Center for Child and Family Studies

UNIVERSITY OF
SOUTH CAROLINA
College of Social Work

Mental Health in the Correctional System: Making Choices for Safety & Well-Being

Trainer Guide

Credits

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The Center for Child and Family Studies

The Center for Child and Family Studies was created in 1986 at the College of Social Work, University of South Carolina, to address issues related to children and families. Since that time The Center has gained a national reputation for its curriculum development, research, conference planning, and student initiatives.

For more information about The Center for Child and Family Studies, please call (803) 777-9408 or write to:

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INTRODUCTION

About This Training

This training was designed and developed to offer essential, actionable information about mental health and mental illness to correctional officers and other safety-related correctional staff. It is context-based and offers practical suggestions and external resources to support staff on the job.

It is written and packaged to be a widely accessible community training with only basic resources necessary. It is free to use, but the Center for Child and Family Studies retains all copyrights. Please contact the Center for further information.

The training is designed for groups of 15-30 people but can be adapted to accommodate groups of other sizes. It is written for a single facilitator, but can be adapted for more facilitators if a large group is being trained. We recommend a second trainer for groups over 35.

We offer estimated times for completion of each module. They range from 30 minutes to 90 minutes. Take the length of the modules into account as you plan your training day or days.

The goal of this project is to better equip correctional staff to recognize and respond effectively to mental illness in the correctional population. This training is a tool to strengthen staff expertise while also supporting protection for the rights and humanity of people who are incarcerated. It does not replace formal mental health training or the expertise of a mental health professional in a correctional setting.

We urge facilitators to adapt the content to align with your institution's or state's policies.

Project Developers

Dana DeHart is Assistant Dean for Research and a Research Professor at the University of South Carolina's College of Social Work. Dr. DeHart's work on violence and victimization has spanned multiple disciplines including social work, psychology, criminal justice, and public health. She has been Principal Investigator on grants and contracts addressing issues such as victimization and survivor services, impact of incarceration on families, gendered pathways to adult and juvenile offending, mental health and substance abuse, and predatory sexual behavior. Dr. DeHart has conducted hundreds of interviews with adult and juvenile offenders, crime victims, justice professionals, and human-service providers. Dr. DeHart has published in peer-reviewed journals such as Psychology of Women Quarterly, Psychiatric Services, Violence Against Women, Violence and Victims, Journal of Interpersonal Violence, Journal of Family Violence, Journal of Child and Adolescent Trauma, Journal of Correctional Health Care, and Journal of Offender Rehabilitation.

Dr. Aidyn Iachini is an Associate Professor at the University of South Carolina's College of Social Work. Her areas of expertise include positive mental health, interdisciplinary collaboration and training, and interagency collaboration. She has served as PI or Co-PI on numerous grants involving evaluation, interdisciplinary training, and mental health. She has published in mental health journals such as Advances in School Mental Health Promotion, and serves on numerous committees and consortia focused on increasing interagency collaboration and enhancing systems capacity to provide quality and effective mental health services to youth and families.

Project Consultants

Shannon M. Lynch, Ph.D., is a licensed clinical psychologist and Professor at Idaho State University. Dr. Lynch utilizes mixed methods to examine incarcerated women's pathways to incarceration, trauma exposure, mental

health, and treatment needs. She regularly conducts research with individuals incarcerated in prisons and jails and trains graduate students to provide empirically based group treatment to incarcerated women.

Christopher R. DeCou, Ph.D., is a senior fellow at the Harborview Injury Prevention and Research Center of the University of Washington School of Medicine, and completed his degree in clinical psychology at Idaho State University. His research centers on the study and prevention of suicide, including the association between violence and suicidality among under-served and under-studied populations. As a former police officer, Dr. DeCou appreciates the importance of promoting awareness of mental illness and trauma-informed care as ways of addressing the multifaceted needs of justice-involved populations, and also enhancing the safety and effectiveness of law enforcement and corrections personnel.

Raymond Smith received his undergraduate degree in social work from North Carolina AandT State University, and then attended the advanced standing MSW program at USC. Prior to entering the academic sphere, he gained a host of experiences that ranged from the U.S. Army, corporate team management, the medical field, and the judicial system at the state and federal levels. Currently, his area of research interest is in the process of identity formation, identity maintenance, and the transition to new identities. Specifically, Mr. Smith studies social identities among persons who have been involved within the criminal justice system.

Overview of Training

This training has twenty modules and is designed in a modular fashion. A facilitator can choose to train all of the modules, in order, over the course of several days or select modules relevant to their interest to offer a shorter, focused training.

Always begin with the Welcome module. Then build your training from there! Then, you can conclude any training series with the Looking Back and Wrapping Up section to close out the work you've done.

To view the entire training package that includes the trainer manual, handouts, and other materials, visit the website: www.cmhtraining.sc.edu

Below is an overview of the modules of the training to orient you to the range of content available. It gives the estimated time of delivery, the format, and the competencies for that module. After the Overview, there are a few suggested mini-trainings that offer themed collections of modules for shorter training events if you don't plan on training the entire 20-module series.

Welcome to the Training

Time: 15 min.

Format: Lecture, discussion

1: What Is Mental Health?

Time: 45 min.

Format: Lecture, video, discussion

Competencies:

- Recognize that mental health includes multiple dimensions, such as emotional, psychological, and social aspects.
- Describe and compare criteria for defining a mental disorder versus serious mental illness.

2: Characteristics of Correctional Populations

Time:	45 min.
Format:	Lecture, video, discussion
Competencies:	• Recognize that incarcerated people disproportionately come from backgrounds of trauma and adversity. • Name mental disorders that are common among people who are incarcerated. • Identify proportion of incarcerated people who have serious mental illness, substance use disorders, and co-occurring disorders.

3: De-Institutionalization and Criminalization

Time:	90 min.
Format:	Lecture, activity, discussion
Competencies:	• Recognize the roles that de-institutionalization and criminalization (e.g., of addiction, homelessness, poverty) play in increasing the number of people in correctional institutions who have mental disorders and/or histories of trauma and adversity.

4: Corrections in the Context of the Justice System

Time:	60 min.
Format:	Lecture, activity, discussion
Competencies:	• Identify the role of corrections within the broader justice system.

- Compare criteria for incarceration in a prison versus a jail.
- Describe corrections' functions of retribution, deterrence, containment, and rehabilitation.
- Understand the Sequential Intercept Model and how it could improve response to mental health of incarcerated people.

5: Challenges of Mental Disorders for Incarcerated People

Time: 45 min.

Format: Lecture, video, discussion

Competencies:

- Recognize increased problems within institution for people with mental disorders.
- Describe other aspects of correctional facilities that create challenges in responding to people with mental disorders.
- Describe the consequences of inadequate responses to incarcerated persons with mental disorders.
- Identify concerning behaviors to observe.

6: The Subjective Experience of Mental Disorders

Time: 30 min.

Format: Lecture, video, discussion

Competencies:

- Understand that the subjective experience of mental disorders

	may create challenges in daily living.

7: Maintaining Safety, Offering Respect

Time:	45 min.
Format:	Discussion, video, activity
Competencies:	• Value one's own role in maintaining the safety of the facility for all involved. • Value a compassionate and effective response to mental disorders.

8: Mental Disorders and Individual Rights

Time:	45 min.
Format:	Lecture, video, discussion
Competencies:	• Recognize basic signs and symptoms of common mental disorders. • Recognize that mental disorders have genetic, environmental, and lifestyle causes. • Understand the rights of people with mental disorders to treatment and to self-determination, as balanced with the safety needs of the individual and others.

9: Medication Side Effects and Malingering

Time:	30 min.
Format:	Lecture, discussion
Competencies:	• Recognize common side effects of medications used to treat mental disorders.

- Describe prevalence and motivations for malingering.
- Understand the rights of people with mental disorders to treatment and to self-determination, as balanced with the safety needs of the individual and others.

10: Mental Health Screening

Time: 45 min.

Format: Lecture, activity

Competencies:

- Describe the purpose of mental health screening in corrections.
- Name a screening instrument that can be administered by correctional officers in prisons and jails.
- Describe appropriate settings within the facility, appropriate body language, and tone for screening.
- Describe timing when screening should take place for incarcerated people.
- Differentiate appropriate and inappropriate use of findings of mental health screens.

11: Crisis and Intervention

Time: 60 min.

Format: Lecture, video, discussion

Competencies:

- Describe elements of a crisis.
- Describe non-verbal and verbal techniques for de-escalating a crisis.

12: The C.A.F. Model

Time:	45 min.
Format:	Discussion, video, activity
Competencies:	• Use the C.A.F. (Calm, Assess, Facilitate) model of crisis intervention.

13: Self-Directed Violence: Suicidality and Self-Injury

Time:	30 min.
Format:	Pre-work, lecture, activity, discussion
Competencies:	• Compare self-injury to suicidality, including risks of each. • Describe signs of suicidality. • Describe precautions for suicidal people and those who self-injure. • Understand policies on suicidality in participant's facility of employment.

14: Crisis Prevention

Time:	30 min.
Format:	Lecture, video, discussion
Competencies:	• Describe general communication strategies that can be used to prevent situations from escalating to a crisis.

15: Understanding Trauma

Time:	45 min.
Format:	Lecture, video, discussion

Competencies:	• Recognize that the correctional setting can mirror or trigger past traumatic experiences of the person who is incarcerated. • Describe contextual stressors that can cause traumatic stress for people who are incarcerated. • Recognize that gender, race, class, age, and other group-level factors may influence exposure and response to trauma.

16: Trauma-Informed Correctional Practices

Time:	45 min.
Format:	Lecture, activity, discussion
Competencies:	• Describe trauma-informed principles for correctional facilities.

17: Understanding the Roles of Correctional Officers and Mental Health Staff

Time:	30 min.
Format:	Lecture, discussion
Competencies:	• Describe the differing roles and missions of correctional officers and mental health staff in responding to incarcerated people with mental disorders. • Value benefits of correctional officers and mental health staff working collaboratively to address mental health of people incarcerated in correctional facilities.

18: Communication Between Correctional Officers and Mental Health Staff

Time:	60 min.
Format:	Activity, discussion, lecture
Competencies:	• Describe strategies for effective communication with other professionals concerning mental health of incarcerated people.

19: Promising Practices for Corrections and Re-entry

Time:	45 min.
Format:	Lecture, activity, discussion
Competencies:	• Describe the Sequential Intercept Model and examples of strategies that can be used at different stages of justice processing to address mental illness of incarcerated people. • Describe three promising practices for addressing mental health of people who are incarcerated or re-entering communities.

20: Managing Workplace Stress

Time:	45 min.
Format:	Pre-work, Activity, discussion, activity, discussion
Competencies:	• Identify sources of workplace stress and burnout. • Describe resources and strategies for addressing workplace stress.

Looking Back and Wrapping Up

Time:	30 min.
Format:	Discussion

Suggested Mini-Trainings

Here are some groups of modules in focused mini-trainings. The full training will offer a rich and wide exploration of mental health in the correctional setting. However, a shorter, targeted training can also be highly effective.

Note that sometimes modules will refer to each other. If you're offering a customized package of select modules, or modules out of order, make sure to adjust any references to modules that you are not training or have not yet trained.

Note that in some cases, a mini-training may offer modules out of numerical order; this is deliberate and contributes to the goals of the mini-training by creating a logical flow of content.

In order to support ongoing continuing education within your organization, the framework of this training could be used to guide a sequence of course offerings stretched over a period of weeks. Likewise, these modules could be offered individually as part of regular staff enrichment or training.

Analyzing Mental Health

This training provides a strong baseline of mental health issues and appropriate response by correctional staff. Estimated time to train: 6 hours 30 minutes

- Welcome
- Module 1: What Is Mental Health?
- Module 2: Characteristics of Correctional Populations

- Module 5: Challenges of Mental Disorders for Incarcerated People
- Module 6: The Subjective Experience of Mental Disorders
- Module 7: Maintaining Safety, Offering Respect
- Module 8: Mental Disorders and Individual Rights
- Module 10: Mental Health Screening
- Module 13: Self-Directed Violence: Suicidality and Self-Injury
- Module 15: Understanding Trauma
- Module 16: Trauma-Informed Correctional Practices
- Looking Back and Wrapping Up

Practical Skills for Correctional Officers

This training focuses on best practices for correctional officers when negotiating mental health issues at work. Estimated time to train: 5 hours 45 minutes

- Welcome
- Module 7: Maintaining Safety, Offering Respect
- Module 9: Medication Side Effects and Malingering
- Module 11: Crisis and Intervention
- Module 12: The C.A.F. Model
- Module 14: Crisis Prevention
- Module 13: Self-Directed Violence: Suicidality and Self-Injury
- Module 16: Trauma-Informed Correctional Practices
- Module 20: Managing Workplace Stress
- Looking Back and Wrapping Up

Mental Health and Crisis Management

This training prepares correctional staff to consider the mental health of incarcerated people as they work to prevent and manage crisis. Estimated time to train: 5 hours 45 minutes

- Welcome
- Module 5: Challenges of Mental Disorders for Incarcerated People
- Module 15: Understanding Trauma
- Module 9: Medication Side Effects and Malingering
- Module 7: Maintaining Safety, Offering Respect
- Module 11: Crisis and Intervention
- Module 12: The C.A.F. Model
- Module 13: Self-Directed Violence: Suicidality and Self-Injury
- Module 14: Crisis Prevention
- Looking Back and Wrapping Up

Supporting Mental Health in the Community

This training focuses on connections between the justice system, the correctional system, and community initiatives. Estimated time to train: 4 hours 15 minutes

- Welcome
- Module 3: De-Institutionalization and Criminalization
- Module 4: Corrections in the Context of the Justice System
- Module 10: Mental Health Screening
- Module 19: Promising Practices in Corrections and Re-entry
- Looking Back and Wrapping Up

Systems Approaches to Mental Health in Correctional Facilities

This training focuses on system-wide strategic thinking to better manage mental illness in the correctional system. Estimated time to train: 4 hours 15 minutes

- Welcome
- Module 4: Corrections in the Context of the Justice System
- Module 16: Trauma-Informed Correctional Practices
- Module 17: Understanding the Roles of Correctional Officers and Mental Health Staff
- Module 18: Communication Between Correctional Officers and Mental Health Staff
- Module 19: Promising Practices in Corrections and Re-entry
- Looking Back and Wrapping Up

Understanding the Importance of Trauma

This training offers all modules that deepen understanding of, and best response to, trauma. Estimated time to train: 4 hours 30 minutes

- Welcome
- Module 15: Understanding Trauma
- Module 5: Challenges of Mental Disorders for Incarcerated People
- Module 16: Trauma-Informed Correctional Practices
- Module 6: The Subjective Experience of Mental Disorders
- Module 12: The C.A.F. Model
- Module 20: Managing Workplace Stress
- Looking Back and Wrapping Up

Trainer Preparation

The training is designed to support you by offering a Facilitator's Manual and supplemental materials for each module.

Select Modules. You may wish to train all twenty modules, or a select few. Once you've selected the modules you wish to train, carefully review what each requires. Study the content carefully. The greater your familiarity with the content, the more smoothly the training will go.

Before Training. Each module has a "Before Training" section to help you prepare before you enter the training room. Please take the time to study these sections and bring all needed materials with you before learners enter the room.

Basic Training Space Requirements.

- The supporting PowerPoint is ideally shown by using a **computer, a projector, and a screen** at the front of the room. The PowerPoint contains supportive text, infographics, and video clips, so being able to display it clearly is very important.

  The module instructions assume you are using the PowerPoint and can project content for learners to see. If you are unable to use the PowerPoint, you may write relevant content from the slides on flip chart pages to show at appropriate times. But please make note that without the PowerPoint, you will lack the supportive text, infographics, images, and videos it contains, which may affect the impact of the training. While the videos are available on the website for download, the rest of the media content is only in the PowerPoint.

- You will need a **large writing surface** for relevant notes during class. A chalkboard, white board, or flip chart is equally effective, so please use whatever is most convenient in your training space. The modules often

instruct the facilitator to use a flip chart and pens, but again, boards may be substituted.

- You will need **writing instruments** appropriate to your writing surface: chalk, dry erase markers, or permanent markers.

A note about terminology. Terminology can vary from state to state. We have used "correctional officer" throughout the training, but you may substitute the title used in your area.

Customizing your training. This training is designed for use in any state and is therefore very general. You may customize the training with information from your local area or specific facility if you choose.

Training Components

Here are the training components and how they work together.

Facilitator's Manual. This manual is only for Facilitators. It contains all of the background and knowledge content you will need for each module.

- **How to Use the Manual**. In addition to directions for guiding the learners through the module, we've included text that is written as if you are speaking to the participants. The expectation is that you will read through the entire module the first time to familiarize yourself with the information. The wide margins have been provided for you to make notes to yourself when you read through the module for the second time. You can then train from your notes, instead of reading from the manual, or however you feel comfortable.
- **How to Use the PowerPoint Slide Decks**. Once you've studied the Facilitator's Manual for the module you're preparing, go through the corresponding PowerPoint deck carefully. Practice coordinating the PowerPoint slides with your training. The connections between the

content of the Manual and the content of the deck will be helpful. You may choose to make notes in the Manual about pacing your use of the slide deck as you go.

The slides are designed as reinforcement to the topics you're discussing, so you won't be able to read the lecture content just by looking at the projection screen. Practice the material so that you can become fluent in the content and use the slides as support, not as the main method of conveying information.

- **How to Use the Web Site**. Explore the website to decide what materials you wish to study and download. You can choose to download the entire Trainer's Guide and associated media, or you can select individual modules to download with all of their associated media. You can also search for individual materials by type (such as PowerPoint or videos). All materials are free to download and use, but the Center for Child and Family Studies retains all copyrights. Find the content at www.cmhtraining.sc.edu
- **Always invite questions**. The Manual often suggests places for participants to ask questions. However, we hope that you will openly state that questions are always welcome and will foster a flexible environment that allows participants to ask questions whenever they need to.

PowerPoint. Use the accompanying PowerPoint slides to support learning in class. The PowerPoint is coordinated with the content of each module.

Videos. There are two kinds of video in this training: animated scenario-based stories, and live-interview content from a subject matter expert, Raymond Smith.

- **Animated Videos.** The animated stories are created to help participants work through real-life, context-based issues. They're brief and designed to generate a rich

discussion of relevant topics. These videos are embedded in the modules appropriate to the topic, but can also be accessed individually on the supporting website.

- **Subject Matter Expert Videos.** The subject matter expert videos offer a fresh perspective from an expert and give new ideas about practice. These are part of the content of the training and focus on giving deeper information and best practices. These videos are embedded in the modules appropriate to the topic, but can also be accessed individually on the supporting website.
    - **A note about introducing the subject matter expert videos.** If you are not training all of the modules or are not training the module that uses Mr. Smith (Module 5, which contains the "Meet Raymond Smith" video), we recommend pulling from the website the video that introduces him and his qualifications. Use this video the first time you train a module that uses his videos. It's important to establish his identity and background in order for his material to have the greatest impact.

Coordinating the PowerPoint Slides with the Training Material. Your experience and comfort with preparing for training is accommodated by the structure of the Manual. In order to support smooth coordination of the PowerPoint slides with the topics as you work through them, images of the relevant PowerPoint slide have been embedded at appropriate places throughout the modules. They show the slide you should be showing when delivering each section of material. Note that each module deck begins with an introductory slide for the entire training since you may be training modules out of order. You may not need to use these and may choose to begin with the title slide for each module. The module's title slide will always begin the During Training section.

We suggest practicing the training and using the PowerPoints before the first day of training to ensure a smooth delivery.

Supplemental Materials. Handouts and activity materials are in separate folders on the website, labeled by module number. When ready to prepare a module, look in the "Format" and "Materials Needed" areas at the beginning of the module to determine if you need to download and print any materials for yourself or learners before arriving at the training space.

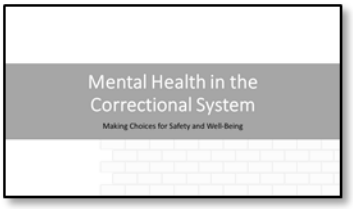
WELCOME TO THE TRAINING

Time:	15 min
Format:	Lecture, discussion
Materials:	PowerPoint, flip chart and markers

Description

This is the orientation to the training's purpose, the introduction to the trainers themselves, and to the training space. Always begin the first day of your training with this Welcome, even if not offering all modules. Customize this outline with information relevant to your current training.

During Training



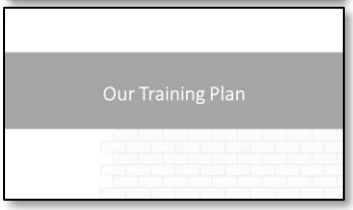
Welcome to the Training

Set Up

Welcome participants to the training.

Explain any housekeeping issues relative to the training space (location of restrooms, daily schedule, planned breaks, food/drink policies, etc.).

Go over the established training schedule (days, times, locations).



Introduce the training staff.

Ask each participant to introduce themselves by name, title, and location of employment.

Connecting to the Training

Discussion

Facilitate discussion with the following questions:

- How many of you have had contact with incarcerated people who have mental health issues? What have you seen or heard about?
- What kind of questions do you have coming in to this training? (NOTE: Write these on a flip chart. Tell them the group can keep returning to these questions throughout the training to make sure they're addressed.)
- What do you think your role is in relation to incarcerated people's mental health?

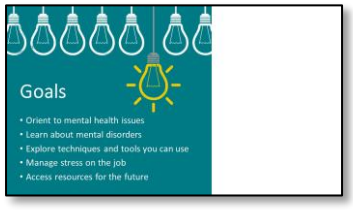
Transition by saying:

The purpose of this training is to help give you clarity about all of these issues. You should always follow the policies and procedures of your work place, so as we progress though this training, make sure that you are as familiar as possible with your workplace's specific expectations for your position.

Goals of the Training

Lecture

Present lecture:



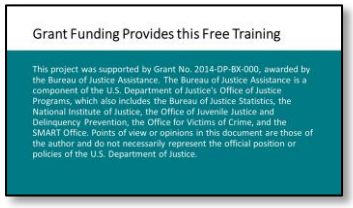
So why are you here? Well, you're **not** here to become a psychiatrist! You are a correctional officer, so you have safety responsibilities to yourself, to fellow COs, and to those incarcerated in your facility.

Rather, this training will:

- Orient you to mental health issues in the corrections system.
- Give you a basic overview of common mental health disorders you may encounter.
- Explore responses to mental health issues and tools to support you.
- Discuss managing your stress in the workplace.
- Give you some resources you can refer to at any time in the future.

This is a Free Training

Show the grant funding information in the PowerPoint deck.



Say:

Finally, it's important to know that all of the materials we'll use in this training are free. The research and development of this training were supported by a grant from the Bureau of Justice Assistance, which is a part of the US Department of Justice's Justice Programs.

Get Started!

Say:

Let's get started!

Introduce the first module you will be training.

1: What Is Mental Health?

Time:	45 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Meet Kim," flip chart and markers
Competencies:	• Recognize that mental health includes multiple dimensions, such as emotional, psychological, and social aspects. • Describe and compare criteria for defining a mental disorder versus serious mental illness.

Description

This is a foundational module that emphasizes the importance of attention to mental health and its complexities. With an animated story, participants will use criteria to determine the overall mental health of a justice-vulnerable character.

During Training

Mental Health

Set Up

Introduce the topic by using the following question to facilitate discussion:

- What does "mental health" mean to you? (NOTE: Write responses on flip chart.)

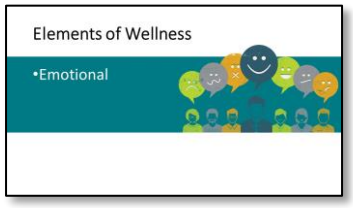
Present lecture:

Mental health is more than mood. It's a complex state, as you might guess. Mental health is a term used to describe our emotional, psychological, and social well-being. Positive mental health helps people to cope with stress, make meaningful contributions to their communities, and realize their own personal potential (MentalHealth.gov, 2016).

Mental health is an important part of overall health. A healthy life is complex because it is the sum total of all of the dimensions of our lives.

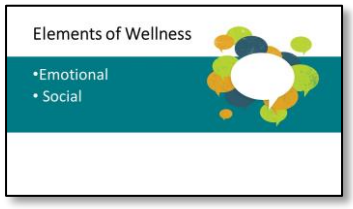
One way to evaluate mental health is to consider three elements:

- The first is **Emotional**. The most obvious component of mental health is a person's emotional state, their feelings. Of course, every day or week has its ups and downs, but what is the most common emotional tone of a person's life? Are they generally content with their life? Or are they sad a lot? Have they recently experienced a loss? Are they handling stress well? What kind of support do they have? Describing a person's emotional life is the first step to getting a sense of their mental health.



    - What are some examples of better or worse emotional health?

- The second element is **Social**. Having a satisfying social life is important to good mental health; this aspect is determined by the kinds of interactions a person has with other people. Everyone is different: some people prefer a large circle of friends while others are content with a few very close friends. It's important to assess the quality of social relationships a person has and whether these are what the person desires. This can include family, friends, and romantic partners. Are the person's relationships fundamentally positive? Are some destructive?



- What are some examples of better or worse social health? How might they affect mental health?

- The third element is **Psychological**. While emotional state is about feelings, the psychological state is about thinking and thought patterns. The way a person frames their own experience can have a big impact on how they experience life. It may be difficult to assess this aspect of experience, so observers can take their clues from emotions and social behaviors.

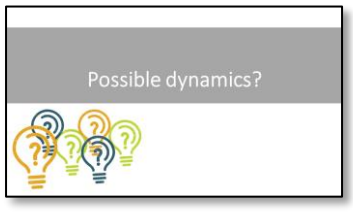
    - How do attitude and thought patterns affect the way that a person experiences the world?

- Also note that **Physical** health can have an impact on mental health. The body's health is connected to mental health. Physical pain or physical comfort can lower or improve a person's mental health. When assessing mental health, don't overlook physical health. And remember that disability isn't necessarily a negative factor.

    - What are some examples of better or worse physical health, and how might those affect mental health?

Discussion

Lead a brief discussion of possible dynamics of mental health with the following questions:



- Mental health can be complex. What happens if a person has good health in one area and not another?
- What might it look like when someone has better emotional and social health but worse physical health?

- What might it look like when someone has strong physical health but worse social and emotional health?
- How can strong psychological health affect emotional and social health?

Transition by saying:

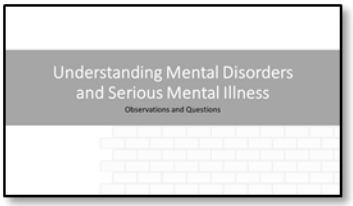
Beyond basic mental health, let's begin to learn more about mental disorders and mental illness.

Understanding Mental Disorders and Serious Mental Illness

Lecture

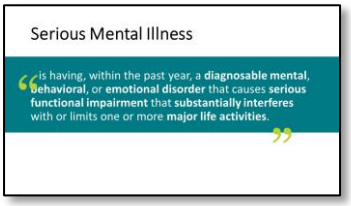
Present lecture:

How serious is "serious" when we talk about issues with mental health?



Let's define "**mental disorders**." Mental disorders (sometimes called mental illness) involve changes in thinking, mood, and/or behavior. Mental disorders are common; they affect people from all age groups and parts of society, and they can affect social relationships and the ability to make decisions. Mental disorders can be persistent or intermittent, and different types of mental disorders have different average ages of onset (SAMHSA, 2016).

By contrast, what is a "**serious mental illness**?" A mental disorder is considered "serious" or not serious by analyzing the individual's ability to function in society. Many adults with mental disorders are able to function in society without major difficulties.

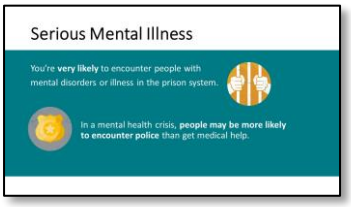


In contrast, serious mental illness among adults is defined as having, within the past year, a diagnosable

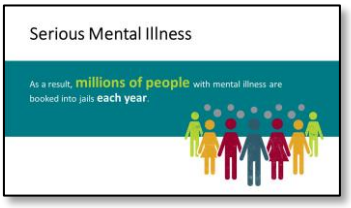
mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. That is, the individual may have substantial difficulty accomplishing the things they need or want to do on a daily basis, such as working, maintaining social relationships, engaging in leisure activities, and caring for him/herself.

Serious mental illness includes major depression, schizophrenia, bipolar disorder, and other disorders that cause serious functional impairment (e.g., schizophrenia spectrum, psychotic disorders; SAMHSA, 2016).

As a correctional officer, you're likely to encounter people with mental disorders or mental illness in the correctional system. In a mental health crisis, people may be more likely to encounter police than to seek out medical help.



Accordingly, millions of people with mental illness cycle through correctional facilities each year.



Transition by saying:

Let's try out what we've learned by thinking about a specific example. Let's meet Kim, see who she is, and discuss how she's doing.

Understanding Mental Health

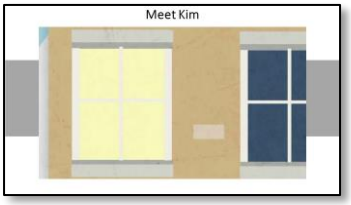
Video: "Meet Kim"

Introduce the video by saying:

Watch Kim's story and note elements of her emotional, social, psychological, and physical health. Ask yourself, how do those elements come together in her life?

We'll discuss your findings together after the video.

Play the video "Meet Kim."



Facilitate discussion by asking the following questions. Write participants' answers on the flip chart. Make sure to ask for examples that illustrate their findings.

- How is Kim's social health?
- How is Kim's emotional health?
- How is Kim's psychological health?
- How is Kim's physical health?
- Overall, how do you think Kim is doing?
- Kim can be anxious sometimes. How much does that seem to affect her life overall?
- Is there anything that might concern you for her future? What are some strengths you see?

Make sure these key points have been made:

- Kim has a challenging family life and is anxious.
- But her strong friendships and good physical health due to a sport she enjoys support her.

Pulling It All Together

Discussion

Facilitate concluding discussion and module wrap-up with the following questions:

- How much of today's information on mental health and mental illness was new to you?
- Have you ever had contact with an incarcerated person who you think may have had a serious mental illness, even if you don't know what it might have been?

Conclude with:

- As you move through your workday, you can start to think about the mental health of those around you by thinking about their dimensions of mental health: social, emotional, and psychological.

Transition to Module 2

Say:

In our next module, we'll talk about mental health specifically in the corrections population. Start thinking about how mental illness is typically recognized and responded to in your workplace.

2: Characteristics of Corrections Populations

Time:	40 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Handout: "The Truth About ACEs," Video: "Changes for Kim," flip chart and markers
Competencies:	• Recognize that incarcerated people disproportionately come from backgrounds of trauma and adversity. • Name mental disorders that are common among people who are incarcerated. • Identify proportion of incarcerated people who have serious mental illness, substance use disorders, and co-occurring disorders.

Description

This module will invite participants to think more closely about the background experience of incarcerated people and how that background might connect to mental health issues and to incarceration. By watching a video that shows changes in Kim's life, participants will observe and discuss how she becomes justice-involved and how her mental health has changed.

Before Training

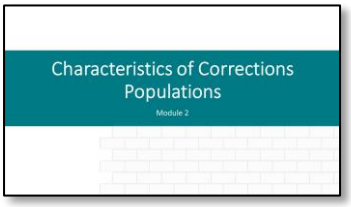
Print enough copies of the handouts "The Truth About ACEs" and "Common Backgrounds of Incarcerated People" for every participant to have one.

During Training

Set Up

Introduce the topic by saying:

People don't arrive in correctional facilities as blank slates. Most have complex and often difficult backgrounds. These life experiences can be directly related to their state of mental health.

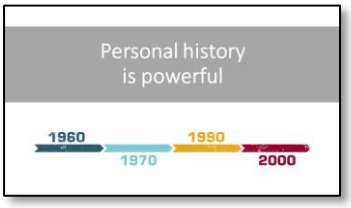


The Adverse Childhood Experiences Study

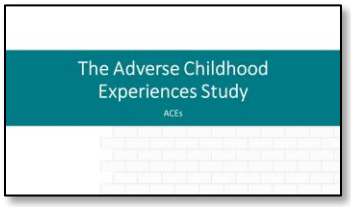
Lecture

Present lecture:

No childhood is perfect, but an important, long-lasting study has found that some childhood experiences can greatly increase major risk factors to mental and physical health as the child grows up.

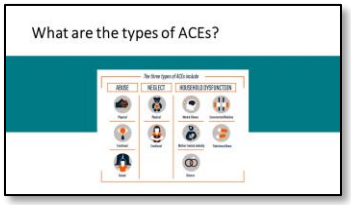


The Adverse Childhood Experiences Study has been following into adulthood children with a history of significant negative childhood experiences. The study uses a questionnaire that homes in on experiences such as whether a child has suffered abuse or neglect, has had their life threatened, has watched a parent be violently abused, lived with a parent who is unstable or addicted to substances or other similar traumatic events.

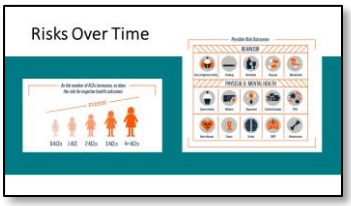


Pass out copies of the handout "The Truth About ACEs."

On your handout, you can see specifics of what these adverse experiences are. (NOTE: Read out a few for examples.)



People whose history has a high number of these experiences are at greater risk for a host of illnesses and poor health outcomes as they mature, and they are at higher likelihood for early death as well.



Refer participants to the handout "The Truth About ACEs."

In your handout, you can see the risks grow with age. And you can see a list of risky behaviors and physical and mental health risks that those with high ACEs scores may face later in life. (NOTE: Read out a few as examples.)

This is troubling, isn't it? And one of the higher risks is incarceration. Let's focus on people who become incarcerated.

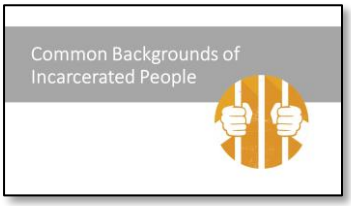
Common Backgrounds of Incarcerated People

Lecture

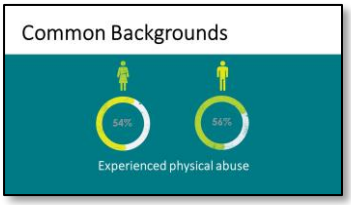
Note for facilitators: This section contains many statistics, so the infographics in the PowerPoint are important to show to help clarify what would otherwise be a very dense lecture.

Present lecture:

The ACEs study often directly connects with large portions of the incarcerated population. Let's consider the histories of this population.



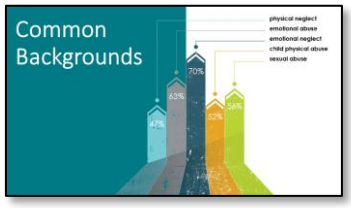
A study of 7,500 men and women incarcerated in prison shows that a majority experienced physical abuse as children (56% of men and 54% of women).



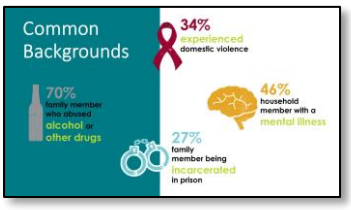
Further, 1 in 10 of incarcerated men and 1 in 2 incarcerated women experienced child sexual abuse.

Nearly 40% of those incarcerated experienced some form of physical or sexual victimization in the prior 6 months while in prison (Wolff, Shi, and Siegel, 2009).

Other types of trauma or adversity are also common in the backgrounds of justice-involved individuals. One study of women in prison indicates that, beyond child physical abuse (52%) and sexual abuse (56%), the women reported high rates of physical neglect (47%), emotional neglect (70%), and emotional abuse (63%).



Their childhood households were also likely to include mothers experiencing domestic violence (34%), a household member with a mental illness (46%), and a family member who abused alcohol or other drugs (70%). 27% grew up with a family member being incarcerated in prison.



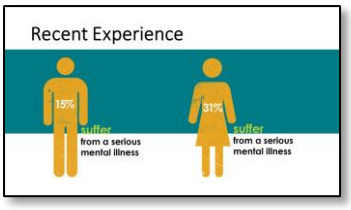
You can see that these numbers bear out what you've learned about the ACEs study.

Now, let's turn from histories to recent experience. Based on surveys of people incarcerated in local jails and state and federal correctional facilities in the United States, a substantial portion report having recent mental health problems. This includes receiving a clinical diagnosis of—or being treated for—a mental disorder in the past 12 months.

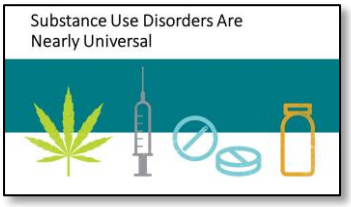
Those in local jails have the highest rates of mental health problems (64%), followed by those in state (56%) and federal (45%) prisons (see Chart; NIMH, 2016).

Based on clinical screening of incarcerated people, common disorders include disorders affecting emotional regulation such as depression and bipolar disorder (sometimes called manic-depression), anxiety disorders such as Post Traumatic Stress Disorder and having panic attacks, and personality disorders such as antisocial personality disorder (sometimes called psychopathy or sociopathy) and borderline personality disorder (Trestman et al., 2007).

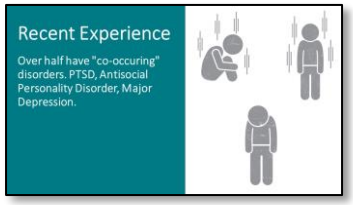
If we focus on current diagnosis by a clinician rather than self-reporting, we find that about 15% of men and 31% of women who are incarcerated suffer from serious mental illness—major depression, bipolar disorder, or schizophrenic spectrum disorders. These are major disorders that substantially interfere with an individual's ability to function.



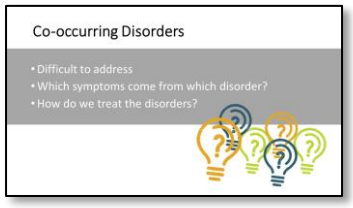
Research indicates that substance use disorders are nearly universal among those who are incarcerated, including dependence on alcohol, cocaine, marijuana, heroin, and stimulants (Lynch et al., 2014; Proctor, 2012a, 2012b).



Over half of these incarcerated people who are substance-dependent also have other "co-occurring" disorders such as PTSD, antisocial personality disorder, or major depression (Lynch et al., 2014; Proctor and Hoffmann, 2012).



These co-occurring disorders can be difficult to address, because it can be challenging to identify whether symptoms come from mental illness or addiction. It can become complicated trying to simultaneously or sequentially treat these varying disorders.



When we consider not just recent or current disorders but the lifetime history of disorders, these numbers are even higher. This is important when you consider that incarceration is extremely stressful, and that relapse or re-emergence of a disorder can be heightened in the jail or prison context.

Say:

The statistics from this module are available online at the training website if you wish to access them at a later time. The web address is www.cmhtraining.sc.edu

You may find them useful as you process today's training and think about it in the context of your workplace.

Video: "Changes for Kim"

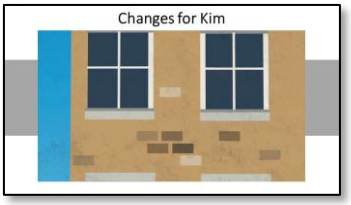
Introduce the video:

Statistics are one important kind of data, but how those numbers are expressed in people's lives show us the actual effect of trauma and adversity in real life circumstances and choices.

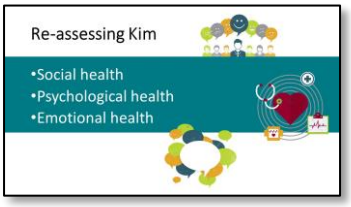
Let's check in again with Kim, whom we met in Module 1.

A year has passed and Kim's life has changed. Watch this video and be ready to discuss her new circumstances and choices, and be ready to re-evaluate her mental health by using examples.

Play the video "Changes for Kim."



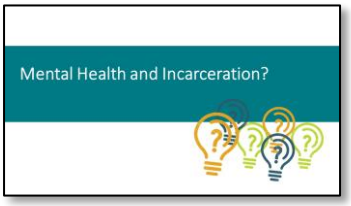
Facilitate the discussion with the following questions:



- What's happened in Kim's life? What's new?
- Let's discuss Kim's mental health again emotionally, psychologically and socially. How do your conclusions compare to her a year before?
- How is Kim's mental health now? How would you characterize it? Is there any sign it will improve any time soon?
- What are your concerns for her future?

Discussion

Facilitate the discussion with the following questions:



- Given what we've discussed today, why do you think it's important for correctional officers to learn about the mental health issues of incarcerated people?
- What are some frequent assumptions about incarcerated people that you're now aware of that may not be correct?
- How does the information in this module change your perspective, if at all, of incarcerated people you encounter?

Conclude:

Awareness of mental health issues in incarcerated people can improve your response and your workplace's safety.

Transition to Module 3

Ask:

But why are we, as part of the corrections system, seeing so many mental health issues in our populations? Shouldn't people with mental illness be treated somewhere else? We'll consider the causes in the next module.

3: De-Institutionalization and Criminalization

Time:	90 min.
Format:	Discussion, video, group activity
Materials:	PowerPoint, Identity Cards for the activity "Staying Free," Invisible tape (or similar), flip chart and markers.
Competencies:	• Recognize the roles that de-institutionalization and criminalization (e.g., of addiction, homelessness, poverty) play in increasing the number of people in correctional institutions who have mental disorders and/or histories of trauma and adversity.

Description

This module gives some American social history that sheds light on prison over-crowding and high incidence of mental illness in current incarcerated populations. A group activity will give insight into the connections between de-institutionalization and criminalization leading to involvement with the justice system.

Before Training

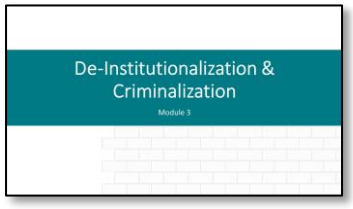
Print out and prepare all of the identity cards for the activity "Staying Free," as directed in the activity materials document.

Bring invisible tape (or similar) to use in the activity. If you have access to a corkboard and tacks, those are also very effective; you may bring the board and tacks in place of the tape.

During Training

Set Up

Say:



America is a dynamic nation and our culture is changing rapidly and constantly. Over the past few decades, correctional facilities have changed a great deal. Let's look at a few recent trends that shed light on why we see so many people with mental illness in correctional populations.

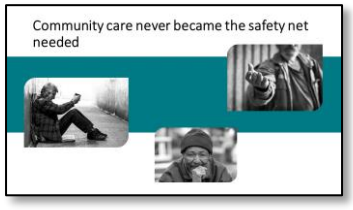
De-Institutionalization of the Mentally Ill

Lecture

Present lecture:

There are currently a large number of incarcerated people with mental illness. These numbers come in part from '**deinstitutionalization**.' Deinstitutionalization began in the 1960s when the treatment of mental illness shifted away from state mental hospitals.

A number of large state hospitals had become infamously identified as using cruel and inhumane or inadequate treatment. Appalled by neglectful or abusive conditions, state legislatures closed these facilities, which led to a housing and treatment gap. The previous residents were expected to be shifted to local facilities such as clinics, halfway houses, and community residential treatment centers.



However, as former residents were released into communities, and state mental hospitals closed, there was a failure to establish the needed community-level treatment facilities.

Inevitably, the untreated, symptomatic behaviors of mental illness often brought individuals to the attention of

police, and people with mental illness were arrested and processed through the justice system. This is an issue that involves policies and resource allocations, often leaving those on the front line (e.g., law enforcement, correctional officers) in a position they have not been trained or resourced to handle.

The policies and practices that drive those in need of care into the criminal justice and correctional systems have been described as the "**criminalization**" of mental illness (Treatment Advocacy Center, 2018). Without treatment, individuals are likely to cycle back in and out of jails and prisons repeatedly (Blevins & Soderstrom, 2015). They become what has been disrespectfully termed as "frequent flyers" (Torrey et al., 2010).

Understanding deinstitutionalization and criminalization makes it easier to understand why there is a growing number of people with mental health problems in the correctional system. A 2010 report, using data from 2004-2005, found that in the United States there were **three times more seriously mentally ill people in jails and prisons than in mental hospitals**. The report states, "America's jails and prisons have become our new mental hospitals" (p. 3, Torrey et al., 2010).

While mental institutions were often under-resourced and under-staffed, which often led to poor or even inhumane care, there have been limited responses in our communities to address the mental health needs of all individuals.

So often, law enforcement and correctional staff now have much more contact with people with mental illness because many persons who are mentally ill may lack safe housing or have limited access to care.

Discussion

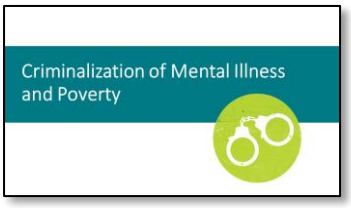
Quickly check with participants by asking:

- Have you seen or heard about the effects of deinstitutionalization? Any examples, if so?
- Does your workplace see a high number of people who you think may struggle with mental health issues?

Criminalization of Mental Illness and Poverty

Lecture

Present lecture:



People are incarcerated for many kinds of violent and non-violent crimes, and not all come from backgrounds with multiple adverse experiences. But given what we know about the backgrounds of persons who are incarcerated, we cannot ignore those who have had these experiences.

Beyond serious mental illness, a number of behaviors associated with trauma and adversity have become criminalized—most notably drug addiction and homelessness, both of which are often survival strategies for people who have backgrounds of extreme adversity.

- **Criminalization of drug addiction.** Human Rights Watch has released a report on laws criminalizing personal drug use. The report shows that drug possession for personal use is the crime for which people are most frequently arrested in the U.S., with someone arrested once every 25 seconds. From this perspective, policy-based enforcement of laws criminalizing drug use drives drug users underground rather than toward treatment; this can be damaging to individual and family lives, undermining public health and subjecting

people of color and other vulnerable populations to discriminatory enforcement (Human Rights Watch, 2016).

- Drug use is often a coping mechanism for people who have suffered adverse events, including abuse or trauma. Some use drugs as treatment for chronic pain, which can sometimes turn into an addiction. For persons who are addicted, use of drugs and alcohol may be motivated by the need to avoid pain and withdrawal rather than to use as a form of recreational fun.
- **Criminalization of homelessness.** Many cities in the United States have laws against life-sustaining activities including sleeping, sheltering, sitting, asking for help, sharing food, and resting. Examples include laws against public camping to shelter from the elements, public sleeping, panhandling, and sharing food with a homeless person (NLCHP, 2014).

- Some people live homeless to avoid dangerous home situations. Others may not be able to maintain jobs to pay for housing due to mental illness or other disadvantage.

Discussion

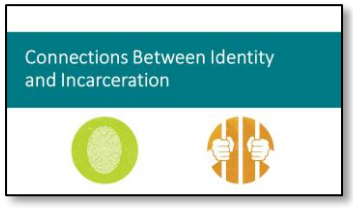
Briefly check in with participants by asking:

- Have you heard about the criminalization of drug addiction or homelessness before today?
- How many inmates have you known who were homeless or addicted to drugs when they arrived in a correctional facility?

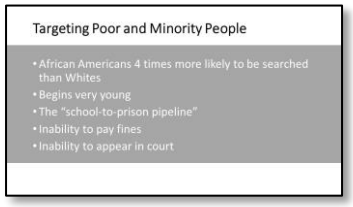
Connections Between Identity and Incarceration

Lecture

Present lecture:



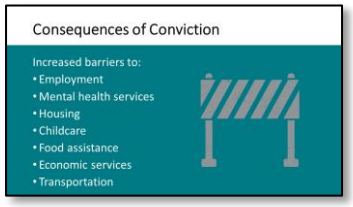
Criminalization of poverty has meant that people from impoverished backgrounds are overrepresented in the correctional system. For instance, those living in poverty and people who are ethnic minorities are more likely to be fined, arrested, and incarcerated for minor offenses than are other Americans (Dolan & Carr, 2015). Contributing factors include:



- Differential targeting and enforcement of those who are poor or from ethnic minority backgrounds. A recent study found that African Americans were four times more likely than Whites in Section 8 housing to be searched by law enforcement as a result of non-criminal complaints against them (Brodie, Pastore, Rosser, & Selbin, 2014).
- Criminalization often begins very early in life for those who are poor or from ethnic minority backgrounds. The 'school-to-prison pipeline' is a term for policies and practices that push poor, ethnic minority, and LGBT youth out of school and into the criminal justice system because of gaps in disciplinary practices for school-based offenses (ACLU, 2016). In a nutshell, these vulnerable youth are more likely to be disciplined for the same behaviors that White, wealthier youth 'get a pass' on, and such discipline is associated with greater likelihood of entering the juvenile justice system (Fabelo et al., 2011).
- **Inability to pay fines or failure to appear in court.** When people are unable to pay fines or don't appear in court for offenses that don't come with

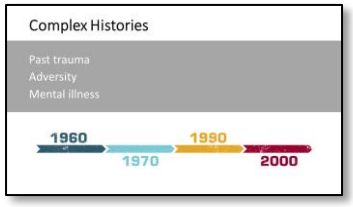
jail time, warrants may be issued for their arrest, resulting in jail or prison time. The person may then accrue additional debt due to charges for public defender services, room and board during lockup, probation and parole supervision, drug and alcohol treatment, and DNA samples (Anderson et al., 2014). For instance, probationers usually end up paying more in additional fees than the actual debt owed for the crime committed (Abin-Lackey, 2014).

- **Collateral consequences of criminal conviction.** When people are arrested and/or incarcerated, their criminal conviction or arrest may increase barriers to employment, mental health services, housing, childcare, food assistance, economic services, and transportation (Dolan & Carr, 2015). The likelihood of someone getting a callback for a job interview for an entry-level job drops about 50% if that person has an arrest or criminal conviction (NELP, 2014).



- **If an individual breaches their probation, federal law disqualifies them from a range of social security benefits** including Temporary Aid to Needy Families and the Supplemental Nutrition Assistance Program, which used to be called 'welfare' and 'food stamps.' The elderly and disabled can lose access to Supplemental Security Income (Bannon, Nagrecha, & Diller, 2010). Such collateral consequences create barriers to returning to mainstream society and may leave former offenders and their families with many unmet needs.

On top of these concerns, it's important to keep in mind the complex histories of trauma, adversity, and mental illness that characterize the lives of people who are incarcerated—as these may contribute to their risks for behavioral and mental health problems, their needs for counseling and healthcare, and their responses to incarceration and daily stressors.



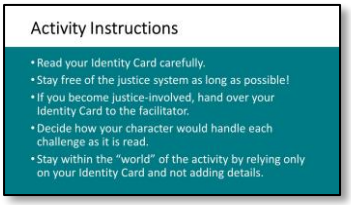
Activity: Staying Free

Note to facilitator: This is a gamification of real-life circumstances meant to engage the learners in the challenges of staying free when a person is justice-vulnerable. It is not intended to make light of very serious circumstances. Make certain that participants understand that this may be a game to them, but it is a daily struggle for many.

1. Explain that this activity is to give learners a chance to simulate the challenges of staying out of the justice system. These challenges are based on real-life experiences of people affected by de-institutionalization and criminalization of drug use and homelessness.

2. Put participants into up to six groups, one group per table. Use fewer than 6 groups if you have fewer than 2 participants per group. NOTE: If you have fewer than six groups, you may give each group more than one identity card. If groups have more than one identity card, allow a few extra minutes to allow them to decide how both characters would fare under each challenge. Adjust times in the instructions below, as needed.

3. Give the following instructions:



   a. Each group will receive one (or more, as needed) Identity Card. The group should read it carefully.

   b. The goal of the activity is to stay free of the justice system as long as possible. Your character ends up in the justice system if they meet ANY ONE of these criteria:

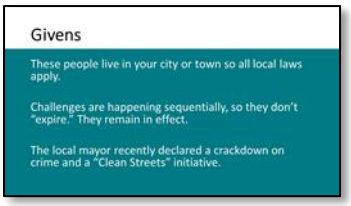
      i. They become homeless.

      ii. They are caught with illegal drugs.

      iii. They lose access to medication for a mental health diagnosis.

   c. If your character becomes justice-involved, give me your Identity card and I will put it at the front of the room.

   d. When I read out a Challenge, your group should take about two minutes to discuss how your character will solve the problem, if a solution is possible. Remember that you have to stay within the "world" of the character by only acting on the information on your Identity cards.



      For the purpose of this activity, these people are living in the town we're in today, so all local laws apply to their situations.

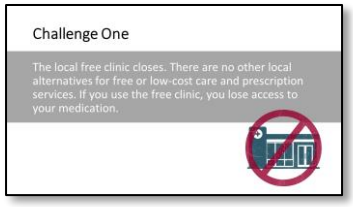
      Also, these challenges are happening sequentially to your characters, so they're cumulative. For example, if a challenge says that the bus route near you closes, it remains a challenge; the bus route does not reopen.

Again, this activity occurs in the town we live in. At this point in time, the mayor has decided that crime is too high and has asked the police to "crack down" on illegal activities to "clean up the streets."

e. After each Challenge, we will debrief as a group to hear how your character fared. I will collect Identity cards after each Challenge if anyone has lost their freedom.

f. See how many rounds your character is able to "stay free."

4. Begin the activity by showing the first Challenge on the PowerPoint and reading it aloud. Then say, "Stay free, everyone." Give them two minutes to discuss its implications for their character.



5. After two minutes, have each group report out in turn by summarizing basic details from their character card and then explaining how the challenge affected that character.

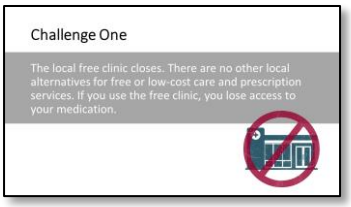
6. If anyone's character meets ANY of the three criteria for justice-involvement, ask for that group's card to tape to the front of the class and say, "I'm sorry. You're no longer free." To the rest of the groups, before each challenge, say, "Stay free, everyone." NOTE: If participants argue about whether a character should remain free or not, you have two choices: (1) Be the authority and decide, or (2) Ask the full group to vote. In the event of a tie, you will be the tie-breaker.

7. Repeat steps 4 through 6 until all Challenges have been read or no characters remain free. NOTE: If any character becomes homeless, is caught using illegal drugs, or loses access to their medication, take that character card and tape it to the front of

the room. That group will then listen in on another group's discussions until the activity is over. Go from group to group as they work to help keep them focused and to answer any questions.

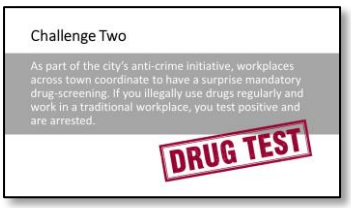
8. Begin the debrief when all of the characters have become justice-involved or when all of the challenges have been read, whichever comes first. Challenges are listed below as well as on the PowerPoint slides:

Challenge 1



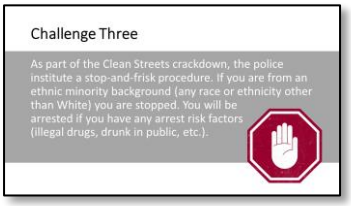
The local free clinic closes. There are no other local alternatives for free or low-cost care and prescription services. If you use the free clinic, you lose access to your medication.

Challenge 2



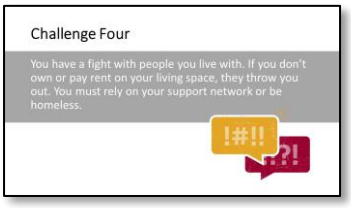
As part of the city's anti-crime initiative, workplaces across town coordinate to have a surprise mandatory drug screening. If you illegally use drugs regularly and work in a traditional workplace, you test positive and are arrested.

Challenge 3



As part of the Clean Streets crackdown, the police institute a stop-and-frisk procedure. If you are from a racial or ethnic minority background (any race or ethnicity other than White) you are stopped. You will be arrested if you have any arrest risk factors (illegal drugs, drunk in public, etc.).

Challenge 4



You have a fight with people you live with. If you don't own or pay rent on your living space, they throw you out. You must rely on your local support network or become homeless.

Activity Debrief

Lead the discussion by asking the following questions:

- Let's look at the ID cards in the front of the room. How many characters are now justice-involved?
- Let's talk to each group whose character is up here. Tell us the following:
    - First, remind us about your character. Then tell us which challenge took out your character and why. How many challenges did your character overcome, and how?
    - Did you expect your character to last longer? Or are you surprised they made it as far as they did?
- Now let's hear from groups whose characters are still free. (NOTE: If no characters remain free, skip this discussion point and move to the concluding questions.)
    - What kept your character free?
    - What kind of challenge might be enough to get your character justice-involved in the future?
- Concluding questions for everyone:
    - Given the characters you had, what did you learn about risk in their lives?
    - Of the characters who went to prison, how do you think they'll handle incarceration?
    - Could any of these characters' issues be more appropriately addressed through means other than serving time in prison? What could be appropriate alternatives?

Transition to Module 4

Say:

In the next module, we'll focus on the role of corrections within the broader justice system.

4: Corrections in the Context of the Justice System

Time:	60 minutes
Format:	Lecture, activity, discussion
Materials:	PowerPoint, Handout: "Sequential Intercept Model," Handout: "This is Richard," Key: "Intercepts and Consequences," flip chart and markers
Competencies:	• Identify the role of corrections within the broader justice system. • Compare criteria for incarceration in a prison versus a jail. • Describe corrections' functions of retribution, deterrence, containment, and rehabilitation. • Understand the Sequential Intercept Model and how it could improve response to mental health of incarcerated people.

Description

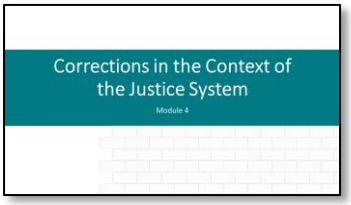
This module reviews the process flow of the justice system and, by teaching the Sequential Intercept Model, shows participants how attention to mental health in the justice system can improve outcomes.

Before Training

Print out enough copies of the handouts "The Sequential Intercept Model" and "This is Richard" for each participant to have one.

Print out copies of the key "Intercepts and Consequences" **for all trainers active this day**. This is an answer key for the activity "Intercept!" and will only be used by trainers, not participants. The Key can be found in the Manual below, at the end of the Activity section.

During Training



Why Are We Doing What We're Doing?

Lecture

Present lecture:

What are the goals of our correctional system? We may not talk about this much, but it's important to ground ourselves in why we do what we do.

Correctional systems were developed to serve four purposes: incapacitation, retribution, rehabilitation, and deterrence (Kifer, Hemmens, & Stohr, 2003, p.54).

- **Retribution** (or punishment): to pay offenders back for the harm they have caused society.
- **Incapacitation** (or containment): to protect society by putting offenders in jail or prison so they can't victimize anyone else in society.
- **Rehabilitation**: to reform offenders so that they will return to society in a constructive rather than destructive way.
- **Deterrence**: to teach offenders as well as other people contemplating the commission of a crime that crime does not pay.

In the United States, jails were developed in colonial times to hold those awaiting trial who could not pay their fines; thus, their original purpose was mostly incapacitation. It wasn't until later that retribution and deterrence from future crime became goals of incarceration.

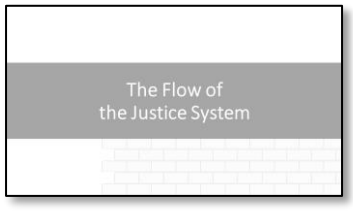
At several points in history, it was thought that prisons may rehabilitate people—either by making them reflect on their crimes, with sorrow and regret leading to individual reform, or through delivery of services.

Our prisons and jails, however, have never adequately achieved the goal of rehabilitation (Kifer, Hemmens, & Stohr, 2003; Sullivan, 2009), which contributes to social consensus that criminal justice reform is needed to promote rehabilitation and reduce recidivism.

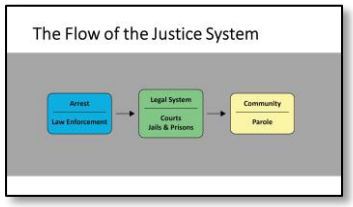
The Flow of the Justice System

Lecture

Present lecture:



It's important to know the ideal flow of our justice system. Legally, this process must be followed carefully: breech of process can compromise a person's legal rights or the appropriate response by the justice system.



Refer to the PowerPoint slide showing the flow chart of the justice system for the rest of the lecture. Adjust time spent based on audience familiarity with the process; you can acknowledge that some audiences may know this well and this is just a review. Use the following talking points to present the chart to the learners:

Arrest: a report comes into the police. Local law enforcement makes a determination and arrests an individual. Law enforcement brings the individual in for detention.

Legal system: there is an initial hearing before a judge. Then the individual either awaits a court case or continues on to jail or prison to serve a sentence.

And here, note that jails and prisons aren't the same thing. Jails are typically operated at the local or county level and house those awaiting trial or sentencing, or offenders found

guilty who will serve less than one year's time. Jails are often administered by local law enforcement. Prisons house those convicted who will serve more than one year's time; they are usually administered by state departments of corrections, or by the federal Bureau of Prisons (Sullivan, 2009).

Community: the individual may re-enter the community by completing their sentence, being paroled, or put on probation.

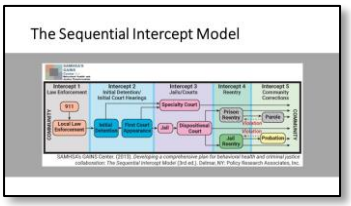
The Sequential Intercept Model

Lecture

Give out the "Sequential Intercept Model" handouts.

Refer participants to their Sequential Intercept Model (SIM) handout and refer to SIM PowerPoint slide as you work through the model.

Present lecture:



The Sequential Intercept Model identifies five key points (intercepts) for identifying persons with mental health needs. These are opportunities to link them to services, preventing further penetration into the criminal justice system. This model builds on collaboration between the criminal justice system and community providers such as mental health and substance abuse treatment services.

Let's examine the intercepts for identifying persons with mental health needs.

Intercept 1: Law Enforcement and Emergency Services. At this stage, community collaboration between law enforcement, emergency services, and substance abuse or mental health providers can help identify persons who may need pre-arrest diversion to treatment. This helps prevent the arrest of people with mental disorders and instead diverts them to treatment. It may also be possible to take those who are addicted to substance abuse detox centers instead of

to detention. Special training for law enforcement officers and 911 operators can help first responders be aware of potential mental health issues or special populations/situations.

Intercept 2: Initial Detention and Court Hearings. This may be another opportunity to identify people with mental disorders and/or substance abuse issues and divert them into community-based treatment and recovery programs, when appropriate. Court-based screening and assessment by substance abuse treatment or mental health professionals can be used as a tool to advise the court on possible options for diversion. The best candidates for diversion may be low-level, nonviolent offenders whose offenses stem from mental health issues.

Intercept 3: Jails/Specialty Courts. The creation of specialty courts—like drug courts or mental health courts—can help problem-solve and link people with mental health needs to treatment. Also, intercepts in jail or prison mean that an incarcerated person with mental disorders can be identified, assessed, and receive targeted care while incarcerated. That might mean treatment while incarcerated or transfer to a more appropriate facility. This would involve training on basics of mental health and trauma for all facility employees who have contact with incarcerated people. It also would involve in-house or coordination with care systems ready to respond to mental health treatment needs.

Intercept 4: Reentry from Jails and Prisons to the Community. At this intercept, reentry planning by social workers or mental health staff might involve assessment, developing a plan for care, identifying programs that may be available in the community for this care, and coordinating with those programs (Osher et al., 2002). Assistance may be provided in applying for benefits or finding safe housing, and some places have peer-support programs to assist. There might also be "in-reach" by community providers or connection to transitional programs like halfway houses or community-based treatment. Ideally, there is some continuity and attention to assuring that the individual will have

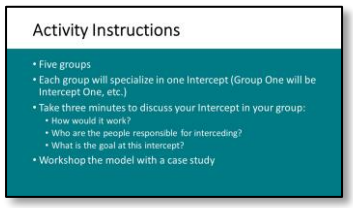
appropriate mental and physical health care for their needs, which may prevent reoffending or further justice-involvement.

Intercept 5: Community Corrections. At this intercept, it is important to assure that individuals receive care for their mental and physical health needs while on parole or probation. This can help prevent violations and avoid re-incarceration. Strategies can include specialized caseloads for officers trained on mental health and trauma, and making sure that supervising officers are aware of any special release plans for treatment.

Activity: Intercept!

1. Explain that participants will have a chance to see how intercepts could affect a person going through the justice system.

2. Give the following instructions (which are also on the PowerPoint slide):



    a. Count off in fives to divide into five groups.

    b. Each group will become the expert in one stage of the Sequential Intercept Model (i.e., Group One will specialize in Intercept 1, etc.)

    c. Take about three minutes to discuss your point of intercept in your groups. How would it work? Who are the people involved? What is the goal?

3. After they are in groups, allow them three to five minutes to discuss their intercept, as they need. This will be a chance to discuss what they all may know about what is available in their community and what gaps in service or coordination may exist.

4. When time is up, show Richard on the PowerPoint slide. Give out the handout "This is Richard." Read the following aloud:

   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 been known to destroy property.

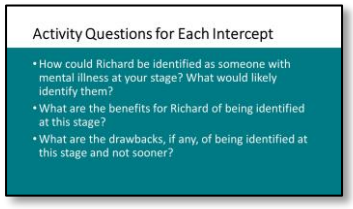
   Because of his behavior, he is no longer welcome at home. He can't hold a job, so he is often homeless. He carries his knife to protect himself, but his mother worries that he might threaten a police officer with it. Perhaps even deliberately, trying to commit "suicide by cop."

   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.

5. Then ask each group one at a time to discuss how that character could be intercepted and what difference it would make. Use these questions (show them on the PowerPoint slide):



a. What might be some signs that Richard may be someone with mental illness at your stage? What types of professionals and procedures would need to be involved to identify potential mental health issues?

b. What are the benefits if they are identified at that stage?

c. What are the drawbacks, if any, to being identified at that stage?

6. Once the character has been discussed by all five groups, get all of the groups involved. Discuss the consequences for the character, fellow incarcerated people, criminal justice professionals and correctional officers, and communities if the person made it all the way through the model without being identified as someone with mental illness.

Key: Intercepts and Consequences

Intercept 1:

Identifying Richard as someone with potential mental health issues would inform police around use of force issues (e.g., if Richard fails to obey or seems agitated in his response). Other first responders (e.g., emergency personnel, mental health providers) may be able to help de-escalate a crisis. If Richard is intercepted at this stage, he may avoid being arrested and instead may get the treatment that he needs. If criminal justice action is needed, Richard may be better able to respond if he is stabilized first.

Downsides: There are no downsides to being identified at this stage.

Intercept 2:

If first responders haven't identified Richard as having a mental health concern, court-based screening or court-ordered assessments may be coordinated by attorneys and judges working in conjunction with mental health providers. If Richard receives treatment at this stage, he may be able to have his charges dropped or reduced.

Downsides: If he wasn't identified at the previous intercept, he may have suffered confusion and the consequences of disobeying police officers even though he was not competent to follow directions.

Intercept 3:

Here, Richard could either be sent to a specialty court prepared to problem-solve on the case and handle a judgment and any sentencing with appropriate consideration of his mental illness.

Or, if he's identified as having mental health issues while in jail, he could begin receiving needed mental health care. He might be transferred, if needed, to a facility that can address his illness or be treated well enough to stay in the general population without having or causing crisis.

Downsides: If he's gotten this far without being identified, he may have been judged without recognition of the role his mental illness may play in his criminal behaviors. Also, his mental illness may already have caused disturbance in his life and the lives of others, including family and community members, as well as other incarcerated men and COs.

Intercept 4:

If Richard is intercepted here, he may have help planning for reentry. Having specific plans for his mental and physical health care, benefits, and housing can lessen the stress of reentry and promote stability during the transition to the community. If Richard is prepared for reentry and is stable, there's less chance he will re-offend or be detained for erratic behavior.

Downsides: If Richard hasn't been intercepted until this point, his time in the prison system has likely been unnecessarily difficult for him and those around him. He may have new trauma from his experiences and may have difficulty coping because of his mental illness.

Intercept 5:

If Richard is intercepted here, his probation officer may be aware of his needs and take those into account as Richard is monitored. The officer might monitor Richard closely during the first few weeks of transition to assure that he is following any plans for mental health treatment during reentry. Being stable in the community brings a much smoother transition than beginning a recurring cycle of erratic behavior, incarceration, and release.

Downsides: If Richard has avoided treatment this entire time, the chances of his re-offending are higher. Without coordinated efforts by the probation officer, mental health professionals, and possibly his family, Richard may likely come to the attention of law enforcement again soon.

Activity Debrief

When the activity is complete, debrief with the following questions:

a. Do you know of any programs designed to work at intercepts like these in our state or where you work?

b. What advantages do you see to being able to identify persons with mental health needs at these intercepts, particularly those in your workplace?

Conclude:

If people with serious mental illness are identified early and connected to treatment, their risk and that of others—

including incarcerated people and correctional officers—is greatly reduced.

Transition to Module 5

Say:

Next, we'll think about what particular challenges a person with a mental disorder may face in correctional facilities—if they were not diverted from incarceration.

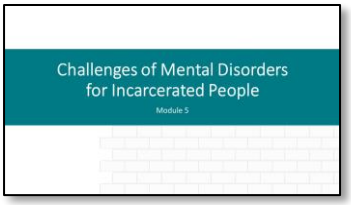
5: Challenges of Mental Disorders for Incarcerated People

Time:	40 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Meet Raymond Smith," Video: "Raymond Smith: Effectively Observing Life in Prison," Video: "Raymond Smith: Malingering," flip chart and markers
Competencies:	• Recognize increased problems within correctional facilities for people with mental disorders. • Describe other aspects of correctional facilities that create challenges in responding to people with mental disorders. • Describe the consequences of inadequate responses to incarcerated persons with mental disorders. • Identify concerning behaviors to observe.

Description

This module will explore the specific challenges for people with mental disorders who are incarcerated. It is enriched with videos of a subject matter expert giving some practical advice for identifying mental health concerns in correctional facilities.

During Training



The Correctional Facility's Impact on Mental Health

Set Up

Present lecture:

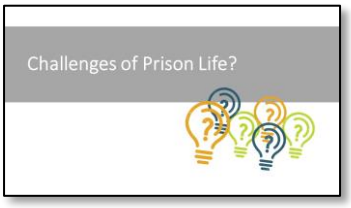
Correctional facilities are not pleasant. They're meant to be restrictive and controlled environments. Most people find being incarcerated very challenging.

So we rarely expect incarcerated people to behave "normally," as they would if living in freedom. In a general correctional population, you'll see a number of behaviors that may be byproducts of life inside that, on the outside, might seem abnormal—like trouble sleeping (either too much or too little), anxiety, agitation, and so forth.

But even in this unusual context, there are behaviors that are concerning and may be signs of deeper problems.

Discussion

Facilitate discussion with the following questions:



- What are some aspects of being in a correctional facility that are challenging for most people? (NOTE: Write a list on the board or flip chart.)
- What aspects of life inside may be particularly hard on someone with a mental disorder? (NOTE: Expect to hear or guide them to the following list: prolonged isolation, rigid schedules, strangers, uncertainty, use of restraints, continuous surveillance.)
- What do you think some consequences might be from an inadequate or inappropriate response to an incarcerated person's mental disorder?

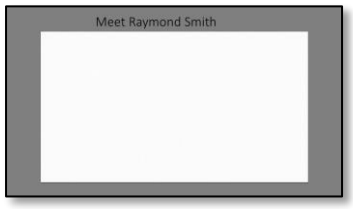
- Specifically, what about consequences to their own safety? To your safety? To the safety of those around them?

Transition by saying:

Let's meet subject matter expert Raymond Smith and then see what he can offer us about watching people for concerning behaviors.

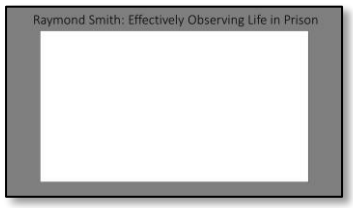
Video: Raymond Smith

Play the video "Meet Raymond Smith."



Video: Raymond Smith

Play the video "Raymond Smith: Effectively Observing Life in Prison."



Facilitate the discussion with the following questions:

- In your experience, have you witnessed behavior that disturbed you or other incarcerated people? Give examples.
- What do you think about Mr. Smith's suggestion to intervene early?
- What steps might you take if you saw a change in behavior that might diffuse trouble or allow you to refer a person to emergency care?
- How could you adapt some of his suggestions to your own workplace?

Transition by saying:

Now, let's focus more on behavior, mental disorders, and safety.

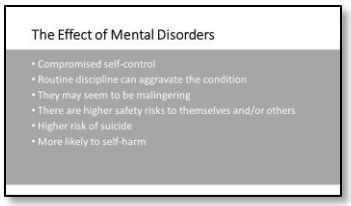
Safety and Behavior

Lecture

Present lecture:

Mental disorders can affect a person's self-control. This might include seemingly aggressive gestures, vocalizations, outbursts, and failure to follow directives (e.g., instructions, orders).

And routine disciplinary action may actually aggravate the behaviors instead of ending them.



Mental disorders can affect energy and motivation. A person may seem to be "malingering," which means intentionally producing false or exaggerated symptoms. It may seem that they are deliberately avoiding work or responsibilities, but they may be unable to function in daily life. You may have noticed this in your workplace: people who can't seem to stop acting out and people who can't seem to get up and function.

You can imagine the potential for higher safety risks with these populations—risks to themselves or to others.

In fact, incarcerated people with mental disorders are at higher risk of suicide than people without mental disorders. They may also be more likely to injure themselves, like cutting themselves with sharp objects, starving themselves, or other harmful behaviors.

And they can put others at risk. Disruptive behavior may trigger other incarcerated people to become disorderly as they respond by yelling or striking back.

So, what can you do to plan for and maintain safety when things can be unpredictable?

Discussion

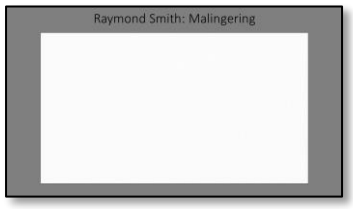
Facilitate discussion:

- How do you like things at work to go in order to have a safe shift?
- How might you use some of Mr. Smith's suggestions in order to help a shift go smoothly?

Transition to video by saying:

But perhaps you've been fooled by someone malingering and you don't want to be fooled again. Let's see what Mr. Smith suggests about things to look out for.

Video: Raymond Smith



Play the video "Raymond Smith: Malingering."

Facilitate discussion with questions:

- What about people mimicking symptoms to get special treatment—have you thought about this at work?
- What kind of special accommodations have you been asked for? Have you felt they've been legitimate?
- Do you worry about making a mistake, either letting someone off the hook when they're fine, or being too hard on someone who isn't ok?
- How might you approach these requests differently in light of today's information?

Transition to Module 6

Say:

Attentiveness and early intervention can make everyone safer.

But what about the uncertainty of encountering a person with mental illness who is experiencing something you don't understand? Our next module will explore the experience of mental disorders from the person's perspective.

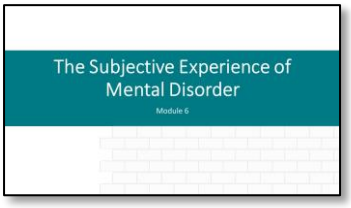
6: The Subjective Experience of Mental Disorders

Time:	30 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Chris in Prison," Video: "Through Chris's Eyes," flip chart and markers.
Competencies:	• Understand that the subjective experience of mental disorders may create challenges in daily living.

Description

This module will explore the experience of mental health from the perspective of an incarcerated person with a mental disorder. An animated, context-based, character-driven video will give perspective on the differences between outward behavior and inner motivation when mental disorders are involved.

During Training



Know That You Can't Know

Set Up

Present lecture:

Mental disorders may have common factors for diagnosis, but each person experiences them in their own way. They're highly unique.

You'll never know what another person is experiencing and feeling unless they're able to describe it to you. That can be very challenging for a person with a mental disorder and for a person who is incarcerated.

Correctional officers, like anyone, might have difficulty understanding what's going on when a person behaves strangely.

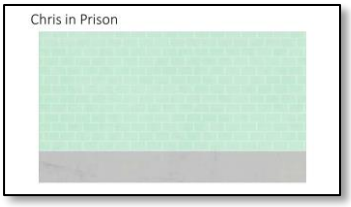
Ask:

Can some of you give examples of when an incarcerated person has behaved strangely and you didn't know why or what was happening?

Video: "Chris in Prison"

Introduce video:

Let's consider how a mental disorder can look to those around the person who have no idea what's going on inside.



Play the video "Chris in Prison."

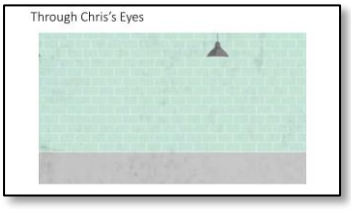
Facilitate the discussion with the following questions:

- What behaviors is Chris showing that may concern you?
- What do you think he's experiencing to cause this behavior? (Hint: no way to know)
- How would you respond to this person if he were in your workplace?

Transition to the next video by saying:

Now let's look at the same person but from their own perspective.

Video: "Through Chris's Eyes"



Play the video "Through Chris's Eyes."

Facilitate the discussion with the following questions:

- Now what do you think is causing Chris's behaviors?

- What is he experiencing? (NOTE: List responses on the flip chart or board.)
- How severe are these flashbacks or hallucinations? Is it clear now why he's behaving so erratically?
- Do you think these symptoms will go away as Chris "settles in"?
- Would discipline resolve the behavior?
- What are some risks if Chris doesn't get treatment? To himself? To other incarcerated people? To correctional officers and staff?

Conclude by saying:

Mental disorders can be an important factor in unusual or dangerous behavior in prison. Understanding that a person may not be responding to reality as you experience it may affect your response.

Transition to Module 7

Say:

Next, we'll start to find ways to respond to erratic or mysterious behavior that may be helpful.

7: Maintaining Safety, Offering Respect

Time:	45 min.
Format:	Video, discussion, activity
Materials:	PowerPoint, Video: "Raymond Smith: 'Maintaining Safety by Offering Respect,'" flip chart and markers
Competencies:	• Value one's own role in maintaining the safety of the facility for all involved. • Value a respectful and effective response to mental disorders.

Description

The module will help participants examine their choices about how they treat people in their charge. It will also offer a chance to explore small ways COs can offer respect to people who are incarcerated for better and safer outcomes.

During Training

What is a Safe Correctional Facility?

Set Up

Say:

You're there for everyone's safety. So let's talk about a safe day.

Discussion

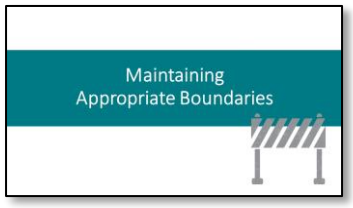
Facilitate discussion with the following questions:

- What does a safe correctional facility look like? Describe a day on the job when everyone was safe.
- What are some ways that you maintain safety while on duty?

Maintaining Appropriate Boundaries

Set Up

Set up the topic by saying:



Every day, you make choices about how to interact with incarcerated people. Every day you make decisions about the boundaries you set between them and yourself.

However, we don't always talk about exactly how we define what appropriate boundaries are. Let's take a minute to talk those out so we can shed light on how we make our decisions.

Discussion

Facilitate discussion with the following questions:

- What are appropriate boundaries in prison between a correctional officer and someone who is incarcerated? Give examples.
- What does professionalism look like at work? Give examples.
- What might poor boundaries between a correctional officer and someone incarcerated look like?
- What are some risks in having poor boundaries?

Transition by saying:

Let's see what Raymond Smith can offer us as we think through the relationship between correctional officers and those who are incarcerated.

Video: Raymond Smith

Play video "Raymond Smith: Maintaining Safety by Offering Respect."

Facilitate discussion with the following questions:

- What did you think of Mr. Smith's suggestions?
- What did you think of his suggestion to be respectful to those who are incarcerated?
- Have you seen respectful behavior or a professional demeanor work well? Work poorly?
- Can you think of a situation where you see an advantage to being respectful? Give an example.

Transition by saying:

Let's try considering a situation when you might offer respect in a stressful circumstance.

Activity: Small Gestures

1. Tell them that you'll give them a brief scenario and they should offer suggestions about how they might respond by offering respect to a person who is incarcerated.
2. Read the following scenario:

> Melinda, who is incarcerated, is talking on the phone during her allotted time. From a distance, you see that she's agitated and is hunched over the phone.
>
> She finally hangs up the phone. Then she picks up the receiver again and bangs it

sharply back into the cradle. She sits still, staring blindly at the phone.

3. Ask them, "Typically, if you saw this behavior, how would you respond?" (Hint: You might hear, "I would ignore it," "I would warn her about being rough with equipment.")

4. Ask, "Based on our conversation about offering respect, how might we interact with Melinda at this moment?" (Hint: Look for and pull out responses that include speaking gently to her, asking if she's ok, making small talk, using her name.)

5. Whoever gives the best response, tell them that when they talk to her in this way, Melinda relaxes a little and says that she was talking on the phone to her brother about their sick mother. She worries he's not taking care of her that well and is frustrated that she can't do anything about it.

6. Tell them that after this interaction, Melinda doesn't seem as tightly wound and goes off to the next part of her day without incident.

Activity Debrief

Facilitate a discussion about the activity by asking:

- How common is it to see little signs of stress in incarcerated people?
- Were our suggestions and solutions complicated or simple?
- Would you feel comfortable beginning to make small changes to your interactions with people who are incarcerated like this?
- Is there a moment you've had recently that you could "redo" by speaking respectfully to a person?

Transition to Module 8

Transition by saying:

We've spent this module thinking about how correctional officers and staff respond to incarcerated people. Let's continue to learn more about mental disorders in our next unit. We'll look at specific diagnoses and begin to talk about what kind of rights people with mental disorders have, even while incarcerated.

8: Mental Disorders and Individual Rights

Time:	45 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Handout: "Common Mental Disorders and their Symptoms," Video: "Rena Changes," flip chart and markers
Competencies:	• Recognize basic signs and symptoms of common mental disorders. • Recognize that mental disorders have genetic, environmental, and lifestyle causes. • Understand the rights of people with mental disorders to treatment and to self-determination, as balanced with the safety needs of the individual and others.

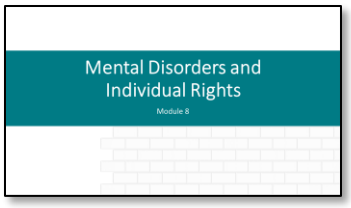
Description

The module will orient participants to common mental health diagnoses and touch on the basic rights of persons with mental illness. An animated, context-based, character-centered video will help them observe an example of what to look for.

Before Training

Print out enough copies of the handout "Common Mental Disorders and their Symptoms" for every participant to have a copy.

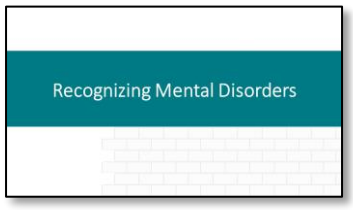
During Training



Recognizing Mental Disorders

Set Up

Begin the topic with the following:



Right now, our society talks more about mental disorders than we ever have before, but that doesn't mean we all have an accurate understanding of the most common disorders. Demystifying mental disorders helps the population at large. Let's get more detail now.

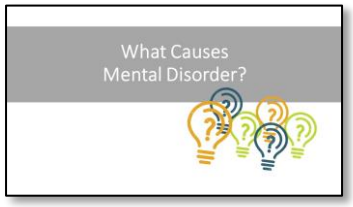
Give out copies of the handout "Common Mental Disorders and their Symptoms."

Tell them to look over the handout for a few minutes. Then ask questions such as, "What surprised you?" "What do you think is most relevant to your job?" "What questions do you have?"

What Causes Mental Disorders?

Lecture

Present lecture:



What can cause mental disorders?

- **Genetics**. It appears that some mental disorders may have a strong genetic component, such as schizophrenia and depression.
- **Environment**. Life experience can affect mental health greatly. Daily stress and trauma can contribute to anxiety, depression, and panic disorders including Post Traumatic Stress Disorder. Also, if a person has a genetic vulnerability to mental illness, whether it is ever expressed or whether it worsens may be influenced by environmental factors.
- **Lifestyle**. A person's daily choices are important to mental health. Substance abuse can impact

mental health. Addiction and side effects from substance abuse can lead to or increase risk of depression, paranoia, and other issues.

Transition by saying:

Let's have a look at someone who is incarcerated and experiencing a change in mental health.

Video: "Rena Changes"

Play the video "Rena Changes."

Facilitate the discussion with the following questions:

- What alerts you that Rena's mental health status has changed? Give examples.
- Can you tell what may have caused the change? (Hint: It happened after visitation, but she hasn't told anyone what happened so you can't know).
- Do you need to know what Rena found out that caused the change? (Hint: No.)
- What concerns do you think you should be on the alert for? (NOTE: Worsening symptoms, conflict with bunkmates).
- How could you get her help?
- What could be some consequences if she doesn't get formal help? (NOTE: Inappropriate punishment for malingering, worsening symptoms, suicide attempt, impact on family relationships, lawsuit against officer or facility, etc.)

Get Help

Lecture

Say:

It's important to keep current on your workplace's policies on how to respond to individuals with acute mental health issues and what to do if you suspect an incarcerated person may be developing a mental disorder.

How many of you already know those policies? What are some of the most important points? (Discuss). If you don't know the policies well, study that part of your employee manual and ask your supervisor for further information when you arrive at your next shift.

The Power of Mental Illness

Lecture

Present lecture:

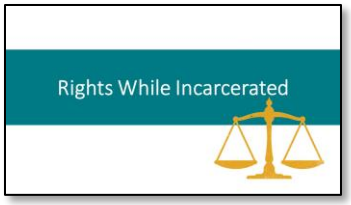
Ultimately, severe mental disorders can reduce or compromise a person's free will. The illness may interfere with their ability to take in information. Or the illness may not give them complete control over their actions and decisions.

However, mental illness doesn't take away an adult's right to self-determination and support. People with mental disorders have a right to treatment in order to have as much control over their decisions as possible.

Rights While Incarcerated

Lecture

Present lecture:



Incarcerated people with mental disorders have the right to treatment, including ability to access a treatment system in which he or she is seen by a person qualified to diagnose and treat his or her ailments, with timely and appropriate treatment for his or her problems.

Similarly, incarcerated people have the right to be free from intrusions into their autonomy over their own bodies; that is, the individual may refuse treatment. There are some exceptions to this rule when the individual is deemed incompetent or presents a danger to self or to others, but these decisions are driven by mental health and administrative staff with consideration of applicable state and federal laws and regulations (Drapkin, 2009).

Discussion

Ask:

- Do you know how your workplace maintains the rights of those with mental illness?
- What is your role in maintaining their rights while incarcerated? (Hint: follow your workplace's policies carefully).
- At your workplace, who can you go to when you're uncertain about the best response to someone with a mental disorder or illness? (Hint: supervisor, mental health staff).

Transition to Module 9

Say:

While you aren't responsible for diagnosing someone unless you are a mental health professional, correctional officers are responsible for the rights and safety of people who are incarcerated.

Sometimes, the symptoms of mental disorders or the side effects of medications for those disorders can appear to be malingering behaviors. Next, we'll explore those issues.

9: Medication Side Effects and Malingering

Time:	30 min.
Format:	Lecture, discussion
Materials:	PowerPoint, Handout: "Common Medications and Side Effects," flip chart and markers
Competencies:	• Recognize common side effects of medications used to treat mental disorders. • Describe prevalence and motivations for malingering. • Understand the rights of people with mental disorders to treatment and to self-determination, as balanced with the safety needs of the individual and others.

Description

This module will orient participants to common psychotropic medications and their side effects while touching on the right of individuals with mental health disorder to make choices about their medical care.

Before Training

Print enough copies of the handout "Common Medications and Side Effects" for each participant to have one.

During Training

Concerns about Malingering

Set Up

Say:

Malingering is a behavior that you are likely to come in contact with in a correctional facility. Malingering is pretending or exaggerating illness or injury. People may malinger for different reasons like to avoid being bothered or to avoid work. In a correctional facility, malingering is sometimes used as a survival strategy that the person may have learned, so the main motivation might not be simply trying to deceive a CO.

But people with mental illness may **appear to be pretending** to be unable to perform their tasks **when they truly are not able**.

How can you begin to determine that someone may be suffering from a mental disorder instead of malingering? Foremost, that's not the job of the CO; it's the job of mental health staff, so always be sure to follow standard procedure for referrals to medical or mental health care.

But beyond that, knowing the individual's habits can be helpful in understanding behavior on a daily basis. If a person is usually attentive and on track, but they have changed and are unresponsive or difficult, they may be more likely to have a mental health concern.

Mental illness often compromises choice for an incarcerated person. If a person has major depression, then getting out of bed may seem impossible to them, not a choice to disturb the daily routine.

Discussion

Facilitate the discussion with the following questions:

- How do you respond to someone who you think may be malingering at your workplace?
- Would you change your response if you knew someone who appeared to be malingering was diagnosed with a mental illness that impeded their ability to control their behavior?
- How might you respond differently? Does your facility have a policy that you would follow?

Transition by saying:

When someone has a mental disorder, appropriate medication may help a person function better. However, medications can have side effects that may alter a person's behavior.

Medication

Set Up

Introduce this topic by saying:

Medication is often used for mental disorders that disrupt a person's life. You may not know what medication someone is taking, but a general awareness of common issues medication might cause can be helpful.

Let's briefly look at a list of common medications and their side effects. You can keep this handout to refer to whenever needed on the job.

Refer participants to the handout "Common Medications and Side Effects."

Discussion

Review the contents of the handout "Common Medications and Side Effects."

Ask:

- How many of these side effects could look like malingering?
- Do you feel qualified to be able to tell when someone is suffering side effects? (Hint: they shouldn't!)
- If you aren't a qualified mental health professional, who at your workplace would you share your concerns about someone's behavior with? (Hint: supervisor, mental health staff. It may differ according to workplace. Emphasize that if they're unsure, then they should ask as soon as they return to work.)

Conclude by saying:

Unless you're a mental health professional, it's not your job to diagnose an incarcerated person. But recognizing that someone may be unable to respond effectively due to mental illness can make a safer facility for everyone and an easier life for correctional officers.

Transition by saying:

Further, people with mental disorders maintain the right to treatment even while incarcerated.

Individual Rights and the Right to Make Choices about Medical Care

Lecture

Present lecture:

Incarcerated people with mental illness may be compromised in their ability to make rational choices while incarcerated.

However, they still maintain their rights.

One right is to proper treatment. Treatment may even restore and improve a person's ability to make choices.

Your job as a correctional officer is to make sure the incarcerated person has access to treatment, which means you must follow your institution's policies on reporting concerns about mental health.

Conclude module:

Unless you are trained and qualified, your job is not to be a doctor or a therapist. However, some basic knowledge of what to look for and how to respond can keep your workplace safer and maintain the rights of any incarcerated people with mental disorders.

You can refer to the resources from this training on the website any time in the future. You should also talk with your supervisor and/or your workplace's mental health specialists for any special details on workplace procedures or about any people you are concerned about.

Being proactive and observant benefits everyone.

Transition to Module 10

Say:

While you are not a mental health expert, there are tools that can help you identify people in correctional facilities who may have a mental disorder. In the next module, we'll explore corrections mental health screening.

10: Mental Health Screening

Time:	45 min.
Format:	Lecture, activity
Materials:	PowerPoint, Handout "The Correctional Mental Health Screen for Men," Handout: "The Correctional Mental Health Screen for Women," flip chart and markers
Competencies:	• Describe the purpose of mental health screening in corrections. • Name a screening instrument that can be administered by correctional officers in prisons and jails. • Describe appropriate settings within the facility, appropriate body language, and tone for screening. • Describe timing when screening should take place for incarcerated people. • Differentiate appropriate and inappropriate use of findings of mental health screens.

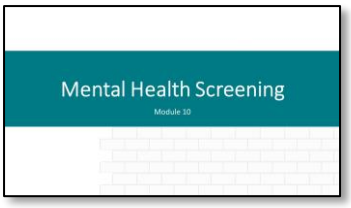
Description

The module will orient participants to the mental health screening tools and to ethical issues surrounding mental health screening. In a pretend activity, participants will have a chance to work through how to give screenings on the job and troubleshoot some important issues. They will be told they will have to use the tool to screen each other in public. While they won't end up having to do it, the uncertainty and discomfort they feel should be important as they think about barriers to using the tool in their workplace.

Before Training

Print out enough copies of the handouts "The Corrections Mental Health Screen for Men" and "The Corrections Mental Health Screen for Women" for every participant to have one.

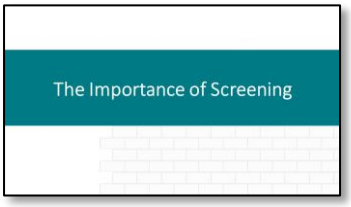
During Training



The Importance of Screening

Set Up

Set up the topic by saying:



Screening is a reliable way to tell if a justice-involved person may have a mental health disorder.

Subjective decisions are unreliable, especially by those who aren't trained in mental health assessment.

Screening tools offer consistency in decision-making and can create a solid paper trail for the justice system to use when an incarcerated person has a mental disorder.

A Screening Tool for Corrections

Lecture

Present lecture:

The Correctional Mental Health Screen (CMHS; Ford and Trestman, 2005) has been shown to be effective in screening for mental disorders among both male and female inmates. There is an 8-item version for women and a 12-item version for men, with items addressing current and lifetime indications of serious mental disorders, as well as some gender-specific items. Each screen takes under 5 minutes to administer. If an inmate

answers a certain number of items affirmatively (e.g., "yes" to 5 questions for females or to 6 questions for males), he or she should be referred to mental health staff for further evaluation.

Discussion

Say:

Let's look at the screening tools to get some familiarity with them. Let's look at the tool for men first.

Refer participants to the handout "The Correctional Mental Health Screen for Men."

Facilitate the discussion with the following questions:

- Looking at the tools and the questions, what kinds of issues are they looking for?
- Do you see any behaviors that might be a concern in a correctional facility?
- Look at the referral instructions on the second page. Does the tool **diagnose** mental illness? (Hint: no – it just dictates when someone should go for a mental health evaluation).
- Do you have any questions about the tool's contents?

Say:

Now let's look at the tool for women.

Refer participants to the handout "The Correctional Mental Health Screen for Women."

Facilitate the discussion with the following questions:

- Looking at the tools and the questions, what kinds of issues are they looking for?
- How does this tool differ from the tool for men? (Talking points here: The difference you see between the two screening tools is based on the difference between gender-based symptoms. The men's

screening items include more explicit aggression, hypervigilance, and negative attitudes towards others, such as grudges or the silent treatment. The women's measure has items that capture negative feelings about their own self, like guilt or that they may be "sinful," and the effects of being taken advantage of.)

- Do you see any behaviors included in the tool that might be a concern in a correctional facility?
- Do you have any questions about the tool's contents?

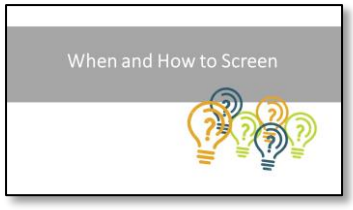
Transition by saying:

Let's talk about when correctional staff might use this screening tool on the job.

When and How to Screen

Lecture

Present lecture:



Best practices suggest that "universal" screening be used for all incarcerated people at intake to identify those with mental disorders. Also, because some people may develop mental disorders while incarcerated, periodic screening of the general correctional population may also be useful.

Screening can be administered by correctional officers, intake staff, or nursing staff. Although those who administer screening do not require specialized mental health training for the Correctional Mental Health Screening, brief training may be helpful.

For screening those who are uncooperative or who express discomfort answering the questions, screening by a nurse or mental health staff member may be preferable.

The screener may read the question aloud to the incarcerated person and fill in the form with the person's answers to each question, providing comments to clarify in

the designated area of the form. This may be a good option since you may encounter varying levels of reading ability.

If the person refuses to answer or does not know the answer, this should be explicitly noted in the comment by writing DECLINED or DON'T KNOW rather than marking the YES or NO boxes.

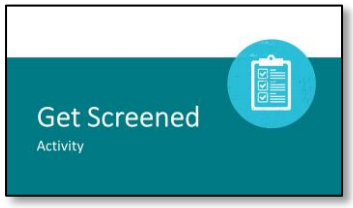
If the person answers YES to the specified number of items for referral, a routine referral may be recommended.

If there is any indication that the inmate is unable to cope emotionally (e.g., severe anxiety, grief, anger, disorientation) or is a suicide risk, the referral should be marked URGENT and referred for immediate mental health evaluation (Ford et al., 2007). The individual should not be left by themselves while awaiting mental health staff.

In order to demonstrate that the facility met its responsibility to become aware of the mental health needs of incarcerated people, documentation should include the name of the person who performed the screening and the exact date and time of the screening (Drapkin, 2009).

Activity: It's Not Easy Being Screened

DO NOT SAY THE FOLLOWING ALOUD: The purpose of this activity is to show participants that screenings should be private and can be uncomfortable for incarcerated people to submit to. The activity pretends that they must screen each other for mental health concerns. IT IS A TRICK.



1. Tell the participants that they will practice giving a mental health screening by screening each other.
2. Give the following instructions:
    a. Find a partner at your table.
    b. You will be giving each other a mental health screening to identify mental health concerns using the tool provided.

Everyone will have a turn to screen and be screened.

c. Decide who will take the first turn as the screener and then wait for further instruction.

3. When they've paired up and settled down, ask them:
   - Are you prepared to answer these questions with a near-stranger? In a public place?
   - Allow a few moments of awkward silence. Then tell them that they will not actually have to conduct the screenings.

Lecture

Debrief the activity by saying:

Perhaps now you can see why choosing an area where you won't be overheard is important. Also, you might now appreciate the difficulty of telling private matters to a near-stranger. You won't be screening each other today—but remember how you felt when you thought you were going to have to talk about your private emotions and experiences. Let that inform how to handle the mental health and privacy of those incarcerated at your workplace.

Transition to screening best practices by saying:

What are screening best practices?

The screening should be conducted in a private setting, out of earshot of other inmates. The person who administers screening should present a professional demeanor and empathetic tone, being conscious of body language and pace of speech in administering the screening. Findings of the screening should be confidential and communicated only to the designated authority for referral, and medical or mental health staff should routinely review all screening forms—typically within 24 hours of when the screen was performed

(Drapkin, 2009). It is important that findings not be shared with other incarcerated people or non-authorized correctional staff.

Conclude:

Ultimately, whether, when, and how to use a screening tool is at the discretion of your workplace's leadership.

But knowing whether an incarcerated person has a mental disorder can help get them appropriate care and help correctional officers prevent crisis.

Transition to Module 11

Say:

Crisis is a constant threat in correctional facilities. Our next module will explore crisis intervention when the subject has a mental disorder.

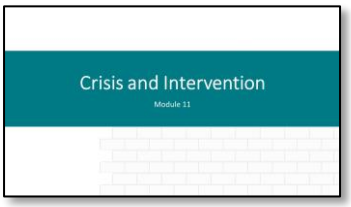
11: Crisis and Mental Illness

Time:	30 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Raymond Smith: Crisis Intervention," Video: "Callous and Cruel Use of Force Against Inmates with Mental Disabilities in US Jails," flip chart and markers
Competencies:	• Describe elements of a crisis. • Describe non-verbal techniques for de-escalating a crisis.

Description

This module focuses on crisis in the correctional setting. It begins with the definition of crisis and then uses a video about the danger of using typical correctional interventions on people with mental disorders.

During Training



Crisis

Set Up

Begin by asking, "What is a crisis?" Ask for examples from the learners about crises that they've observed.

Then, define crisis in a correctional facility by saying:

The National Institute of Corrections (2010) defines a crisis as a short-term, overwhelming event that disrupts an individual's stable state, where the usual methods of coping

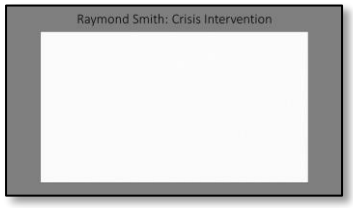
and problem-solving do not work to restore stability. In such situations, correctional officers may need to analyze the situation and act quickly to keep the crisis from escalating while the facility's crisis intervention team is being called to the scene.

Transition by saying:

Let's see what Mr. Smith says about expecting and being prepared for crises.

Video

Play the video "Raymond Smith: Crisis Intervention."



Facilitate the discussion with the following questions:

- Mr. Smith says that there are certain times and places that are commonly associated with crisis. Do you agree?
- Based on your experience, are there any other times/ places/activities that you would add to that list?
- What about when a crisis seems to come out of the blue with no noticeable event causing it? What do you do to handle it?

The Importance of Preventing Crisis

Discussion

Facilitate discussion with the following questions:

- In your experience, what happens when an incarcerated person with mental illness suffers a crisis? (NOTE: they may not know. Move on if there's protracted silence).
- Are correctional facilities well-equipped to handle this kind of crisis? (Note: you may get varying answers depending on where participants work).

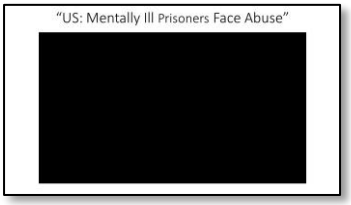
Transition by saying:

Correctional facilities are often unprepared for appropriate solutions for crises involving people with mental disorders. In fact, sensational cases have been covered in the media because the response was poor.

Let's look at a short video that focuses on worst-case-scenarios when facilities and staff haven't been equipped to respond appropriately.

Video

Play the video "Callous and Cruel Use of Force against Inmates with Mental Disabilities in US Jails." This link is embedded in the PowerPoint for this module. The persistent link is:



https://www.youtube.com/watch?time_continue=1andv=OCaKethFbEg

Facilitate discussion:

- What is your response to this video?
- Could you have been one of these responding officers? Do your current policies dictate that you respond in a similar manner?
- With the given information (what you saw and the comments made by officers), would you have done anything differently?
- How many times have you been presented with a person who is not compliant? Have you initiated similar responses as the officers in the video? Have you had moments when you were uncertain how best to respond?
- Can you identity some warning signs that this was not a typical encounter?
- One of the experts says that excessive force isn't just because of a "few bad apples" on staff—that this is

simply the way that prison works and how staff are trained. What could prevent excessive use of force against people with mental disorders?

Finding Solutions: Non-verbal De-escalation Techniques

Set Up

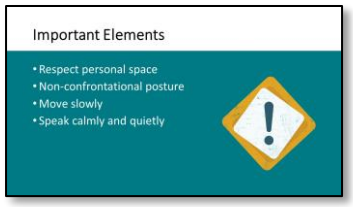
Say:

We're talking about crisis and have watched some crises playing out in the video. Intervening in a crisis can be dangerous and complex, especially if someone is suffering with a mental illness. We'll talk more about de-escalating crises in a later module, but one foundational skill is non-verbal de-escalation.

Lecture

You may have been trained in observing the body language of others to meet your safety goals. However, as you focus on de-escalating situations, paying attention to your own body language can be just as important.

Here are some elements to always bear in mind:



- **Respect the individual's personal space.** Invading their space is an immediate threat, even if you don't intend harm.
- **Use a non-confrontational posture**. Don't clench your fists or hide your hands, as this may create a threat. Keep your hands relaxed and open and in plain sight.
- **Keep your movements slow.** Moving quickly and suddenly can startle a person and increase their agitation, leading them to react violently or aggressively.

- **Speak calmly and quietly.** The tone and loudness of your voice also provide nonverbal cues. Keep your voice at a lower level than the individual's. A loud voice can be seen as aggressive or insulting, which can escalate the situation.

Discussion

Facilitate a discussion with the following questions:

- What kind of body language do you, as a CO, usually use at work?
- Would you characterize it as confrontational or non-confrontational?
- What do you think of changing to de-escalating body language?
- What are some circumstances in which you might find it useful? Give some examples.

Transition to Module 12

Say:

We've looked at crisis as part of the corrections experience, but we're starting to think about ways to defuse or prevent it by starting with body language. In our next module, we'll learn a method you can use on the job to intervene in a crisis that may improve outcomes for you and people who are incarcerated.

12: The C.A.F. Model

Time:	40 min.
Format:	Discussion, video, activity
Materials:	PowerPoint, Handout: "The C.A.F. Model: Tips for De-escalation," flip chart and markers
Competencies:	• Use the C.A.F. (Calm, Assess, Facilitate) Model of crisis intervention.

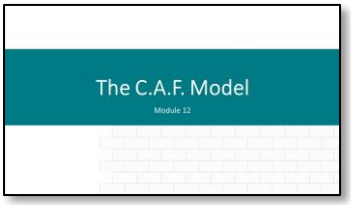
Description

This module teaches the C.A.F (Calm, Assess, Facilitate) Model of crisis response. After learning the model, participants will "road test" the model in a context-based activity.

Before Training

Print out enough copies of the handout "The C.A.F. Model: Tips for De-escalation" so that each of the participants can have one.

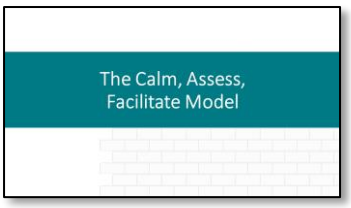
During Training



The Calm, Assess, Facilitate Model

Set Up

Ask:



At your workplace, what is standard operating procedure if an incarcerated person has a crisis? (Hint: May hear anything, from talking it out to using restraints, tear gas, etc.).

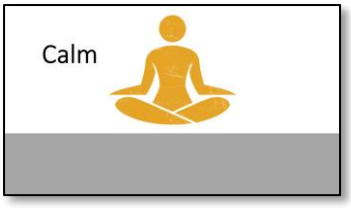
Here's a concrete model that can be useful for any crisis situation but can be especially useful if the incarcerated person has a mental disorder. It's founded upon de-escalation.

Lecture

Pass out the handout "The C.A.F. Model: Tips for De-escalation" so that participants can refer to it throughout this module.

Present lecture:

The C.A.F. (Hint: pronounce this "kaff") model is a three-step process that you can use as soon as you become aware that something is wrong. Here are the three steps and how to follow them:



Calm. Decrease the emotional, behavioral, and mental intensity of the situation. Try to establish the safety of the situation with regard to the safety of the individual, other people who are incarcerated, and correctional officers or other staff.

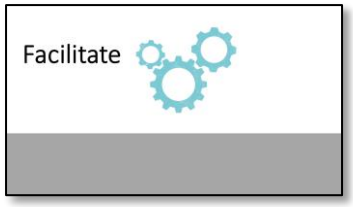
Briefly check in with participants by asking:

- How could you "calm" a crisis situation at work? How could tone of voice and what you say be important?
- What about body language? Could that be part of the solution? (NOTE: if you have not taught Module 11: Crisis Intervention, then briefly discuss how calm and non-threatening body language can help defuse a crisis.)

Assess. Determine the most appropriate response based on the facts of the situation. Listen to the person in crisis, exercise respect, and try to understand the situation and its meaning from his or her perspective. Identify the facts of the situation before you act. Be alert to potential triggers that could feed into the crisis and endanger anyone involved (for example, interference from bystanders).

Briefly check in with participants by asking:

- Assessing during a crisis can be hard. What could you do to help yourself assess things clearly before acting?



Facilitate. Promote the most appropriate resolution based on an assessment of the facts. Review various alternative courses of action or options that will help stabilize the individual. Focus only on goals related to the crisis, and build hope for a positive outcome based on the individual's strengths. Provide supportive communication in a nonjudgmental and positive tone. If possible, obtain a commitment from the individual to carry out the identified plan.

Briefly check in with participants by asking:

- How is "facilitating" different from "reacting?" (Hint: should hear answers like "you work with the individual rather than imposing your own ideas, it's more thoughtful, it's based on joint decisions, not snap judgements," etc.).
- Is "facilitating" a standard part of your workplace procedure? How or how not? What are its

advantages? (Hint: it lets the person have more of a sense of control over what is happening to him, it builds rapport by working together.)

- Can you think of a circumstance at your workplace where you might "facilitate" during a crisis instead of reacting?

Transition by saying:

Let's add body language and the C.A.F. Model all together with an activity.

Activity: Can You CAF It?

1. Explain that the purpose of this activity is to "road test" the C.A.F. Model in a corrections crisis scenario.
2. NOTE: As the facilitator, you will need to critique their decisions based on the criteria for the C.A.F. Model. If they make any decisions that violate the model, point this out to them and why it's not C.A.F.-based. Then, ask them to try again within the parameters of the model.
3. Give the following instructions:
    a. We'll all work together to see if we can use the C.A.F. Model on a corrections crisis.
    b. I'll give you some information about an event, and we'll work through each step of the model.
    c. Here's what happens:

    A woman comes to you and tells you that her cellmate, DeeDee, has gotten some bad news when she opened her mail today. The woman says that DeeDee has been distraught since reading the letter and is saying things like she can't take it anymore. She worries DeeDee may hurt herself during shower time.

When you approach DeeDee, she looks wild-eyed and agitated. As you come nearer, she sees you and backs away against the wall saying, "No. Go away from me, get out of my face!" When you start to speak, she turns her face away from you saying, "This is none of your business! You don't know me! Get out of my face!"

If the first step is Calm, what do you do? Discuss a few options as a group before deciding on what to do.

4. Allow them 2 minutes to explore how they could calm DeeDee. Ask for their plan and critique it. You and the participants should refer often to the C.A.F. Model to check that their responses fit the model.

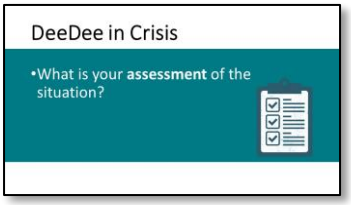
5. When they've reached a good answer, affirm their choices and move on to Assess by saying the following:

   DeeDee is now calmer. She's breathing more easily. She sits down on the ground with her back against the wall.

   She tells you that the letter warned her that her parental rights over her daughter may be terminated. That would mean a stranger could adopt her toddler.

   She tells you that when she thinks about this, she feels "so crazy she could burst." She says she might as well just ram her head into the wall. Even that would feel better than thinking about that letter. She says she has so many questions about what's going on with her child but no idea who to ask.

6. Facilitate a discussion about assessing the situation with the following questions:



    a. What's the problem here?
    b. Is there any potential danger to her, you, or others?
    c. Are there any signs of a mental health concern?
    d. What are your goals for this interaction?

7. Allow the group 2 minutes to discuss the answers to these questions and decide what their goals are.
8. Critique their plan, helping them improve it as needed.
9. Move on to Facilitate with the following questions:

    a. To facilitate your goals, what steps can you take? What are a few ways you could act to achieve your goal?
    b. What's the plan with the least amount of physical or emotional damage to anyone?
    c. How do you plan to speak to DeeDee? What words would you use? What kind of body language or posture do you want to use?

10. Once they formulate a good plan to facilitate, tell them that DeeDee follows through the plan and does not harm herself. She is able to go on with her day, and there is no crisis.

Discussion

Debrief the "Can You C.A.F. It?" activity with the following questions:

- Was it easy or hard to make a good plan with this crisis?

- Did you find you had to be creative and find new ways of thinking about crisis resolution?
- If you had responded to the event without using the C.A.F. Model, what would you have done?
- What strengths does the C.A.F. Model have? What other kinds of scenarios might you use it in on the job?
- What are some situations in which it wouldn't be useful? (Hint: riots, mass chaos, etc.)

Conclude:

- Can we connect remaining calm and the C.A.F. Model with showing respect for the people who are incarcerated?
- What are some benefits to remaining calm? What are some drawbacks?

Say:

You can use your handout of the C.A.F. Model for future reference on the job. You now have another tool to help address crises at work.

Transition to Module 13

Say:

Using the C.A.F. Model can be about maintaining safety in a correctional facility—and the stakes can be high. In our next module, we'll consider two things that are too common in a correctional environment: self-harm and suicidality.

13: Self-Directed Violence: Suicidality and Self-Injury

Time:	30 min.
Format:	Lecture, activity, discussion
Materials:	PowerPoint, Handout: "Precautions for People Who Are Suicidal or Who Self-Injure," Cards for activity: "What Can I Say?," Handout: "What to Say," flip chart and markers
Competencies:	• Compare self-injury to suicidality, including risks of each. • Describe signs of suicidality. • Describe precautions for suicidal people and those who self-injure. • Understand policies on suicidality in participant's facility of employment.

Description

This module grounds the participants in the definitions of and differences between suicidality and self-injury, both of which are much more common in people with mental illness. It also teaches best practices for taking precautions with people who are suicidal or who self-injure and uses an activity to model fruitful ways to talk with a person who displays either of these concerns.

THIS MODULE HAS PRE-WORK.

Before Training

Pre-work for Participants

Notify participants BEFORE training that they should come to the training day well versed in their institution's policies

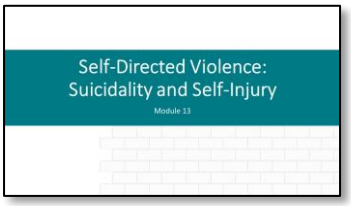
and procedures for crisis intervention with people who are suicidal or who harm themselves. If allowed by their institution, they can bring a hard copy of these policies to the training day.

For Trainer

Print and cut out the Conversation cards for the activity "What Can I Say?" as directed.

Print out enough copies of the handout "Precautions for People Who Are Suicidal or Who Self-Injure" and the handout "What to Say" for everyone to have one.

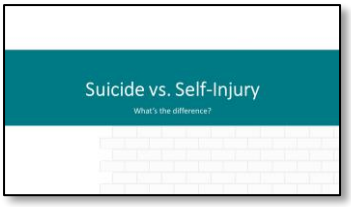
During Training



Suicide vs. Self-Injury

Set Up

Say:



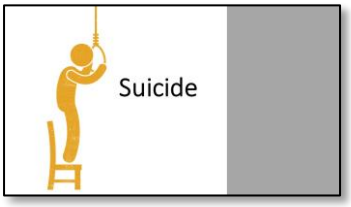
Suicide and self-injury are serious risks in correctional facilities, and people with mental illness are at higher risk. In order to help you best respond to these concerns, we'll carefully define both of these conditions and work to understand how the conditions differ. They may seem the same on the surface but are quite different and can require different responses.

Suicide and Attempted Suicide

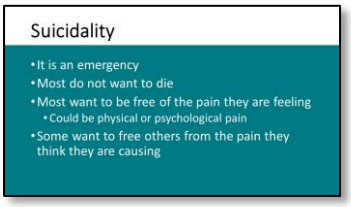
Lecture

Say:

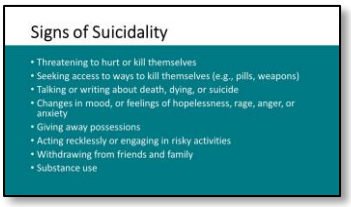
A suicide attempt is a medical emergency. It requires immediate and urgent response. What lies behind a suicide attempt?



Suicide is a complex behavior, often enacted by someone who may be fearful or ambivalent about whether they want to live. The suicidal person may not want to die, but rather may not want to live with the physical or psychological pain they are experiencing or that they believe that they are causing others (MHFAA, 2014b).



Signs that someone may be suicidal include:



- Threatening to hurt or kill themselves;
- Seeking access to ways to kill themselves (e.g., pills, weapons);
- Talking or writing about death, dying, or suicide;
- Changes in mood, or feelings of hopelessness, rage, anger, or anxiety;
- Giving away possessions;
- Acting recklessly or engaging in risky activities;
- Withdrawing from friends and family;
- Substance use.

Discussion

Check in briefly by asking:

- In a show of hands, have any of you had contact with a suicidal person in a correctional facility? If you're

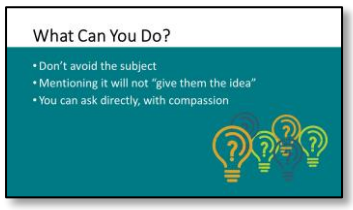
comfortable talking about it, how was the person acting leading up to the time you realized they were suicidal? **(NOTE: if there is an uncomfortable silence, you may move on.** Responding to a suicide or attempted suicide can be traumatic for first responders.)

Say:

Keep in mind that it is sometimes challenging to recognize the signs of suicide risk. Thus, those around the suicidal individual, including family members, other inmates, and COs, may struggle with self-blame for not recognizing signs. This underscores not only the importance of being vigilant to potential indicators of suicidality and following workplace procedures for response, but also the importance of self-care in the wake of an event. After helping someone who is suicidal—no matter what the outcome—the correctional officer should take appropriate self-care, as providing assistance to a suicidal person can be emotional and stressful (MHFAA, 2014b).

Lecture

Say:



So, what can you do? Sometimes we avoid asking a person directly about suicide, fearing that we may be putting the idea into their head. Studies show that asking a person directly is actually the most effective way to get a true answer. You can ask: "Are you thinking of hurting or killing yourself?" Avoiding the issue can mean missed opportunities to intervene before a person makes an actual attempt.

Do note, however, that a person may be reluctant to admit to suicidal thoughts or actions since many institutions respond by removing privileges or putting the person in isolation. As always, you should follow your institution's procedures for working with an incarcerated person who may be suicidal, and alert your supervisor or mental health staff if anything seems 'off.'

Conclude the topic by asking:

How many of you know those policies and procedures or have brought them in on paper today? Raise your hand. Let's discuss some of the key points (host discussion). Those of you who are not well-versed in your facility's procedures, please consult your employee manual and clarify anything you aren't sure about with your supervisor prior to your next shift.

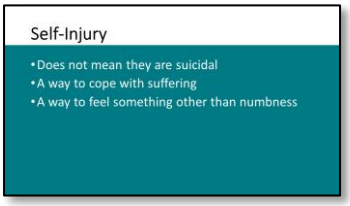
Non-Suicidal Self-Injury

Lecture

Say:

Some people who injure themselves may not be suicidal.

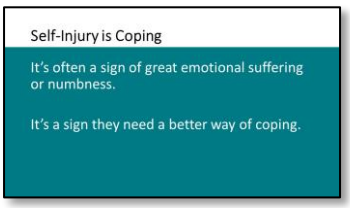
Rather, some people self-injure as a coping mechanism to deal with emotional anguish, to stop feeling numb, to feel in control, or other reasons.



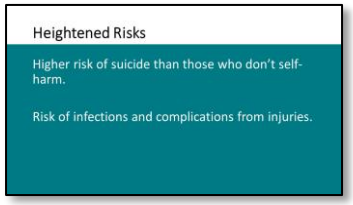
The most common methods of self-injury are cutting, scratching, biting, burning, hitting oneself, or deliberately hitting their body on a hard surface (e.g., punching walls, head-banging).

If someone has frequent unexplained injuries or tries to conceal injuries, it may indicate that self-injury is occurring.

Self-injury may also become the main way a person copes, which interferes with their ability to develop more appropriate coping skills.



People who self-injure have a heightened risk of suicide as well as risk of infections and complications from treated or untreated injuries.



So what can you do? As with suicidal behavior, you can ask directly about self-injurious behavior ("Some people hurt themselves on purpose; is that how this happened?"). As with any crisis, if there is a physical health emergency, it should be handled immediately; in the case of self-injury, this might include injuries such as gaping wounds; injuries to eyes or genitals; burns to the hands, feet, or face; or overdose/poisoning.

Also, mental health professionals should be alerted not only to the existence of self-injury, but also to changes in the pattern, such as the pattern of injuries becoming more severe (MHFAA, 2014a).

As always, you should follow your institution's procedures for addressing situations in which people are injuring themselves.

Briefly check in with participants by asking:

How many of you know those policies and procedures or have brought them in on paper today? Raise your hand. Let's discuss some of the key points (host discussion). Those of you who are not well-versed in your facility's procedures, please consult your employee manual and clarify anything you aren't sure about with your supervisor prior to your next shift.

Give out copies of the handout "Precautions for People Who Are Suicidal or Who Self-Injure."

Review the ideas on this sheet that may help secure the safety of someone who intends to hurt themselves. Ask them a few questions about the information on the handout such as:

- What have you used before?
- In your experience, what works?
- What would you be worried about?

Conclude lecture by saying:

Now, what shouldn't you do or say? There is no substitute for a mental health expert on the scene, but sometimes they aren't present when you detect a problem.

If you encounter someone who is in a suicidal or self-harming crisis, keep in mind:

- Don't argue with them. Listen to them and take them seriously.
- Don't use guilt, minimize the person's problems, or "call their bluff." Suicidal threats should be taken seriously.

Transition by saying:

Let's try a few best practices to see what you could or should say in these situations.

Activity: What Can I Say?

1. Underscore the importance of following facility policy in responding to suicidality and self-injury, but note that sometimes a CO must address the situation while awaiting crisis response or mental health staff. Explain that the purpose of this activity is to try out different ways of talking to someone who is having a suicidal or self-injuring crisis and hear and see the effect of how you speak to someone in that moment.

2. Give the following instructions:
    a. Choose a partner for this activity.
    b. You will each get a card with statements.
    c. You will take turns being the correctional officer and being the person in crisis.
    d. When you are the CO, read the first comment off the list on your card. Ask yourself, how did that sound out loud?
    e. When you are the person in crisis, tell your partner how what they said came across. Tell them how you might react to what they've said.
    f. Work your way through your cards, alternating turns reading aloud. Make notes on which statements seem fruitful and follow best practices. Note which statements are not good choices and may make things worse.
3. When they are in pairs, hand out the cards so that in each pair one person gets a copy of Card A and the other gets a copy of Card B. If there is a group of three, ask the group members to pass the cards around so that all three can take turns reading statements aloud.
4. Give them 10 minutes in pairs to work their way through the statements and make notes of which were useful and which weren't.

Activity Debrief

Debrief the activity with the following questions:

- How did it go? What stood out to you?
- What was the worst, least helpful statement that you and your partner identified? Break it down – why?
- Which was the most useful and why?
- What was it like to say some of these things out loud, either good or bad?
- How will you use the information from this activity on the job?

Pass out the handout "What to Say."

Say:

Here's a sheet that gathers some suggestions on useful ways of talking to someone in a suicidal or self-harming crisis. You can add to this anything you heard today that you would like to remember. Keep this sheet for when you want to refresh your memory on best practices when talking with a person in crisis.

Ask:

With a show of hands, how many of you are confident you know your workplace's procedures for responding to someone who is suicidal or who is hurting themselves?

Say:

If you were unable to look those up before coming in today, your first task on the job when you return to work will be to find out those procedures and be ready to implement them.

Conclude:

Remember that suicide attempts are medical emergencies. De-escalate the situation if possible, but you should be ready to activate your facility's emergency procedure to save a person's life.

Transition to Module 14

Next, we'll move from handling a crisis in progress to preventing crises when at all possible.

14: Crisis Prevention

Time:	45 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Raymond Smith: Crisis Prevention," Handout: "Crisis Prevention," flip chart and markers
Competencies:	• Describe general communication strategies that can be used to prevent situations from escalating to a crisis.

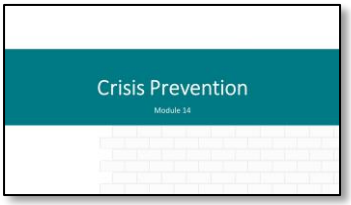
Description

This module explores strategies to prevent risky or concerning situations from becoming full-blown crises. A video with an expert will highlight the power that correctional staff have in creating the environment in a correctional facility, which can directly affect the chance of crisis. Also, a targeted discussion about an incarcerated man named Justin, a person with a serious mental disorder, will explore how to use best practices in difficult situations.

Before Training

Print out enough copies of the handout "Crisis Prevention" so that every participant may have one.

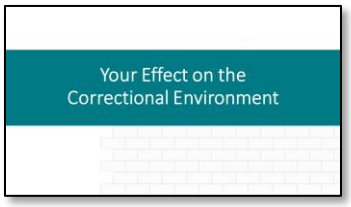
During Training



Your Effect on the Correctional Environment

Set Up

Begin by saying:



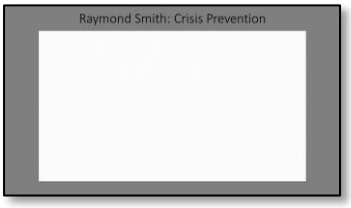
Correctional environments are complex, but you have a big role in creating the day-to-day environment in your workplace. You have power and influence you may not know about.

Transition by saying:

What is that power? And what is the power of your choices? Mr. Smith has some examples for us.

Video

Play the video "Raymond Smith: Crisis Prevention."

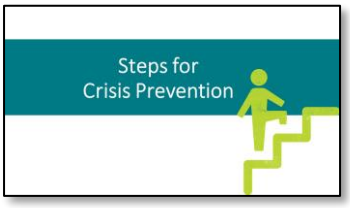


Facilitate the discussion with the following questions:

- Have you been aware of moments at work when you can choose to escalate or de-escalate?
- How can showing respect be powerful in keeping a calm environment?
- Do you feel you have the power to prevent some crises?

Discussion

Give out copies of the handout "Crisis Prevention."



Say:

Let's look at this handout and discuss which of these suggestions may be useful in your workplace.

Work through the four items on the handout. After each item, ask participants what they think about its usefulness. How would they use it in their particular workplace?

Transition by saying:

Let's pull together a number of ideas about crisis prevention by thinking about a particular person.

Justin, When He Doesn't Take His Medications

Lecture

Read the following scenario with Justin's first picture on the screen:

This is Justin. Justin is in his 50s and is serving ten to fifteen years. Justin is difficult to handle. He's been diagnosed with paranoid schizophrenia and has been prescribed medication. But he doesn't take it consistently.

When he isn't on his medication, he is completely unpredictable. When in the grip of his psychosis, he hears voices whispering to him and constantly feels like someone is sneaking up on him. So he often randomly lashes out with his fists or feet, trying to fend off his perceived stalkers.

He's easily triggered into rage and can suddenly become argumentative with COs, shouting and flailing his arms.

He's incredibly disruptive, often violent, and disliked by his peers.

Discussion

Say:

- What are some challenges that occur when Justin doesn't take his medications?
- What are the risks of having Justin under your watch?
- What do you think a crisis with Justin might look like?
- How do you think you could prevent him from having a crisis?

NOTE: Answers to the last question could include: by asking if he's taking his meds, using examples from the crisis prevention sheet, other ideas from other modules that you've taught the group earlier. Please make certain they offer specific examples and actions they could take.

Justin, When Taking His Medications

Lecture

Say:

Ok, we've talked about Justin when he's not using his medication, which is very challenging. So, what is he like when he **does** take his medication?

Read the following scenario and show Justin's second picture on the screen:

When Justin takes his medication, he's an utterly different person.

The medication certainly calms him down. When he takes it, he's not violent or argumentative. He doesn't hear voices or feel constantly watched and afraid.

However, the medication has some side effects.

The one that's most obvious is that he becomes unfocused and unmotivated. He can be hard to rouse from sleep, or hard to transition from one part of the day to the next.

COs often feel they have to hustle him and raise their voices to get him to pay attention and do what he has to do. They often have to repeat themselves to get him to comprehend and act on what they're saying.

He's definitely less dangerous, but perhaps just as frustrating.

Discussion

Say:

So now we see that Justin actually presents TWO sets of challenges. What are the challenges when Justin takes his medications?

Where do the risks come from? (NOTE: Answers may include that Justin may withdraw or become isolated, worsening his condition. There may be other medications that would reduce problematic behavior without so many side effects. Since Justin can't focus, COs might become aggravated or use excessive force. Also, other incarcerated people may be frustrated with him and take it out on him physically or socially.)

How could you prevent this kind of crisis from happening? (NOTE: Answers may include alerting mental health staff about potential negative reactions Justin may be experiencing, cautioning other COs to be patient, keeping an eye on Justin in his interactions with other incarcerated persons).

Conclude discussion:

How do you think having mental health services involved would help? What could you do at your workplace to alert mental health staff or to coordinate with them?

Conclude module by saying:

What's better than handling a crisis well? Not having a crisis in the first place, right?

A good CO can head off a crisis before it starts, when possible.

Some crises can be prevented and now you have more tools to use.

Transition to Module 15

Say:

Trauma can also be a source of crisis. Next, we'll focus on what trauma is and how it can affect a person's behavior.

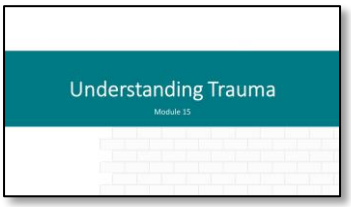
15: Understanding Trauma

Time:	45 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Raymond Smith: Prison and Trauma," Video: "Trauma and the Brain," flip chart and markers
Competencies:	• Recognize that the correctional setting can mirror or trigger past traumatic experiences of the person who is incarcerated. • Describe contextual stressors that can cause traumatic stress for people who are incarcerated. • Recognize that gender, race, class, age, and other group-level factors may influence exposure and response to trauma.

Description

This is a foundational module that teaches the causes and nature of trauma with both lecture and video about how trauma affects the human brain. A short video explains the profound effect of trauma on the human brain and behavior. This module also covers trauma triggers in correctional facilities with a supporting video from a subject matter expert.

During Training



What Is Trauma?

Set Up

Introduce the module by saying:

Trauma is an important topic to understand for anyone working in the correctional system.

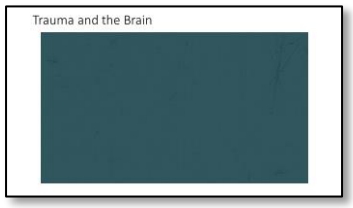
Trauma can come from a variety of sources, including experiences of physical or sexual abuse, neglect, witnessing violence, accidents, war, natural disasters, death or illness of a loved one, or other events. Trauma occurs when an individual is exposed to an overwhelming experience that involves a threat to his or her physical, emotional, or psychological safety (Benedict, 2014). The effects of traumatic experiences may last for days, weeks, months, or years after the event.

Trauma doesn't end with the traumatizing event. After a traumatic event, individuals may re-experience the event through intense feelings, memories, and behaviors. So the event returns again and again in the person's mind and body. This can have a major impact on a person's life.

Transition:

Let's watch a short video that explains the impact of trauma on the brain because that impact can be deep and long-lasting, with many consequences.

Video



Play the video "Trauma and the Brain."

Facilitate the discussion with the following questions:

- Was anything in this video new to you? What stood out?
- Is trauma easy to "get over?" Why is it important to understand how big of an impact trauma can have on a person?
- Do you see how trauma might be important in the correctional context?

Trauma and Offending

Lecture

Say:

As we saw in the video, trauma's impact can last for years, if not a lifetime. It can alter a person's behavior and can lead to some problematic behaviors. Let's explore some connections between trauma and offending.

Women and girls. There is considerable evidence that trauma may play a role in criminal behavior, particularly for women and girls. For instance, they may begin to use alcohol and drugs to numb themselves to sexual abuse, they may get involved in street life after running away to escape abuse at home, or they may commit violent acts in retaliation or self-defense against partners who beat them (DeHart, 2009).

Men and boys. Trauma has also been shown to relate to antisocial or aggressive behavior for men, as in a recent study of Marines deployed to combat, which demonstrated that those with PTSD were more likely than those without to engage in antisocial and aggressive acts such as physical confrontations and trouble with the police (Booth-Kewley et al., 2010).

During incarceration. Trauma may also be related to some of the behaviors offenders display while incarcerated, such as rule violations, aggressive outbursts, self-injury, manipulative behavior, drug use, and failure to progress in treatment. Such behaviors may stem from reaction to trauma triggers or may be the individual's attempt to cope with a persistent state of traumatic stress or arousal (Benedict, 2014).

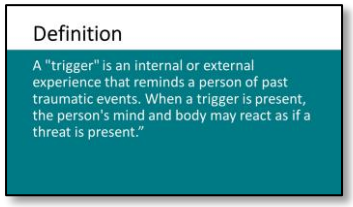
Triggers

Lecture

Say:

What is a trauma trigger and how does a person with trauma become triggered?

A **"trigger"** is an internal or external experience that reminds a person of past traumatic events. When a trigger is present, the person's mind and body may react as if a threat is present. Such triggers can make it difficult for the brain to "reset" the body from fight-or-flight mode to rest-and-digest mode.



Triggers can be obvious or subtle. For example, a loud noise could be interpreted as a gunshot. And loud noises, like a metal door slamming, often occur in correctional facilities. More subtle and less obvious triggers can be things like a particular sight or smell that reminds the person of the traumatic experience. For example, smelling the cologne that an abuser wore during assault or smelling diesel fuel that reminds someone of a car accident may trigger traumatic stress for a person. Others would never make the connection, but for the person who has experienced trauma, it is powerful and inescapable.

Remember that a trigger is an activation of *past trauma*. A person who is triggered becomes suddenly connected to their past trauma vividly and may have trouble being completely present with current circumstances.

Trauma Triggers in Correctional Facilities

Lecture

Say:

Daily experiences in a correctional facility can include many triggers for traumatized persons. Potential triggers include:

- Conducting strip searches for contraband;
- Transitioning incarcerated people from one place to another inside a facility;
- Supervision by a staff member during personal hygiene, toileting, or dressing;
- Extracting an incarcerated person from his or her cell;
- Placing an incarcerated person into isolation or restraints.

For people who have experienced violence and abuse, some aspects of incarceration (e.g., coercion, bullying) may mirror these experiences, re-creating trauma for those survivors.

Other common stressors include crime anniversaries, parole hearings, and institutional events such as lock-downs or executions.

There are also a number of **routine practices** within prisons and jails that may cause additional trauma to incarcerated people, especially those who may have experienced sexual or physical abuse in the past.

Other stressors may include noises and other factors often present throughout jails and prisons—loud voices, banging doors, buzzers, unfamiliar people, and so on. Sometimes even visits and contacts with family or friends can be stressful and may act as triggers (Benedict, 2014).

And even the experience of being incarcerated itself—being removed from family and placed in a secure, controlled facility—can be traumatic.

This means that a person who is incarcerated may have layers of trauma. They may have **past trauma** that can be **triggered** by experience in prison and they can be **traumatized anew** by **current experience** in prison.
Layers of trauma may account for certain disruptive, self-harming or defeatist behavior that you, as prison staff, see and must respond to.

Remember the Stakes

Lecture

Say:

Are correctional facilities equipped to handle people who have experienced trauma? What about people with mental illness who also have experienced trauma?

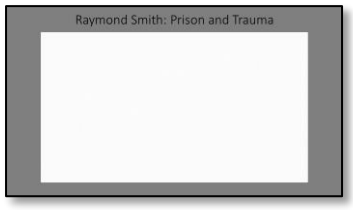
Remember that the stakes for preventing or handling crisis are high. The safety and wellbeing of many people can depend on it.

Transition by saying:

Let's see what Mr. Smith has to say about trauma and life inside.

Video: Raymond Smith

Play the video "Raymond Smith: Prison and Trauma."



Facilitate discussion with the following questions:

- Have you thought of going to a correctional facility as trauma? What do you think of that?

- Mr. Smith talks about sudden behavior change as a possible sign of a trauma trigger for a person. Have you ever seen someone suddenly go straight into crisis? Might they have been triggered by something you didn't notice?
- How could you apply Mr. Smith's advice about trauma and trigger awareness at work?

Conclude:

Trauma is a common experience among incarcerated people, for many reasons. You don't have to know how they have experienced trauma, but you do need to understand that trauma triggers can affect some people. This understanding helps you anticipate potential crises and maintain safety in the facility.

Transition to Module 16

Say:

Knowing about trauma and triggers is important—but what should you do about it? In our next module, we'll discuss trauma-informed correctional practices. These are best practices being developed to minimize trauma-related risk and crises in correctional facilities. In light of the high prevalence of trauma among incarcerated persons, these practices could have a major impact on your work environment, for the better.

16: Trauma-Informed Correctional Practices

Time:	45 min.
Format:	Lecture, activity, discussion
Materials:	PowerPoint, Handout: "Trauma-Informed Correctional Practice," Handout: "Trauma-Informed pat Down," flip chart and markers
Competencies:	• Describe trauma-informed principles for correctional facilities.

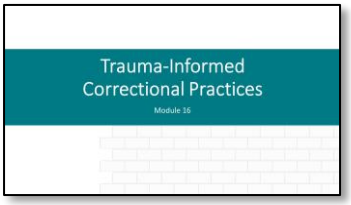
Description

This module defines and describes trauma-informed correctional practices. It gives concrete examples and guidelines and explores the benefits of using these practices. It also has a supporting activity that allows participants, by considering a day in the life of a correctional officer and a person who is incarcerated, to consider how a CO's behavior can affect the correctional environment.

Before Training

Print out enough copies of the handout "Trauma-Informed Correctional Practice" for every participant to have one. Print out one copy of the handout "A Trauma-Informed Pat Down" to give for the volunteer for the activity "Inform Yourself."

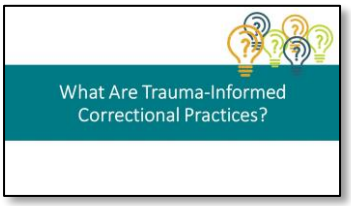
During Training



What Are Trauma-Informed Correctional Practices?

Set Up

Say:



People's traumatic experiences can influence daily life in correctional facilities. It's important to take trauma into account as you move through your workday.

Correctional facilities across the United States (especially women's facilities) are beginning to follow guidelines for "trauma-informed" approaches to safety and security.

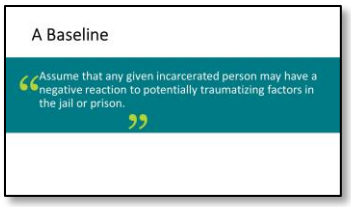
Lecture

Present lecture:

Trauma-informed correctional guidelines include training for staff and incarcerated people on the effects of trauma, as well as developing operational practices that help incarcerated people manage difficult symptoms so that they can safely engage in institutional programs and services.

Trauma-informed environments **may help incarcerated people to self-regulate** psychologically and physically, becoming more stable and being less likely to be triggered into self-protective responses that complicate facility operations.

Trauma-informed practices can also **enhance job satisfaction** for correctional staff, resulting in less burnout and staff turnover (Benedict, 2014).

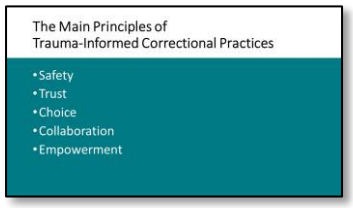


Given the prevalence of trauma among incarcerated people and the need for a humane, respectful response to all people, experts recommend the use of "universal precautions" to help protect incarcerated people from being re-traumatized. **That is, assume that any given incarcerated person may have a negative reaction to potentially traumatizing factors in the jail or prison.** If correctional systems can try to reduce unneeded trauma for all incarcerated people, it can produce a safer, more secure facility for those incarcerated and for correctional staff (Benedict, 2014).

The Main Principles

Lecture

Present lecture:



The main principles of trauma-informed corrections include:

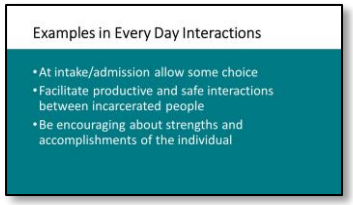
- Safety
- Trust
- Choice
- Collaboration
- Empowerment

So, what does using these principles look like?

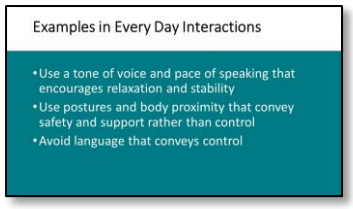
By making small adjustments to correctional practice to incorporate these principles, the facility can be made safer, with a potential reduction in unsafe behaviors of incarcerated people.

Examples of trauma-informed strategies in everyday interactions include:

- At intake/admission, let incarcerated people choose where to sit down within a defined, safe, and secure space.
- Facilitate productive and safe interactions between incarcerated people as part of unit meetings, recreation, and other activities.



- 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.
- Avoid language that conveys control (e.g., instead of referring to "cells" or "shake downs," refer to "rooms" or "safety checks").
- As part of routine inmate-staff interactions, encourage strengths and accomplishments of the incarcerated people.



Of course, correctional leadership makes policy, but correctional officers can make everyday choices to be aware of trauma-related crises and work to prevent them from arising.

Transition by saying:

Let's focus in on one very important aspect in corrections: language and voice.

Language is Important

Lecture

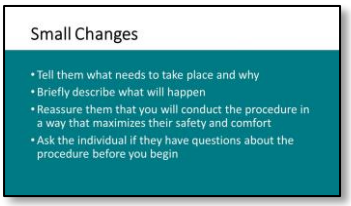
Present lecture:

Sometimes, we may feel impatient about thinking before speaking. However, language is powerful.

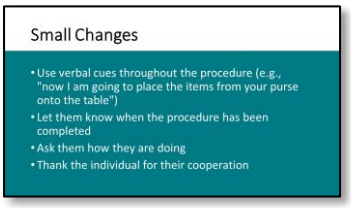
As a CO, you can harness that power to change the environment of your workplace.

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

For instance, instead of referring to incarcerated people and staff by last names, using titles of respect such as "Ms. Smith" or "Sergeant Smith" can promote trust. During pat-downs and searches, correctional officers may reduce trauma by calmly talking the incarcerated person through the procedure, just as doctors do with patients during sensitive procedures. 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.

Transition by saying:

A number of these suggestions may be quite different from the way you typically do things at your workplace. So, is change worth it? What are the benefits?

Activity: Inform Yourself

1. Explain the purpose of the activity, which is to become aware of how we speak to incarcerated people and how we can inform our language with trauma-based principles for a chance at better outcomes.
2. Give the following instructions:
    a. I'd like a volunteer to come to the front to read aloud a script. The script is some typical language we may use when doing a pat down.
    b. To those of you listening, imagine that **you** are the one getting a pat down and that they are speaking to you personally.
3. Give the handout "A Trauma-Informed Pat Down," which you have printed ahead of time, to the volunteer and have them read the first version aloud. Remind them to read it in a hard, loud voice and that they may shout if they feel like it:
    a. Read the following:
        i. Ok, inmate. Face the wall, right now!
        ii. You cannot complain about search. If you hadn't done the crime, you wouldn't be here.
        iii. Are you disrespecting me? Does my nametag say "man?" You call me OFFICER when you speak to me. Now shut up.
        iv. Hold still, inmate!
        v. You can pick up your crap when we're done. Leave it on the floor now.
        vi. Ok. Get your crap and go.

b. Once they're done reading it, ask the group the following questions:

    i. Is this pretty typical of pat down language in your facility?

    ii. How did you find yourself responding as you listened to the script?

    iii. Given what you know about the effects of trauma on a person, how might this language be problematic for getting cooperation?

4. Initiate a brief discussion, asking them to highlight words or phrases that may agitate someone who is traumatized.

5. Now have the volunteer read the second version of the script. Tell them to speak in a calm and steady voice. Remind the participants to imagine that **they** are the ones getting a pat down and that the reader is speaking to them, personally.

    a. Mr. Walters, please come over here for search.

    b. I know, I know, nobody likes to be searched. Let's get through it together.

    c. Do you have anything that will stab or poke me?

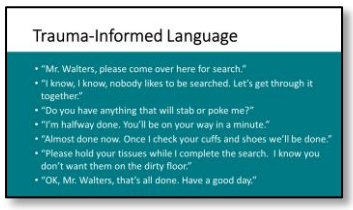
    d. I'm halfway done. You'll be on your way in a minute.

    e. Almost done now. Once I check your cuffs and shoes we'll be done.

    f. Please hold your tissues while I complete the search. I know you don't want them on the dirty floor.

g. OK, Mr. Walters, that's all done. Have a good day.

6. Show the slide with the script on it for their reference. Initiate a brief discussion with the following questions:



   a. How did you find yourself responding as you listened to the script?

   b. How does it differ from the previous script? Give some examples.

   c. Can you imagine yourself speaking in this way to people in you facility? Why or why not?

7. Debrief by asking:

   a. How could this be useful on the job? Do you think this trauma-informed language might help make pat downs go more smoothly?

   b. Are there other procedures that you could use this approach with?

Transition by saying:

A number of these suggestions may be quite different from the way you typically do things at your workplace. So, is change worth it? What are the benefits?

Benefits

Lecture

Present lecture:

Some facilities that have implemented trauma-informed practices report the following specific benefits:

- Improvements in incarcerated people's ability to fall asleep and stay asleep at night
- Improved attendance and participation in programs and services
- Decreases in disciplinary infractions
- Decreases in inmate-on-inmate assaults
- Decreases in inmate-on-staff assaults
- Decreases in suicide attempts (Benedict, 2014).

Discussion

Check in with participants by asking:

- What sounds interesting and useful to you of what you've just heard? Why?
- What worried you or didn't sound plausible in your workplace? Why?

Transition by saying:

Let's test some of these ideas with an exercise.

Activity: Making Choices

1. Explain that the purpose of this exercise is to consider how everyday circumstances might change if we apply the Main Principles of trauma-informed practice.
2. Tell the participants they will work in small groups made up of their tables. Each table will have part of a scenario that will explore helping a traumatized person get through a challenging day. There will be three encounters that you, as the CO, have during one day with Sheena, a woman who is incarcerated.

If there are more than three tables, you may assign each scenario to more than one table.

3. Give the following instructions:

   > Once you have your group's scenario, refer to the main principles of trauma-informed practice and make choices about how to respond to and interact with Sheena in order to get the best possible results: keeping her, yourself, and the prison population safe.
   >
   > Refer to your handout "Trauma-Informed Correctional Practice" as needed.

4. To the first table(s), read:

   > A group of women who are incarcerated are participating in a psychoeducational trauma group. Sheena is among them. The group is meeting for the first time. Introductions are in progress. Some look very tense.
   >
   > Then an announcement is made that everyone must return to their cells for a full count. Women have three minutes to return.
   >
   > Doors begin slamming all over the facility, a noise you are used to. But when you check to make sure everyone has left the group meeting room, you see Sheena standing as if frozen. Every time a door slams, she jumps and looks terrified. She seems unable to move.

5. To the second table(s), read the previous scenario and tell them that they know that Sheena is having a challenging day. Then read them their scenario:

   > Later when the count is over and people may move around again, it's time for Sheena to leave for work time. However, she's huddled on her bed. When you ask what's going on,

she says that being in the group exhausted her. She can't do any more today. She just wants to sleep.

You know she must leave the cell. What do you do? (Hint: look for solutions that are non-combative and create trust in the CO and empower Sheena to make good choices.)

6. To the third table(s), read the previous two scenarios and tell them that they know that Sheena is having a very challenging day. Then read them their scenario:

   Finally, you encounter Sheena again during recreation time, but she is very agitated. You overheard that a woman in the trauma group shared stories about rape at the hands of her dealer/partner. Sheena was deeply upset by this, and when you speak to her, she is very agitated and keeps saying, "I can't calm down! I can't stop thinking about it! I don't know what to do!"

7. Give the groups 5 minutes to work to come up with a trauma-informed plan to get Sheena through her day.

   a. Ask all participants, how do you approach Sheena and what do you say? How do you treat her? (Hint: have them refer to their handout if they are unsure. Encourage responses that are non-confrontational and explain to Sheena what is happening and what she needs to do.)

8. When the 5 minutes are up, recall the group's attention and start with those working on the first scenario. Ask them what they came up with. Listen to all responses, and then offer a constructive critique of their good choices and guide changes to choices that were not trauma-informed. When they

reach a good trauma-informed response, congratulate them and tell them that they've gotten Sheena successfully to the next part of the day.

9. Repeat Step 8 above with the second and then the third group. Once each group comes up with a good trauma-informed response to Sheena, tell them that they've successfully gotten Sheena safely to the next part of the day.

10. Once the third group completes their report, tell all participants that they have helped Sheena calm down, and the evening progresses peacefully without a crisis.

Activity Debrief

Conclude the activity with the following reflective questions:

- How difficult was it to come up with trauma-informed responses?
- How might you use the main principles at your workplace?
- Are there any barriers to using them at your workplace?
- What are some advantages you see in beginning to use these practices and principles?

Conclude by saying:

Trauma is pervasive in corrections, and some people arrive with more in their life histories. While trauma-informed practices might one day be routine in your workplace, you can make trauma-informed decisions and actions every day.

Transition to Module 17

Say:

We've focused on the advantages of being trauma-informed. Making small adjustments to everyday tasks is crisis prevention. With attention and focus you're heading off incidents that could escalate into a dangerous situation. Let's now take a deeper look at your role and the role of mental health staff in corrections.

17: Understanding the Roles of Correctional Officers and Mental Health Staff

Time:	30 min.
Format:	Lecture, discussion
Materials:	PowerPoint, Handout: "Roles in Correctional Mental Health Care," flip chart and markers
Competencies:	• Describe the differing roles and missions of correctional officers and mental health staff in responding to incarcerated people with mental disorders. • Value benefits of correctional officers and mental health staff working collaboratively to address mental health issues of incarcerated people.

Description

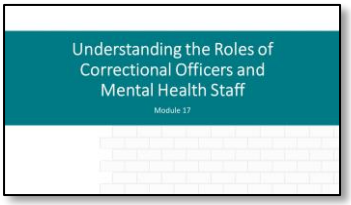
This module supports a clear understanding of the roles of mental health staff and correctional officers. Through lecture and discussion, participants will explore the benefits of collaboration between these two groups.

Before Training

Customize this module based upon the particular roles and policies at the facility. Options include inviting mental health professionals as guest speakers or as panelists to discuss misconceptions around roles and how COs and mental health staff can work together.

Print out enough copies of the handout "Roles in Correctional Mental Health Care" for every participant to have one.

During Training



Roles and Missions of Correctional and Mental Health Staff

Set Up

Begin by saying:

To effectively address mental health disorders of incarcerated people, both correctional security staff and clinical mental health staff must work cooperatively. Because the correctional setting is intended to serve multiple functions, including those that are punitive, protective, and rehabilitative, these goals may sometimes conflict with other functions (Dvoskin & Spiers, 2004).

Correctional officers and mental health staff, as part of this broader multi-functioned system, have distinct professional backgrounds, cultures, and missions. Recognizing this is an essential step toward collaborative work (Appelbaum et al., 2001).

Mental Health Staff

Lecture

Present lecture:

Who are the mental health staff in corrections, and what do they do?

Psychologists are mental health staff commonly employed in correctional facilities. However, there are often very few psychologists for very many incarcerated persons. Psychologists' duties may include administrative tasks, crisis intervention, individual and group treatment, psychological evaluation for courts and classification

purposes, referral for further psychiatric evaluation, and training of other staff. In some jurisdictions, psychologists may prescribe medication for mental health disorders, but in other jurisdictions, this is the role of medical staff.

Nurses often are on the front lines of contact with incarcerated people, with duties including dispensing medications, educating patients, and identifying symptoms of mental disorders. They may also contribute to management of inpatient psychiatric units, providing daily monitoring of patients, assessing suicidality, providing individual and group treatment, and monitoring medications.

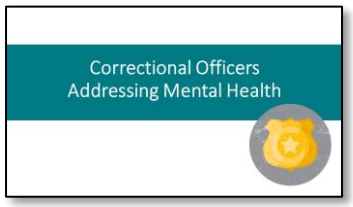
Social workers are in roles ranging from direct care to serving as a link to outside agencies on behalf of incarcerated persons. Their direct care can include individual and group treatment, assistance with discharge planning, substance abuse treatment, recommendations for vocational and educational programming, and advocacy for persons who are incarcerated (Temporini, 2010).

All of these staff may play a role in mental health services at correctional facilities.

Role of Correctional Officers in Addressing Mental Health

Lecture

Present lecture:



How are COs connected to the mental health of those who are incarcerated?

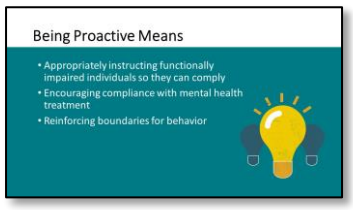
Because correctional officers have more daily contact with incarcerated people than do mental health staff and may be at the facility on days/times when mental health staff are not, correctional officers can help by identifying, addressing, or reporting mental health issues witnessed during this daily contact. Because of their

proximity to behavior of those incarcerated, correctional officers can in some ways provide a **proactive response** to potential problems rather than a reactive response of simply calling in mental health staff once things have escalated (Lazaretto-Green et al., 2011).

For instance, correctional officers may:

- **Help diffuse potential problems before they develop into larger crises.** Correctional officers are more likely than mental health staff to be present when potential disturbances begin to arise, and officers can help by listening to concerns of incarcerated individuals, helping to calm or redirect individuals, and/or provide instructions on ways to avoid similar problems in the future (e.g., "Stay away from him if he irritates you"; Dvoskin & Spiers, 2004).
- **Help identify potential mental health issues.** Correctional officers are sometimes the first to observe significant changes in an incarcerated person's routine or behavior. They can alert mental health staff if they notice an individual's behavior to be bizarre or disruptive, or if they notice deterioration in self-care, aggression, or irritability.
- **Keep an eye on incarcerated people who are at increased risk.** Mental health staff may alert correctional officers to pay special attention to individuals who are noncompliant with treatments or who may experience personal or legal setbacks.
- **Report if an individual displays warning signs of suicidality.** For instance, an officer might inform mental health staff if he/she notices an individual becoming increasingly depressed or giving away possessions. The officer can be alert to such issues during high risk times or in high risk places, such as

after denial of parole or in segregation cells at night or on weekends.

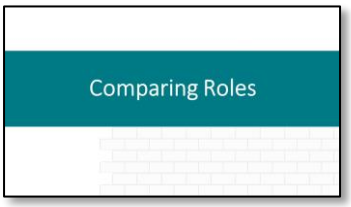


- **Help instruct a person who is functionally impaired (has problems in daily living)** using prompts or resources that assist the person in meeting the demands of the correctional environment. When an incarcerated person's mental health or impairment prevents him/her from understanding or carrying out a task, the officer might assist by breaking instructions down into simpler steps, having the individual watch another person demonstrate the task, and setting achievable benchmarks that can be used as points of encouragement for the incarcerated person.
- **Encourage compliance with mental health treatment.** This might include encouraging attendance at mental health appointments or alerting mental health staff when an incarcerated person's routines or other factors interfere with treatment needs (e.g., the individual falls asleep before nightly medication is taken).
- **Reinforce boundaries for an individual's behavior.** This might also include the officer underscoring boundaries and consequences regarding negative behaviors, while using appropriate flexibility in managing incarcerated people with mental disorders; ideally, officers and mental health staff can communicate with one another to determine the level of enforcement versus flexibility that is feasible given security concerns as well as the individual's level of impairment. This communication is especially important in addressing security and clinical concerns if any special privileges may be granted to incarcerated people with mental disorders (Appelbaum et al., 2001)

The Roles of Correctional Officers and Mental Health Staff

Discussion

Give participants one copy each of the handout "Roles in Correctional Mental Health Care."



Say:

Let's have a look at this chart and discuss how roles contribute to caring for mental health concerns in correctional facilities.

Review the chart together.

Facilitate the discussion with the following questions:

- What stands out to you about responsibilities in the chart?
- In your workplace, do you have any other kinds of mental health workers? Describe what they do—or what you think they do.
- At your workplace, do you have much contact with mental health staff?
- Can you identify a staff member at your workplace to whom you could bring concerns?
- What could you do at work to strengthen cooperation between the two groups of staff? Are there things administration could do?

Conclude:

Mental health workers and correctional officers are both crucial in addressing and maintaining positive mental health in people who are incarcerated.

Transition to Module 18

Transition by saying:

Effective communication between the two groups is essential.

To effectively address mental health in correctional facilities, mutual respect between correctional officers and mental health staff for one another's roles and expertise is essential. Both parties bring unique and valuable information about behavior and wellbeing of those incarcerated. Understanding common ground for correctional officers and mental health staff in fulfilling their missions can help. Both officers and mental health staff benefit from keeping everyone safe, maximizing morale of staff and those incarcerated, and helping maintain systemic operations (Dvoskin & Spiers, 2004).

In our next module, we'll focus on the importance of communication between mental health care staff and COs.

18: Communication Between Correctional Officers and Mental Health Staff

Time:	60 min.
Format:	Lecture, activity, discussion
Materials:	PowerPoint, Handout: "Questions about the Need for Mental Health Referral," flip chart and markers
Competencies:	• Describe strategies for effective communication with other professionals concerning mental health of incarcerated people.

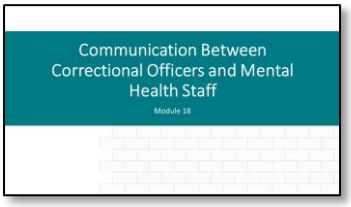
Description

This module outlines best practices in communications and offers materials COs can use on the job to improve their awareness of potential crises and their communication with mental health staff. With an activity that simulates decision-making during a shift and during shift-change, the module opens discussion about the outright dangers of poor communication between COs and mental health staff, and between CO shifts.

Before Training

Print out enough copies of the handout "Questions about the Need for Mental Health Referral" for each participant to have one.

During Training



Communicating Well

Set Up

Say:

In 2014, Michael Kerr, who was incarcerated in the North Carolina corrections system, entered solitary confinement. He had stopped taking his medication for delusions months before. 35 days later, he was dead.

In 2017, Andrew Holland, who suffered from schizophrenia, died after 46 hours shackled to a chair in the San Luis Obispo County Jail.

Neither of these men would have died without serious problems in the response by correctional staff. These deaths caused great outrage and resulted in job loss and legal liability.

When a person dies while incarcerated, there's intense scrutiny of the correctional facility. When the deceased had a mental illness, questions are asked about a facility's procedures, staffing, and training to address those issues.

Only people with formal training in mental health can properly treat incarcerated people with mental illness. But they can't treat someone if they don't receive timely and accurate reports of warning signs. So communication between correctional officers and mental health staff is crucial if an incarcerated person has a mental health disorder or if there is concern they might be at-risk for experiencing one.

Let's focus on responsibilities of, and communication between, staff when addressing mental illness of persons who are incarcerated.

Improving Daily Communications

Lecture

Present lecture:

Let's consider the levels of urgency for a CO to communicate with mental health staff.

It can be useful to differentiate referral events using the terms emergency, urgent, and routine. Specifically:

- A mental health event is an **emergency** when it has potential to jeopardize an individual's life or cause severe impairment or disability. This includes when an individual is imminently threatening harm to self or others, is severely disoriented or out of touch with reality, has severe inability to function, or is otherwise out of control. Examples include attempted suicide, acts of violence against others, self-injury that requires immediate medical attention (e.g., head injury, choking, continued bleeding), severe impairment by alcohol or drugs, or highly erratic and unusual behavior. Emergency conditions require immediate attention from mental health staff. Such events may also necessitate mobilizing the facility's crisis intervention team.
- A mental health event is **urgent** when there is a non-life threatening situation that could deteriorate or may be unbearable for periods of time. This includes situations in which the individual is exhibiting extreme emotional disturbance or distress, considering (but not acting on) harm to self or others, disoriented or out of touch with reality, has compromised ability

to function, or is agitated and unable to be calmed. Examples include considering (but not acting on) suicide or harm to others, self-injury that does not require immediate medical attention, alcohol or substance abuse, eating disorders, not taking prescribed psychiatric medications, being emotionally distraught or very depressed or anxious. Urgent conditions require attention from mental health staff within a specified period of time, usually 24 hours or less. It is notable that for anything that has potential life-threatening consequences, such as suicidality, it is best to have mental health staff determine if the situation is urgent or an emergency, rather than a CO attempting to make that determination.

- A mental health event is **routine** when it is non-life threatening and does not require immediate attention. Routine events apply to stable people whose condition is unlikely to deteriorate over time and/or will typically resolve on its own. Routine care may help to prevent deterioration to a more severe level. Routine mental health referrals should occur within a specified period of time, often 10 business days or less (SLOCHA, 2016; Trestman et al., 2015; UH, 2016).

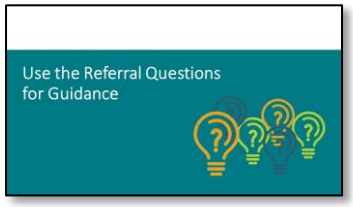
It is important to follow your facility's policies for referrals. Referrals should be made with as little delay as possible and should be documented, including the exact date and time of the referral, the name and affiliation to whom the referral was made, the name of the incarcerated person(s) referred, and any relevant response from the professionals to whom the referral was made (e.g., instructions; Drapkin, 2009).

When Is Mental Health Referral Needed?

Lecture

Say:

If an incarcerated person is not asking for a mental health referral, it may seem difficult for a non-mental health professional to determine if one may be needed. You should always follow the policies of your workplace.



To support you, here is a tool, which is a list of questions you can ask about the person or situation that can help you decide when you should refer someone for an evaluation by a mental health professional.

Pass out copies of "Questions about the Need for Mental Health Referral."

Review the questions with the participants. Ask questions such as:

- What do you think of the effectiveness of these questions?
- Can you think of any people in your workplace who might need a mental health referral based on these questions?
- If you can think of anyone, are you confident you know the correct procedure to follow at your workplace to refer them to mental health services?

Handle It Now

Lecture

Say:

When a mental health situation is developing and a shift change is approaching, correctional officers have a responsibility to attempt to address the issue rather than passing problems on to the next shift. If no resolution can be achieved by the end of the shift, officers should be sure to inform supervisors and/or officers on the next shift of the emerging situation. If mental health issues can be addressed during daytime or weekday shifts when more mental health staff are on duty, this can also be helpful.

If you observe any behaviors that trouble you, you should give that information to the next shift as they come onto duty. What may seem just a little off may develop into something much more urgent over time. You should prepare your fellow COs so that they can prevent a crisis.

Activity: Check Points Can Be Help Points

Note to facilitator: read through this activity and decided if you want to make any small changes to better align this activity with your facility's policies. This is to help COs and staff recognize when to refer for mental health evaluation, so it is written to be as general as possible.

1. Explain that the purpose of this activity is to follow a series of events in 24 hours in a correctional facility and respond appropriately to mental health concerns. It will give them practice in using the Mental Health Referral Checklist, deciding the urgency of events and the importance of continuity.

2. Give the following instructions:

a. We're going to simulate 24 hours in a correctional facility through story. We'll work in two groups, one group as a day shift and one group as a night shift.

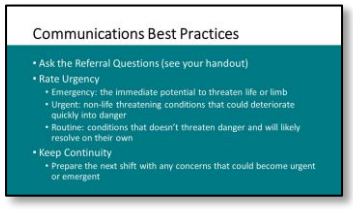
b. We'll divide the room in half to make the two groups. Group 1 is to my right and Group 2 is to my left. (NOTE: divide so that the groups are approximately the same number of participants.)

c. I'm going to read the events that occur every few hours in a 24-hour day at a local correctional facility. Group 1, you're working first shift, from 8am to 8pm. Group 2, you're second shift from 8pm to 8am.

d. Group 1, you'll be the ones responding to daytime events. You'll need to discuss what you'll do at check-in points and tell us your decisions. Also, you'll have to prepare the second shift when they arrive. The second shift will have to attend to information from the first shift and then respond to events in the night shift. Then Group 2 will have to give information to the returning day shift.

e. Don't forget continuity between shifts as you respond to events!

3. Read the Event Log below in sections, as directed. At each Check Point, stop reading and ask the participants what the COs on duty should do, based on what they've learned in this module.



4. When you get to the Shift Change, the next group should become the responders.

5. When groups give you their decisions and fail to take needed action, correct them using the answers provided in the Event Log.

6. Throughout the activity, show the PowerPoint slide titled "Communications Best Practices" so that participants can refer to it as needed.

Event Log

(NOTE: Read the time of each event before reading the information.)

8:00 AM First Shift – Group One.

Read:

You arrive at work. In passing, a night shift CO swears and says that **Sam**, who is incarcerated, was difficult to get out of bed this morning; he took forever and frustrated the COs. And someone else says that **Reggie** has been scaring his cellmate at night again with noises and pacing. And **Chris** woke a lot of people up, yelling from nightmares, and other inmates are mad at him for disturbing them yet again with nighttime screaming.

Ask:

Do you make any plans for the day based on this information?

Answer: Keep an eye out for these men in general. No special action needs to be taken at this time. If they suggest that Chris needs a referral, you can have them review the rubric and see if he meets the threshold for intervention (he doesn't). If they suggest having a conversation with him, tell them that Chris gets stiff-backed and claims that "everything is fine."

10 AM First Shift – Group One

Read:

During the work shift, you see that **Sam** is mostly idle. His head is down and he's not concentrating on his workbench. He doesn't speak to anyone at all. An on-duty CO goes up and speaks to him. Sam briefly rouses but quickly slumps back down again.

Reggie is working in his usual way, completing his tasks but sneering at anyone who comes near him.

Chris is working steadily. He looks tired and angry.

Check Point:

Is there anything to be concerned about? Anything to act on? (Refer them to the Best Practices slide to see if any are important now.) Is anything urgent or emergent?

Answer: They can either continue to watch **Sam** or they could decide to talk to him. If they talk to him, read to them: "Sam doesn't look you in the eye. He says, 'Just having a bad day.' And won't say more."

Answer: There's no special action to take with **Reggie** or **Chris** at this time.

2 PM First Shift – Group One

Read:

During lunch, **Sam** does not eat, which is unusual for him. Then he does not want to leave the mess hall; he doesn't seem to want to move at all, which is different. When a CO speaks to him, he barely looks up. But he does finally obey. A CO asks one of Sam's friends what's going on and the man says that Sam is miserable and is having a hard time caring about anything. Sam's friend says Sam won't talk to him or tell him what's wrong.

Reggie is eyeing a man he often has conflict with and also looking aggressively at his own cellmate. Reggie looks back and forth between the two men. He makes threatening gestures with his head and hands at them, which is unusual.

Chris has gobbled his lunch and is watchfully observing the mess hall. He keeps a sharp eye on the doors and on everyone near him. This is his typical behavior. A couple of guys appear to purposely bump into him, looking angrily at him. He ignores them completely.

Check Point:

Do you have any concerns? Do you take any action? (Refer them to the "Best Practices" slide). Is anything urgent or an emergency?

Answer: **Sam** may be depressed. He might be suicidal. They should talk to Sam. When they talk to Sam, he starts to cry and says that he can't stand his life anymore. He wants to die.

Participants should tick off the following items on the Mental Health Referral Checklist: "Is the inmate excessively isolating himself/herself from staff and other inmates?" (Yes, not talking to anyone unless forced to.) "Are the sleeping and eating patterns of the inmate causing concern?" (Yes, he's not eating.) "Does the inmate have any other symptoms that are likely to suggest a mental illness?" (Yes. He says he wants to die, so he may be depressed.)

What level of referral is suicidality? Suicidality is an urgent to emergent (emergency) mental health risk. For potentially life-threatening issues, it is best to have a mental health staff member make this determination. The facility's policy should be followed, and the best practice would be to report a concern as soon as possible, particularly given the sudden changes to Sam's behavior.

Action: They should refer Sam to Mental Health as a potential emergency case. He says he doesn't want to live and his behavior has changed suddenly, which indicates he may be suicidal.

Result: Sam is interviewed by Mental Health workers and found to indeed be suicidal. He was planning a suicide attempt after Lights Out with a contraband weapon he has created. He is safe because you reported your concerns.

Answer: **Reggie** is being threatening so watch out for violence. He doesn't trigger another action at this time.

Answer: **Chris** isn't displaying concerning behaviors at this time, but people are angry at him and being a bit hostile.

Shift Change

(NOTE: This is the transition from Group 1 to Group 2.)

Ask:

Group 2, what information do you think you'd need to know from Group 1?

Answer: They should want to hear Sam's story and that he's been removed from his cell as a suicide risk. Also, they should definitely know that Reggie looks like he may be planning some trouble but hasn't actually done anything violent. They should also hear that they previously heard from the night shift that Reggie's cellmate is afraid of Reggie. They should know that people are angry at Chris for disturbing their sleep again.

From here on, questions are directed to Group 2.

Say:

While we go through the second shift, Group 1 should now take notes about what they would want to know when they come back in at 8AM.

8 PM Second Shift – Group Two

Say:

You have arrived and hear the report. Any plans as you start your day?

Answer: **Reggie** should be watched. He may be planning violence against his adversary or his cellmate.

Answer: Might watch **Chris** to make sure that no one tries to retaliate against him. His behavior isn't a concern right now.

9 PM Second Shift – Group Two

Read:

Dinner passed without anything too unusual.

In the evening, **Reggie** attends his anger management group. As the men file out of the meeting, you overhear them talking about his behavior tonight. In the group, he became disruptive. He didn't act angry, which is fairly common in the group. Rather, he ranted about how he's figured out how his cellmate is tracking him throughout the day and that he's going to put a stop to it, tonight. He said he knows that the man he often has conflict with is planning something with Reggie's roommate and he's figured it all out. He will end their plans against him. When the men questioned him, he grinned frighteningly and put his finger to his lips, as though he has a secret.

Chris attend his AA meeting. He doesn't speak. Through the glass window to the room, you see that he looks very tired and angry. He sits so that he can keep an eye on the door, as usual. You know that he's an Army veteran and that's where he learned his habit of never having his back to a door.

Check Point:

Do you have any concerns? Do you take any action? (Refer them to the "Best Practices" slide.) Is anything urgent or an emergency?

Answer: **Reggie** has ticked off two boxes on the Mental Health Referral checklist: "Is the inmate's behavior persistently erratic and/or bizarre? (Yes, he's been frightening his cellmate and making threatening gestures. His responses are unusual. Also, he seems to think there is a conspiracy against him.) Does the inmate have any other symptoms that may suggest mental illness? (Maybe: his conspiracy theory and threats to put a stop to it.)

Ask how urgent it is. It should be urgent since he seems to be threatening other people.

Action: They should follow their facility's protocol. This might include making a referral to mental health for Reggie due to his threatening behavior.

Result: Mental Health discovers that Reggie has stopped taking his medication for paranoid delusions and had indeed decided there was a plot against him. He had planned to "teach his cellmate a lesson" that night. Your action may have prevented a crisis or worse.

Answer: There's nothing unusual about **Chris's** behavior at this time.

3 AM Second Shift – Group 2

Read:

You hear a crashing noise, then yelling. Someone is yelling, "Help him! Help him! He's busted his face!" You trace the noise to Chris's cell. **Chris** is lying on the floor, with a bloodied face. He's groping around as though he's lost something, and he's yelling incoherently about "arm up, they're past the perimeter." His cellmate, who was the one yelling for help, says that Chris often has nightmares. The cellmate says that this time, Chris jumped from the bed, maybe still in his sleep, and tried to run out of the cell. He hurt his face when he ran into the cell door. Chris yells, "WHERE'S MY WEAPON," still groping around. He doesn't seem to know where he is. He jumps when you say his name several times, as though waking up.

Check Point:

Do you have any concerns? Do you take any action? (Refer them to the "Best Practices" slide.) Is anything urgent or an emergency?

Answer: **Chris** has obviously had some sort of nightmare and maybe hallucinations or flashbacks related to his combat experiences. He doesn't seem to have intentionally done anything wrong. They should tick off two boxes in the Mental Health Referral form: "Are the sleeping and eating patterns of the inmate causing concerns?" (Yes, frequent nightmares and disrupted sleep.) "Does the inmate have any other symptoms that are likely to suggest a mental illness?" (Maybe; it's unclear if he's just having nightmares or if he's not in touch with reality while awake).

Action: Get medical help and inform medical staff of possible need for mental health referral.

Result: Medical staff treat Chris for cuts to his face and a broken nose. Mental health staff evaluate him and discover he's suffering from PTSD. They start him on treatment, which seems to be helping him sleep and remain in touch with reality. By alerting medical staff to a potential mental health issue, you helped get him necessary treatment that contributes to a calmer and safer facility.

Activity Debrief

Debrief the activity with the following questions:

- How was this activity? Were the "Best Practices" helpful?
- What would have happened if you didn't report concerns to Mental Health?
- You prevented a crisis for Sam and Reggie but not Chris. Was there any way you could have prevented his crisis? (Hint: Maybe. His nightmares were a concerning sign, but nothing could have been guessed without a diagnosis).
- Do you think the "Best Practices" will be helpful to you on the job?

Transition to Module 19

Say:

Best practices in communications between correctional and mental health staff can greatly increase the level of safety in a correctional facility and maintain the rights of incarcerated people to mental health care.

19: Promising Practices in Corrections and Reentry

Time:	45 min.
Format:	Lecture, activity, discussion
Materials:	PowerPoint, Key: "The Facilitator's Model," Handout: "The Sequential Intercept Model," Handout: "Promising Practices in Corrections," flip chart and markers
Competencies:	• Describe the Sequential Intercept Model and examples of strategies that can be used at different stages of justice processing to address mental illness of incarcerated people. • Describe three promising practices for addressing mental health of people who are incarcerated or reentering communities.

Description

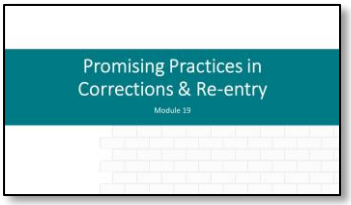
This module addresses promising practices in corrections and reentry for persons with mental disorders. An activity will help participants explore such promising practices and how they fit into the overall sequence of justice processing.

Before Training

Print out enough copies of the handouts "The Sequential Intercept Model," and "Promising Practices in Corrections and Reentry" for every participant to have one.

Print out copies of "The Facilitator's Model" for all **trainers** active this day. This is an answer key for the activity "Intercept Again!" and will only be used by trainers, not participants. The Key can be found in the Manual below, at the end of the Activity section.

During Training



Intercepting Early

Set Up

Say:

Remember the Sequential Intercept Model that we worked with in an earlier module? Well, there are additional strategies to address mental health needs of a person with a mental disorder while they are incarcerated or as they reenter communities.

There are a series of potential points of intervention that might keep people with mental illness from slipping more deeply into the justice system. The Sequential Intercept Model (Munetz & Griffin, 2006) examines each of these points as an "intercept" where assessment and services might be utilized to engage people with mental disorders in treatment and reduce incarceration and reoffending. Ideally, professionals from criminal justice systems and mental health services can work together toward these goals.

Examples of activities that may be conducted at specific intercepts include use of crisis intervention teams in the community, pre-arrest and post-arrest diversion programs, mental health and drug courts, specialized mental health caseloads for probation and parole officers, and transition planning for offenders reentering communities. Here we will focus on promising programs that can be implemented inside correctional facilities or with coordination between correctional systems, probation and parole, and community-based service systems.

The Future is Near: Promising Practices in Corrections and Reentry

Lecture

Present lecture:

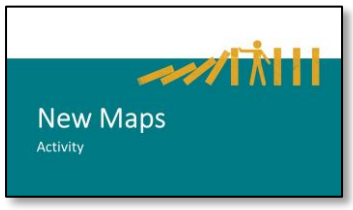
The National Alliance on Mental Illness (PRA, 2012) has documented a number of promising practices for working with justice-involved people who have mental disorders. These practices have evidence that show promise of their effectiveness in achieving mental health or public safety outcomes. Implementing such practices typically requires support of facility administrators and coordination among a variety of staff, including mental health staff, correctional officers, and others. Here we provide a brief overview of some practices that are promising for use by jails, prisons, or in the transition for reentry into communities.

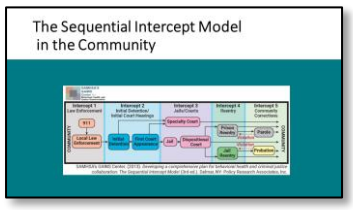
Give out enough copies of the handout "Promising Practices in Corrections and Reentry" for every participant to have one.

Ask:

- Which practice do you think holds the most promise and why?
- Have you heard of similar practices?
- Have you heard of anything in your communities that may be coming into place to help with mental health issues in corrections?

Activity: New Maps





1. Explain that the purpose of this activity is to map promising practices onto the Sequential Intercept Model in order to better see how promising practices can address mental health issues in the justice system.
2. Give out enough copies of the handout "The Sequential Intercept Model" so that each participant has one. Make sure the slide showing the Model is showing on the PowerPoint.
3. Give the following instructions:
    a. Let's look at the "Promising Practices in Corrections and Reentry" handout and see how the practices could map on to the Sequential Intercept Model.
    b. Let's work to add practices to the model. As we go, mark up your model as we add practices to the intercept points.
4. As you work through the activity, use the Facilitator's Model as a key to help you guide the group to the best answers.
5. Ask the group to pick one of the practices they see value in. Ask, "Which intercept stage would this practice fall under?"
6. Have them choose an intercept and explain why they are interested in that particular stage.
7. Have all of them write on their copy of the model the name of the practice at the correct stage it would be used.
8. Discuss how that practice would be useful or not useful to the justice system.

9. Take 10 minutes and repeat steps 4-8, filling the model up with as many practices as you have time for. Make sure that they find at least one practice for each intercept.

10. When their models have been labeled and the 10 minutes are up, move into the Debrief.

Key: The Facilitator's Model

- **Peer support for incarcerated persons with mental disorders.** Intercept 3. These services would occur while incarcerated. They would support life while incarcerated.
- **Wellness self-management (WSM).** Intercept 3. These services occur while incarcerated but would teach coping skills useful after incarceration.
- **Trauma, Addiction, Mental Health, and Recovery (TAMAR**). Intercept 3. These services support mental health while in prison and this kind of treatment here could improve life after reentry.
- **Forensic Assertive Community Treatment (FACT) teams**. Intercept 5. Continuity of care and oversight can help maintain good mental health and prevent re-offending.
- **Assisted Outpatient Treatment (AOT).** Intercept 5. This maintains on-going treatment practices in the community and can prevent re-offending.
- **Planned Reentry Programs**. Intercept 4. 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. Sometimes reentry checklists are used to help with planning. A reentry checklist can be used to track these elements.

Note: there are supplementary materials that include a copy of the GAINS reentry checklist. They are available on the training website under Resources.

- **Parole Officer Training**. Intercept 5. Parole officers are trained to respond to mental health concerns and to refer people on probation to support before they reoffend.

Activity Debrief

Use the following questions to debrief:

- Looking at your model, do you think it's strengthened by these promising practices?
- What are the roles that would need to be involved in these practices? (Such as parole officers, medical staff, etc.)
- Overall, what do you think of this level of connection between the correctional system and the larger community?
- What concerns might you have about coordinating with community providers for programs and practices like this?
- What would you like to see implemented in your community?

Conclude:

New ideas are starting to improve our system and communities. Coordinating with useful programs as they become available can improve the justice system and the community.

Transition to Module 20

Say:

These promising practices are focused on intervening for justice-involved people. But what about the mental health of correctional staff?

In the next module, we'll focus on the mental health and well-being of correctional staff. These jobs can be stressful and challenging, so self-care is crucial.

20: Managing Workplace Stress

Time:	45 min.
Format:	Pre-work, activity, discussion
Materials:	PowerPoint, Handout: "Support Systems to Combat Stress," Handout: "This is Kevin," flip chart and markers. Optional: Handout: "Workplace Stress Survey." Optional: materials such as brochures that give information about any relevant workplace or agency Employee Assistance Programs (EAPs) or other local sources for mental health care for correctional staff.
Competencies:	• Identify sources of workplace stress and burnout. • Describe resources and strategies for addressing workplace stress.

Description

This module focuses on the stress of being a corrections professional, especially a correctional officer. After identifying specific sources of stress, participants will engage in an activity to better understand how stress can lead to burnout. Finally, the module will end with a discussion of ways to get support to remain emotionally and mentally healthy at work.

THIS MODULE HAS PRE-WORK. If pre-work is not feasible, you may have the participants take the workplace stress survey as part of the training day.

Before Training

Pre-work for Participants

Ask participants to take the Workplace Stress Survey online and bring the results in to the training day. The survey can be found at https://www.stress.org/wp-content/uploads/2011/08/Workplace-Stress-Survey.pdf

For Trainer

Make enough copies of the handouts "Support Systems to Combat Stress" and "This is Kevin" for every participant to have one.

If you've decided that taking the "Workplace Stress Survey" before the training day is unfeasible for participants, print and bring in enough copies of it for every participant.

If you have relevant materials for participants about EAP programs or other local support for correctional staff, assemble and bring enough for all participant

During Training

Workplace Stress is Powerful

Set Up

Say:

It's important to acknowledge that all workplaces have stress and that being a CO has its own particular set of stressors.

Activity: Add It Up

Say:

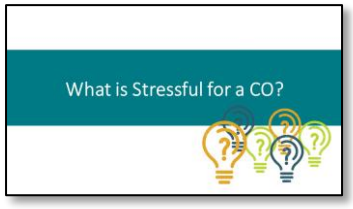
So what are some common sources of stress in the life of a CO? Let's invent a corrections officer and see what might cause him or her stress.

Go to flipchart or board and say:

Let's give the CO a name – what shall we call him/her? Write the name they decide on at the top of the board.

Then have them call out stressful things about life as a CO and write them down on a flip chart or white board, as is available to you. Give them time to think and to decide what they want to say. You may find that they'll start with things that are easy to admit but will slowly make more suggestions as they grow more comfortable and continue to think carefully.

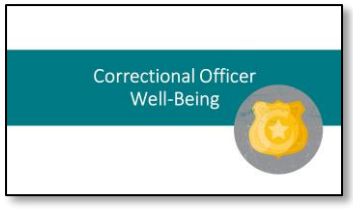
Facilitate discussion with the following:



- That's a lot of stressful events. Can these lead to burnout?
- What does burnout look like on the job? How does a burned out CO behave? (NOTE: Make list of what they relate.)
- What kind of consequences can stress bring to a CO, on and off the job?

Transition by saying:

Let's look at the life of one CO.



Correctional Officer Well-being

Activity: Kevin the Correctional Officer

1. Explain that this activity will have them assess the well-being of a correctional officer, in the same way they assessed the well-being of an incarcerated person in earlier modules.

2. Give a copy of the handout "This is Kevin" to every participant.

3. Read the following scenario:

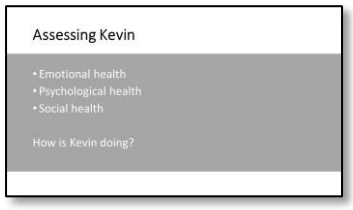
Kevin has been a CO for six years. The last two years have been particularly stressful. He was in two major prison riots that left him injured, once with a knife. He's moved around within the correctional system recently so he doesn't have a new peer group yet. He's in great physical shape from frequent 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 lots 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. Those who are incarcerated and their families are angry at the lockdowns and often verbally assault the officers. When lockdowns are over, there have sometimes been fights due to lockdown stress. Kevin is tired and sore from trying to break up the fights and putting

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

4. Give the following instructions:



   a. Let's discuss Kevin's well-being.

   b. What do you think about the state of Kevin's emotional health? (Hint: Lots of personal and work-related stress. Also mention that people handle stress differently, so this will vary widely).

   c. What about the state of his social health? (Hint: He's separated from his wife and doesn't have a peer group at work or time to see friends outside of work).

   d. If Kevin were your co-worker, what advice would you give him?

How Can We Feel Better?

Discussion

Say:

Based on Kevin's experience and what you know from your own life, what are some things we can do to feel better? (NOTE: keep a list, again.)

Facilitate a discussion based on the following questions:

How can you improve the following?

- Emotional health
- Social health
- Physical health

Give the handout "Support Systems to Combat Stress" and review it with them.

Say:

If you don't know if your workplace offers an Employee Assistance Program (EAP) or if you don't know how to access it, make sure to consult your employee manual or ask when you return to work.

Facilitator Note: If all (or most) participants are covered under the same EAP or similar program, hand out the materials you've brought in and explain how to access these services and the benefits.

Say:

Take a moment to think and write down at least one thing you know you can do to keep yourself healthy. It might be for your emotional, social or physical health.

Give them a few minutes to think and write and then say:

After you leave today, make a plan to try out one of the ideas you've had to help relieve your stress so you can enjoy your life and have success on the job.

How Are You?

Discussion: The Workplace Stress Survey

If you're giving the "Workplace Stress Survey" in class, pass it out now. Tell them that this survey is for their own benefit. It is confidential and will not be collected. Allow them five minutes to complete the survey.

If they've taken the survey outside of the training day, ask them to bring out their copies for their own reference. Again, emphasize that this is for their own use and it will not be collected.

A Note on Confidentiality: participants have the right to keep their scores to themselves. Be sensitive to the fact that

these scores are highly personal and participants may not be proud of what they scored. In light of their right to confidentiality, the questions are general and do not require anyone to disclose their score. The survey is a tool for participants to use for self-awareness so they can make choices about their own well-being so be sure to keep that in mind.

Say:

Let's think about our own workplace stress surveys. Let's take a few minutes of self-reflection and think about our individual scores.

Facilitate self-reflection with the following questions:

- Were you surprised by the results of your survey? Or did it seem about right to you?
- Are you aware of any programs your workplace or agency has in place to support you?

What Are You Living For?

Discussion

Introduce the discussion by saying:

People need purpose and meaning in their lives in order to keep living. What kinds of things can give us meaning and keep us going when life gets hard?

Facilitate discussion with the following:

- What makes life good and worth living to you?
- How are hopes for the future and personal goals important to well-being?

Concluding

Say:

Your own health--physical, social and emotional—is a crucial part of your job. While a lot of focus goes to interacting with people who are incarcerated, you should all keep your own health in mind. Support each other. Talk to your co-workers if you need support or talk to a friend who seems to be struggling on the job. The work you do is important. Care for yourself!

LOOKING BACK AND WRAPPING UP

Description

This is designed as the end of a training series and will allow for meaningful reflection and planning for future use of the content participants have learned. Always use this at the end of any training series.

During Training

Say:

This is the end of the training! Let's take a minute to think back over all that we've learned and discussed here. If you have all of your materials from the previous modules, you can get them out to help jog your memory.

Discussion

Lead a discussion with the following:

- What stands out in your memory most, as you think back?
- Which of the resources we gave you do you feel you'll use on the job, and why?
- Let's take 2 or 3 minutes and make a list of the three most important things you learned. In three minutes, I'll call on some of you to hear what was important to you. (When they offer examples, write them up on the flip chart.)
- If your perspective about mental health in people who are incarcerated has changed at all, explain how it's changed.

- What topic would you like to learn more about in the future? (After they say a few things, encourage them to seek out resources and trainings about these topics.)

Thank You and Dismissal

If this the final module you're teaching in a training, conclude the training with the following:

- Discuss the website they can refer to while showing the slide with the web address.

- Thank them for their time and their effort to be ethical, informed COs.
- Wish them the very best and dismiss.

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