THE TRUTH ABOUT ACEs

WHAT ARE THEY?

ACEs are

ADVERSE CHILDHOOD EXPERIENCES

The three types of ACEs include

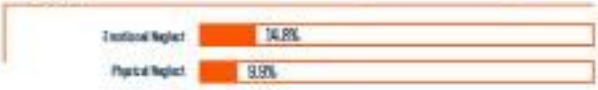
ABUSE | NEGLECT | HOUSEHOLD DYSFUNCTION

HOW PREVALENT ARE ACEs?

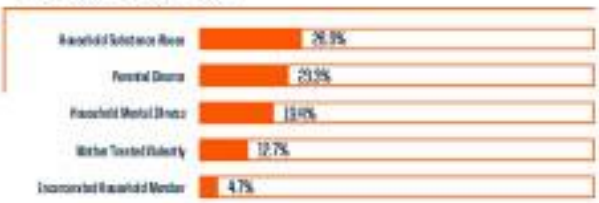
The ACE study revealed the following estimates:*

ABUSE

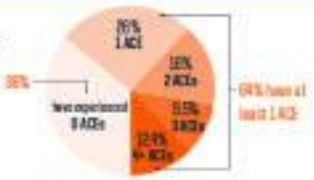
NEGLECT



HOUSEHOLD DYSFUNCTION



Of 17,000 ACE study participants:



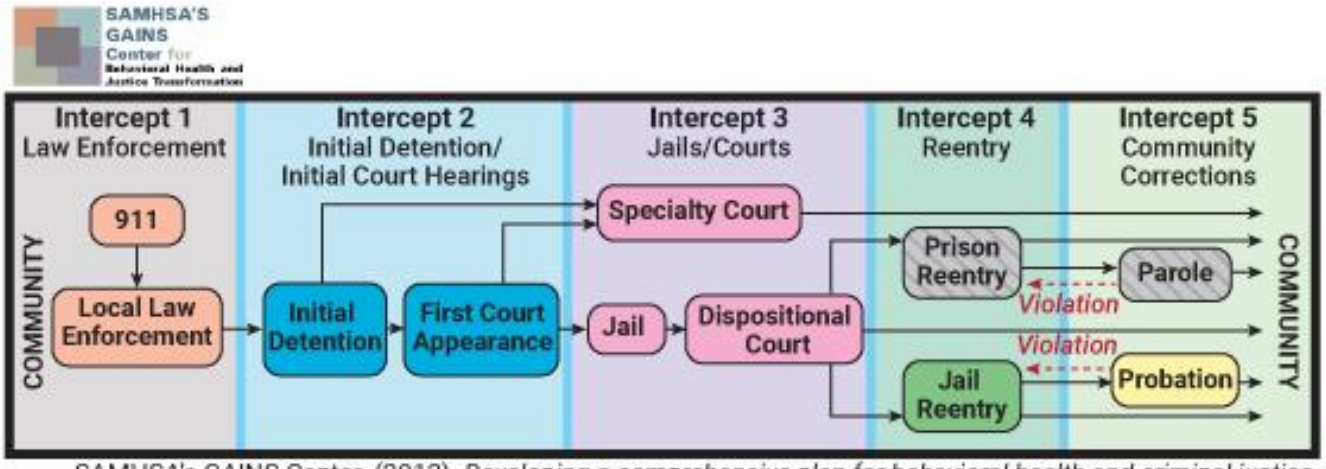
WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes

Possible Risk Outcomes:

Source: https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html

The Sequential Intercept Model



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

THIS IS RICHARD

MODULE FOUR

Richard is 36 years old and has bipolar disorder. He also developed PTSD from witnessing his brother's murder by an uncle who is mentally ill years ago.

When he cycles into a depressive phase of his illness, he becomes overwhelmingly angry and sometimes suicidal. He carries a knife that his family is afraid he will use on himself—or maybe them. He's never actually violent to anyone, but his anger is frightening, and he's known to destroy property.

Because of his behavior, he is no longer welcome at home. He can't hold a job, so he is often homeless. He carries his knife to protect himself, but his mother worries that he might threaten a police officer with it. Perhaps even deliberately, trying to commit "suicide by cop."

When found sleeping in the public park, he is regularly arrested, spends a few nights in jail, and then is released.

His behavior is uneven and unpredictable. It can be hard for him to focus to make decisions given his intense mood and difficulty meeting his own basic needs like eating and sleeping enough.

When he was diagnosed as a young man, he was prescribed medication but hasn't taken it in years.

COMMON MENTAL DISORDERS AND THEIR SYMPTOMS

MODULE EIGHT

Serious Mental Illnesses

Depression

- People with depression may have feelings of sadness, hopelessness, or feeling like life isn't worth living. While many people experience some of these symptoms in response to negative life events—like being arrested or incarcerated—major depression (also called "serious," "severe," or "clinical" depression) is a disease characterized by a chemical imbalance in the brain. Major depression may be associated with suicidal thoughts and behavior as well as signs such as excessive sleeping, difficulty sleeping or staying asleep, overeating or lack of eating, significant weight loss, and/or withdrawal from activities or recreation that they normally enjoy. It is also important to note that even "normal" depression can sometimes escalate into crisis situation, so indicators of depression should not be ignored.

Bipolar Disorder

- People with bipolar disorder have severe high and low moods with changes in energy, sleep, and behavior. There are different types of bipolar disorder, but most people have more depressive episodes than manic episodes, with these depressive episodes demonstrating the same characteristics as those listed above for 'depression.' Manic episodes are characterized by feelings of great happiness or euphoria, feelings of inflated self-importance, great energy and rapid thought, and sometimes feelings of great creativity or insight. Outward behaviors may include: less need for sleep, unusual talkativeness, talking over people, jumping from one idea to another when talking, restlessness, aggression, starting fights, and engaging in activities they normally don't engage in. It is important to know that persons with bipolar disorder may cycle between manic and depressive phases, may have sudden mood changes, and can have substantial influence on other incarcerated persons during the manic phases--during which the individual is sometimes charming and persuasive.

Schizophrenia

- People with schizophrenia often have delusions or hallucinations. For example, people with schizophrenia may have false or odd beliefs, hear voices, or see things that other people do not. They may also display disorganized speech or behavior, inappropriate or muted emotions, poor grooming, or withdrawal. It is important to pay attention to individuals with schizophrenia to assure they are performing daily living tasks. Schizophrenia usually begins in late adolescence or young adulthood and can put severe strain on family members of the individual.

OTHER MENTAL DISORDERS

Substance Use Disorders

- Substance use disorders are the over use or dependence on drugs or alcohol that can lead to health problems, social problems, or poor decision-making. When there is no longer access to drugs or alcohol, these persons may experience shakiness, feeling cold or sweating, or sleeping difficulty. The vast majority of incarcerated persons have substance use disorders.

Anxiety/Panic Disorders

- People with anxiety or panic disorders have worrisome or negative thoughts and fears that do not go away over time. They may experience trouble falling asleep or staying asleep, tension headaches, heart palpitations, sweating or shaking, difficulty breathing, or panic attacks.

Trauma-Related Disorders

- Post-Traumatic Stress Disorder (PTSD) is prevalent among incarcerated persons. The individual re-experiences a traumatic life event through distressing memories, nightmares, and flashbacks. Beyond these symptoms, people with PTSD may also experience outbursts of anger or irritability, difficulty concentrating, and an exaggerated startle response to certain sounds or sights.

Personality Disorders

- People who have personality disorders have rigid ways of thinking and behaving and often have difficulty relating to other people. They may not recognize that they have a problem, and they do not respond to changes well. Unlike many mental disorders, there is no medication to change a person's personality disorder; counseling and behavioral management are the main treatments for personality disorders. These persons can be disruptive and manipulative, and sometimes dangerous. There are a number of different personality disorders, with the most common being antisocial personality disorder and borderline personality disorder. People with antisocial personality disorder may be deceitful or manipulative for personal gain or pleasure, with little regard for the feelings and rights of others; they tend to lack remorse for consequences of their own acts and often blame others or provide rationalizations for bad behavior. Persons with borderline personality disorder tend to have difficulty managing their emotions and have insecure, intense relationships; they have difficulty trusting others and difficulty maintaining close relationships.

Cognitive disorders

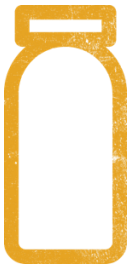
- Cognitive disorders (e.g., amnesia, dementia, delirium) affect learning, memory, perception, or problem solving. They are typically caused by aging or an injury to the brain. Symptoms may include: confusion, poor motor coordination, loss of short-term or long-term memory, difficulty planning or making decisions, and not remembering who they are or important information about themselves. These disorders can stem from a variety of causes, including injury, illness, and aging.

Developmental disabilities

- These disabilities begin earlier in life, before the age of 22. They may affect physical, intellectual, or emotional development. Developmental disabilities often relate to physical issues, but some people may have both physical and intellectual challenges related to their disability. Persons with developmental disabilities have functional limitations in several areas, which may include skills such as self-care, language, self-sufficiency, or mobility.

COMMON MEDICATIONS AND SIDE EFFECTS

MODULE NINE



Prescription medication can be a form of treatment for someone diagnosed with a mental disorder. While many are effective at helping people, some medications can have significant side effects. Thus, even if you refer an individual to treatment, there is always the chance the treatment may not be effective or may need to be altered to find a medication that works to reduce symptoms without causing extreme side effects. Observing someone who is experiencing substantial side effects may signal the need to alert mental health staff. Here are some examples of medications for mental disorders and their potential side effects.

Antidepressants

These are medications often used to treat depression. Fluoxetine, Citalopram, Sertraline, Paroxetine, Escitalopram, Bupropion, Venlafaxine, and Duloxetine, and MAOIs (monoamine oxidase inhibitors) are popular anti-depressants. Some side effects can include nausea and vomiting, diarrhea, and sleepiness.

Anti-Anxiety Medications

These are medications often used to treat and help reduce the symptoms of anxiety, such as panic attacks, extreme fear, and worry. The most common anti-anxiety medications are benzodiazepines; some specific ones are Clonazepam, Alprazolam, and Lorazepam. Some side effects of these medications include: drowsiness and dizziness, nausea, blurred vision, headache, confusion, and nightmares.

Antipsychotic Medications

These medications are often used to manage psychosis that can be related to bipolar disorder, schizophrenia, or drug abuse. These medications can also be used to treat major depression, post-traumatic stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. Some names of these medications include: Chlorpromazine, Holoperidol, Risperidone, Seroquel, Quetiapine and Lurasidone. Some side effects of these medications can include: drowsiness, restlessness, weight gain, dry mouth, constipation, nausea, vomiting, blurred vision, low blood pressure, and uncontrollable movements (e.g., tics, tremors, and seizures).

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Mood stabilizers

These medications are commonly used to help treat bipolar disorder and mood swings associated with certain mental disorders, and can also be used in conjunction with other treatments to help treat depression. Lithium is a mood stabilizer. Some side effects include itching, rash, excessive thirst, frequent urination, shaky hands, nausea and vomiting, slurred speech, irregular heartbeat, blackouts, changes in vision, seizures, hallucinations, loss of coordination, and swelling of the face or limbs (NIH, 2016b).

Correctional Mental Health Screen for Men (CMHS-M)

Name _____ Last, First, MI	**Detainee #** _____	**Date** _ _ /_ _ /_ _ _ _ mm/dd/year	**Time** __:__

QUESTIONS	NO	YES	COMMENTS
1. Have you ever had worries that you just can't get rid of?			
2. Some people find their mood changes frequently – as if they spend everyday on an emotional roller coaster. Does this sound like you?			
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?			
4. Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?			
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?			
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?			
7. Do you tend to hold grudges or give people the silent treatment for days at a time?			
8. Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?			
9. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?			
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?			

TOTAL # YES: _____	**General Comments**:

Refer for further Mental Health Evaluation if the Detainee answered *Yes* to **6** or more items ***OR*** If you are concerned for any other reason

- **URGENT Referral** on _ _/ _ _/ _ _ _ _ to _____
- **ROUTINE Referral** on _ _/ _ _/ _ _ _ _ to _____
- **Not Referred**

Person Completing Screen: _____

INSTRUCTIONS FOR COMPLETING THE CMHS-M

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Men (CMHS-M) with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-M:

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial
Detainee#: Detainee's facility identification number
Date: Today's month, date, year
Time: Current time (24hr or AM/PM)

Questions #1-12 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in his answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says he does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering **"YES" to 6 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-M the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) he should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Correctional Mental Health Screen for Women (CMHS-W)

Name _____ Last, First, MI	**Detainee #** _____	**Date** _ _ /_ _ /_ _ _ _ mm/dd/year	**Time** __:__

Questions	No	Yes	Comments
1. Do you get annoyed when friends and family complain about their problems? Or do people complain you are not sympathetic to their problems?			
2. Have you ever tried to avoid reminders of, or to not think about, something terrible that you experienced or witnessed?			
3. Some people find their mood changes frequently-as if they spend everyday on an emotional rollercoaster. For example, switching from feeling angry to depressed to anxious many times a day. Does this sound like you?			
4. Have there ever been a few weeks when you felt you were useless, sinful, or guilty?			
5. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
6. Do you find that most people will take advantage of you if you let them know too much about you?			
7. Have you been troubled by repeated thoughts, feelings, or nightmares about something terrible that you experienced or witnessed?			
8. Have you ever been in the hospital for non-medical reasons, such as a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			

TOTAL # YES: _____	**General Comments**:

Refer for further Mental Health Evaluation if the Detainee answered
Yes to **5** or more items ***OR*** If you are concerned for any other reason

- **URGENT Referral** on _ _/ _ _/ _ _ _ _ to _____
- **ROUTINE Referral** on _ _/ _ _/ _ _ _ _ to _____
- **Not Referred**

Person Completing Screen: _____

INSTRUCTIONS FOR COMPLETING THE CMHS-W

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Women (CMHS-W), with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-W:

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial
Detainee#: Detainee's facility identification number
Date: Today's month, date, year
Time: Current time (24hr or AM/PM)

Questions #1-8 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in her answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says she does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering **"YES" to 5 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-W the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) she should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

THE C.A.F. MODEL: TIPS FOR DE-ESCALATION

MODULE TWELVE

There are a number of evidence-based tactics for de-escalating a crisis (Klugiewicz, 2011; Richmond et al., 2012). Here we present tips for de-escalation within the context of the C.A.F. Model.

Calm

- Only one person verbally interacts with the individual at a time--more people may create confusion or may escalate the issue; if possible, you might clear the area of other incarcerated persons and non-essential staff.
- Respect the individual's personal space and use a non-confrontational posture--don't clench your fists or hide your hands, as this may create a threat.
- Keep your movements slow and your voice at a lower level than the individual's--avoid sudden movements and try not to raise your voice.
- Introduce yourself and your purpose--you are there to keep everyone safe, including the individual and others in the environment.

Assess

- Ask the individual what he/she is seeing and feeling—try to figure out the individual's perception of reality and orientation to time/place (e.g., "Can you help me understand..."); whether harm to self/others is imminent (e.g., "Are you thinking of hurting yourself..."); and whether there may be an issue with physical health, medications, or substance use.

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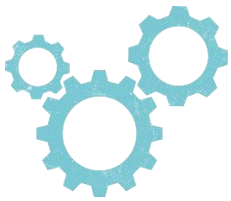
- Use active listening to identify needs--acknowledge with body language and brief encouragements (e.g., "Okay," "I see") that you are paying attention; check that you understand by summarizing or paraphrasing what they are saying back to them (e.g., "Tell me if I have this right...").

- Validate the individual's perceptions when you can, or agree to disagree. Be simple and truthful. If the individual is experiencing delusions or hallucinations, instead of arguing, focus on what the person is feeling and acknowledge your willingness to help them (e.g., "I don't hear any voices, but I am willing to help you"). If you can find common ground to validate some of the individual's perceptions, then do so (e.g., "Yes, everyone ought to be treated with respect," "Other people would probably feel upset too...").



Facilitate

- Invite the inmate to help resolve the issue--this can help "save face" for the individual and provide him/her with a sense of regaining personal control.

- Keep your message short and simple, repeat as needed--this will give the individual ability and time to process what you are saying.

- Offer encouragement and hope about the future--focus on strengths, build hope that a resolution is possible and that things will get better.

PRECAUTIONS FOR PEOPLE WHO ARE SUICIDAL OR WHO SELF-INJURE

MODULE THIRTEEN

If an individual demonstrates a tendency to suicidal or self-injuring behavior, some general precautions might be implemented. Please check institutional policies to determine recommended procedures for preventing death or serious injury.

Examples include:

- Treating all suicide attempts (even those that appear successful) as medical emergencies
- Placing the inmate in a suicide-resistant location
- Monitoring a person under suicide watch constantly (not intermittently), and if closed-circuit monitoring is used, it should be used ONLY as a supplement to personal observation
- Removing potentially harmful objects (e.g., shoelaces, belts, sharp objects)
- Issuing special utensils for meals and counting these to assure that they are returned
- Requiring authorization to access potentially dangerous materials
- Monitoring the individual's social interactions for signs of exploitation or bullying by others (e.g., others providing self-injurers with prohibited materials)
- Refraining from use of pepper spray on persons who self-injure, as the spray may cause extreme pain on cuts and abrasions

WHAT TO SAY

MODULE THIRTEEN

It's important to determine if a person's life is in danger. It's ok to ask directly.

- Are you thinking of taking your life right now?
- Have you made a suicide plan?

Listen to the person without interrupting. Don't be judgmental. Listen to the suicidal person's feelings.

You can ask open-ended questions such as:

- When did you begin feeling like this?
- Did something happen that made you start feeling this way?
- What do you need right now?

Don't offer meaningless platitudes like, "You'll feel better soon," or "Cheer up!" Instead, focus on showing that you respect the pain they're in. You may say such things as,

- You may not believe it now, but the way you're feeling will change.
- Have you felt this way before? What helped change things for the better?
- I may not be able to understand exactly how you feel, but I want to help you.

Preventing a suicide is urgent. You should contact mental health professionals as soon as you can. Staying with the person can keep them from harming themselves; if possible, do not leave the person alone. Treat them with respect, physically and emotionally, so that their condition doesn't worsen before they can get help.

CRISIS PREVENTION

MODULE FOURTEEN

Awareness of mental health issues and effective communication can sometimes prevent problems from escalating to the point of being a crisis. Strategies that correctional officers can use on a daily basis in working with incarcerated persons with mental disorders include:

- **Keeping incarcerated persons informed about changes to routine operations or situations that may affect them.** This can reduce unnecessary anxiety that may result from not knowing what is going on. Information about routines such as meals, visitation, phone calls, mail, recreation, commissary, etc., can help provide structure in the correctional setting.

- **Getting to know the person's daily routines and concerns.** In this way, the correctional officer has a sense of the individual's "normal" behavior that can serve as a basis for comparison when behavior changes occur.

- **Using reflective listening, constructive feedback, and encouragement** in response to daily concerns. This can provide the incarcerated person with an opportunity to vent and can build rapport, which can assist in coaching the individual toward more appropriate behavior. This might include encouragement to participate in activities or to utilize networks of support like family and friends.

- **Adhering to appropriate boundaries of communication**. Trying not to take things personally and keeping emotions in check can help convey a sense of calm, direct professionalism that will enhance daily communications between correctional officers and incarcerated persons.

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TRAUMA-INFORMED CORRECTIONAL PRACTICE

MODULE SIXTEEN

Main Principles

The main principles of trauma-informed corrections include:

- Safety
- Trust
- Choice
- Collaboration
- Empowerment

By making small adjustments to correctional practice to incorporate these principles, the facility can be made safer, with a reduction in unsafe behaviors of incarcerated persons.

Examples of trauma-informed strategies in everyday interactions include:

- At intake/admission, let incarcerated persons choose where to sit down within a defined, safe, and secure space.
- Facilitate productive and safe interactions between incarcerated persons as part of unit meetings, recreation, and other activities.
- Model turn-taking, listening, and allowing each person to speak.
- As part of routine inmate-staff interactions, be encouraging about strengths and accomplishments of the individual.
- Use a tone of voice and pace of speaking that encourages relaxation and stability.
- Use postures and body proximity that convey safety and support rather than control.

- Avoiding language that conveys control (e.g., instead of referring to "cells" or "shake downs," refer to "rooms" or "safety checks").

Of course, prison leadership makes policy choices, but correctional officers can make everyday choices to be aware of trauma-induced crisis and work to prevent it.

Language Is Important

Small changes. Even small changes to language can make the correctional environment feel less traumatizing to incarcerated persons.

The National Resource Center on Justice Involved Women (Benedict, 2014) provides a series of strategies that can make most procedures trauma-informed. These are:

- Tell the incarcerated person what procedure needs to take place and why.
- Briefly describe what will happen during the procedure.
- Reassure the individual that you will conduct the procedure in a way that maximizes his/her safety and comfort.
- Ask the individual if he/she has any questions about the procedure before you begin.
- Use verbal cues throughout the procedure (e.g., "now I am going to place the items from your purse onto the table").
- Let the individual know when the procedure has been completed.
- Ask the individual how he/she is doing.
- Thank the individual for his/her cooperation.

A Trauma-Informed Pat Down

Module Sixteen

Script One: Typical Language

Instructions: Read aloud in a hard, loud voice. Some lines may be shouted, if you choose. Please pause between each numbered line.

1. Ok, inmate. Face the wall, now!
2. You cannot complain about search. If you hadn't done the crime, you wouldn't be here.
3. Are you disrespecting me? Does my nametag say "man?" You call me OFFICER when you speak to me. Now shut up.
4. Hold still, inmate!
5. You can pick up your crap when we're done. Leave it on the floor now.
6. Ok. Get your crap and go.

Script Two: Trauma-informed Language

Instructions: Read aloud in a calm, patient voice. Please pause between each numbered line.

1. Mr. Walters, please come over here for search.
2. I know, I know, nobody likes to be searched. Let's get through it together.
3. Do you have anything that will stab or poke me?
4. I'm halfway done. You'll be on your way in a minute.
5. Almost done now. Once I check your cuffs and shoes we'll be done.
6. Please hold your tissues while I complete the search. I know you don't want them on the dirty floor.
7. OK, Mr. Walters, that's all done. Have a good day.

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ROLES IN CORRECTIONAL MENTAL HEALTH CARE

MODULE SEVENTEEN

	Correctional Officers	**Mental Health Staff**
Mission	Maintain safety and security of the facility for incarcerated persons and staff.	Provide treatment to improve functioning of incarcerated individuals.
Culture	Perception: based on application of universal rules, authority of officers in relation to incarcerated persons, punitive sanctions for violations.	Based on clinical relationship with client/patient, informed consent regarding choices, and negotiated compliance.
Beliefs About Mental Disorders	May perceive mental disorders as character flaws. May view negative behaviors as deserving of punishment. May resent that incarcerated persons have access to free services that are not accessible to some others in the community.	Trained that mental disorders are result of a combination of biological and social causes. May view negative behaviors as indications of the need for treatment.
Challenges For Collaboration	May be perceived as harsh or punitive.	May be perceived as soft, coddling, or protecting incarcerated persons from consequences of bad behavior.

QUESTIONS ABOUT THE NEED FOR MENTAL HEALTH REFERRAL

MODULE EIGHTEEN

A simple tool to assist officers in referral to mental health includes the following six questions:

Questions	**Present? Y/N**
Is the inmate excessively **isolating** himself/herself from staff and other inmates?	
Is the inmate's **behavior** persistently erratic and/or bizarre?	
Are the **sleeping and eating** patterns of the inmate causing concern?	
Has there been a **sudden unexplained change** in the inmate's presentation, such as stopping work for no obvious reason?	
Has the inmate's **personal hygiene** appeared strange, changed suddenly, or deteriorated?	
Does the inmate have any **other symptoms** that are likely to suggest a mental illness?	
Total # of Yes answers	

If the answer to **two or more of** these questions is 'yes,' the officer should refer the inmate to mental health staff for further evaluation.

PROMISING PRACTICES IN CORRECTIONS AND RE-ENTRY

MODULE NINETEEN

Peer support for incarcerated persons with mental disorders

Forensic peer specialists serve as a positive role model while providing support to help individuals change negative attitudes and behaviors and engage in mental health and substance abuse treatment services. They also may provide resources on housing, employment, and educational opportunities in the community (PRA, 2012). In Massachusetts, the Framingham facility implemented a peer support program in which specially selected incarcerated persons attend a 2-day peer support training, then provide services to their peers via office hours, on-call, or request processes. Peer supporters receive monthly supervision and individual support, as well as incentives and appreciation for their work.

Wellness self-management (WSM)

WSM is an education and skills training program for justice-involved persons that helps develop coping skills and social skills, as well as skills for managing their mental disorders. The goals of these programs include reducing disciplinary actions, decreased use of crisis services, and improved transitions back into communities by persons with mental illness. In New York State, several prisons have implemented WSM for incarcerated persons diagnosed with severe mental illness. WSM is delivered in 40 sessions on topics including stress, substance use, recovery, building social supports, using medication effectively, reducing relapse, and self-advocacy.

Trauma, Addiction, Mental Health, and Recovery (TAMAR)

TAMAR is a program for incarcerated adults with histories of physical or sexual abuse, mental disorders, and substance abuse. The 20-session program provides trauma education to incarcerated persons and introduces correctional staff and community providers to principles of trauma-informed approaches.

Reentry checklists

The GAINS Center for Behavioral Health and Justice Transformation published a Re-Entry Checklist to provide a centralized record of an incarcerated person's potential needs in areas such as mental health services, medications, and health care. The form includes

a column to note what actions correctional staff have taken regarding each need, as well as contact information for key professionals or resources. Four copies are made to be distributed to the correctional facility, the mental health unit, the medical unit, and the incarcerated person.

Forensic Assertive Community Treatment (FACT) teams

FACT programs combine treatment, rehabilitation, and support services through the use of teams in the community. The goal of these programs is to help offenders with mental disorders engage in community-based treatment in order to reduce repeated incarcerations or hospitalizations. The programs include case management, medication management and monitoring, housing assistance, individual therapy, chemical dependency and socialization groups, and vocational assistance.

Assisted Outpatient Treatment (AOT)

AOT is court-supervised treatment in the community. It has been authorized for use in most states and endorsed by key justice, mental health, and health professional organizations. AOT has demonstrated effects in reducing hospitalizations, arrests, incarceration, homelessness, victimization, suicide, and violence against others.

Pre-arrest Diversion Programs

Police are trained to recognize mental health issues and take those identified to mental health centers for evaluation instead of straight to jail.

Post-arrest Diversion Programs

Systematic and mandatory mental health screening after arrest to identify any mental health-related issues. Those identified would be diverted to treatment. Treatment may be a condition of deferred prosecution, sentencing, or probation.

Planned Reentry Programs

Pre-release programming prepares the person emotionally and practically to establish stable conditions once they arrive back in the community. This includes making a plan for mental health treatment and medication. This may mean coordinating with community counselors, pharmacies, housing, and employment.

Parole Officer Training

Parole officers are trained to respond to mental health concerns and to refer people on probation to support before they reoffend.

THIS IS KEVIN

MODULE TWENTY

Kevin has been a CO for six years. The last two years have been particularly stressful. He was in two major prison brawls that left him injured, once with a knife. He's moved around within the prison system recently so he doesn't have a new peer group yet. He's in great physical shape from frequent exercise since he wants to be able to control situations physically.

Recent circumstances have been tough. Mandatory overtime has strained his marriage, and his wife has moved out. Because of his hours, he's not in contact with many of his friends outside of work. He's having trouble sleeping, and his only outlet is exercise. At work, he has a lot of eyes on him because an inmate committed suicide last month. There's lot of inquiry and pressure on him and other COs to find out what happened.

For the past few months, his unit has often been on lockdown due to staff shortages. Inmates are angry at the lockdown and often verbally assault the officers. When the inmates are let out, there have been several fights due to lockdown stress. Kevin is tired and sore from trying to break up the fights and putting incarcerated people in restraints.

Further, an incarcerated person has accused Kevin of purposely breaking personal possessions (a radio) during a cell search.

SUPPORT SYSTEMS TO COMBAT STRESS

MODULE TWENTY

Employee Assistance Programs (EAPs)

EAPs are an important source of support for correctional officers. These programs can help support correctional officers in dealing with stressors related to work and home that may be impacting wellbeing and performance. Some EAPs are offered internal to the agency, and others are offered by external providers.

Peer Support Programs

If available, peer support programs are another important source of support (Brower, 2013). With these programs, correctional officers are trained to offer support to their peers (Brower, 2013). This often makes accessing support less stigmatizing and more desirable, as correctional officers may talk to someone who knows what their day-to-day experiences are like (Brower, 2013).

Mindfulness-Based Stress Reduction

Mindfulness-based stress reduction (MBSR) is another strategy of increasing interest to those in correctional settings. "Mindfulness is a sustained nonreactive attention to one's ongoing mental contents and processes (physical sensations, perceptions, affective states, thoughts, and imagery)" (Samuelson et al., 2007, p. 255). Engaging in mindfulness can increase individuals' "capacity for attentiveness and presence and generally promotes a more open, relaxed, flexible, and less reactive state of mind."

That is, being aware of stressors and reactions to these can help cope with such stressors in a calm way. Mindfulness techniques are being used with correctional officers, police, court personnel, and incarcerated adults and youth around the nation.

Other free resources can be found at the Prison Mindfulness Institute. Visit http://www.prisonmindfulness.org/resources/prisoners/

The Self-Care Exercises and Activities within the Self-Care Starter Kit https://socialwork.buffalo.edu/resources/self-care-starter-kit/self-care-assessments-exercises/exercises-and-activities.html#title_5