups is an opportunity to build on others' ideas

--the process works toward something, rather than trying to figure out "whys"

--process requires the selection of "do-able" goals

AT ARE THE OUTCOMES?

-- a product, the action agenda, detailing the jobs for accomplishment

--a process that encourages people to share responsibility for implementation of the solution

--process allows for follow-up

ACTION PLANNING

An Overview

HAT ARE THE BENEFITS OF USING ACTION PLANNING?

--opens up your system

--provides for the involvement of the people who are part of the change

--invites people to make investments of interest, time and responsibility for the outcome

--provides for the proper identification and prioritization of problems

--continues the process of revision, review and change

--develops a starting point for even the largest problem

HAT ARE THE COMPONENTS?

Problem Identification

--examining problems

--prioritizing problems

--describing the existing situation

--selecting the priority problem areas

:oblem Solutions

--describing the ideal situation

--deciding on the action solution

--identifying obstacles and resources

ction Agenda

--developing steps to accomplishment with tasks, responsiblities and time frames

--planning for evaluation

3. ANALYZING POSSIBLE SOLUTIONS

For the solution you have describe, identify:

a) What resources are currently available or possible?

b) What obstacles will you meet in implementation of the solution?

CURRENT RESOURCES	OBSTACLES

GOAL SETTING

POSSIBLE SOLUTIONS

What is the ideal solution for your priority problem and what would you like to see happening:

Describe your ideal solution:

. ANALYZING POSSIBLE SOLUTIONS

For the solution you have describe, identify:

a) What resources are currently available or possible?

b) What obstacles will you meet in implementation of the solution?

CURRENT RESOURCES	OBSTACLES

. PROBLEM SOLUTION

Based on your information and analysis, what is the best solution to your problem that can be implemented upon return to your jail?

ACTION AGENDA

NAME_______________________ OBJECTIVE/SOLUTION____________________

AGENCY_____________________

AJOR TASK ACTION STEPS What is to be done)	Person Responsible	Date of Completion	Resources Required

)URSE TITLE	A BASIC GUIDE TO MENTAL HEALTH SERVICES
:SSON TITLE	Evaluation/Graduation
:ME ALLOCATED	One Half Hour
'ACE :QUIREMENTS	Large classroom for all participants
:SSON |JECTIVES	Each student will: 1. Evaluate the course contents and instructors. 2. Receive a certification of achievement for attending and participating in the course.
.AINING STAFF	Encourage as many of the instructors from the course to attend the graduation ceremony. The certificates should be distributed to the students by a senior ranking administrator, e.g., Sheriff, Chief of Mental Health, etc.
UDENT MATERIALS	Writing materials
STRUCTOR TERIALS & UIPMENT	Flip charts, signed certificates, marking pens
THODS AND QUENCES	Ceremony, question and answers

:NSTRUCTIONS	DISCUSSION
:NSTRUCTOR	(Congratulations! This final session has been designed to provide closure to the course. Here you will have the opportunit to answer any remaining questions that the students may ask. You should ask them if the course material assisted them in understanding the mental health problems and issues of their organizations).
	(Encourage participation)
	(Next, have the students fill out the provided course evaluation and pass it in to the instructor. The graduation ceremon should be attended by as many instructors as possible. Schedule a senior ranking official to pass out the certificates of achievement).
	END OF COURSE!

HANDOUT

INSTRUCTOR AND COURSE EVALUATION

CLASS TITLE:____________________ DATES:______________________________

INSTRUCTOR:_____________________ LOCATION:___________________________

INSTRUCTION: Please Circle the Appropriate Number for each question

1. Unsatisfactory
2. Below Average
3. Average
4. Above average
5. Excellent

---

ow prepared was the Instructor?	1	2	3	4	5
ow well did the Instructor state he objectives of the class?	1	2	3	4	5
ow well did the Instructor use isual aids?	1	2	3	4	5
ow well did the Instructor nvolve the class?	1	2	3	4	5
ow well did the Instructor llustrate and clarify key points?	1	2	3	4	5
ow responsive was the Instructor o questions?	1	2	3	4	5
id the Instructor present the aterial in a logical sequence?	1	2	3	4	5

. CLASS CONTENT: . Please Check

. How worthwhile was the class to you?

A waste of time________ Worthwhile_______ Very Worthwhile___________

. For you, did the class have:

Too much theory_______ Too practical_______ The right amounts of theory and practical____

. OVERALL: Please Check

ɔuld you like to see the class: Shortened___ Lengthened___ About right______

ɔuld you recommend this class to others? No___ Maybe___ Yes___

/ERALL EVALUATION: 1 2 3 4 5

ɜe back for comments Are there comments on the back: Yes__ No__

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RECOMMENDED ADDITIONAL RESOURCES LIST

---NIC MENTAL IN JAILS 6J1201 NOTEBOOK

---STAKEHOLDER MAPPING

---ADVANCED DRAFTS: DETENTION AND CORRECTIONS CATEGORIES 29 AND 3(

---CRISIS INTERVENTION/SUICIDE PREVENTION

---POLICY AND PROCEDURE - ST. JOHNS COUNTY SHERIFF'S OFFICE

---PRISON REFERRAL PROCEDURES/LANCASTER GUIDANCE CLINIC

---MENTAL HEALTH SYSTEMS EVALUATION AND CHECK UP

---SUICIDE PREVENTION SCREENING GUIDELINES - STATE OF NEW YORK

---APPLICATIONS FOR INVOLUNTARY EMERGENCY EXAMINATION AND TREATMENT/MENTAL HEALTH PROCEDURES ACT OF 1976, SECTIONS 302 AND 303

---LEGAL PERSPECTIVES IN JAIL MENTAL HEALTH, MICHAEL J. DALE, ESQ.

---OBSERVING AND UNDERSTANDING INMATE BEHAVIOR BY WILLIAM J. ARAUJO AND ALVIN W. COHN

---SURVEY OF FACILITIES AND PROGRAMS FOR MENTAL DISORDERED OFFENDERS, MARCH 1984

---CONFLICT INTERVENTION BY CONNECTICUT DEPARTMENT OF CORRECTIONS

---THE MANAGEMENT AND TREATMENT OF INSTITUTIONALIZED VIOLENT AGGRESSORS, H.R. CELLINI

This information can be found at:

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