Department of Health

HM PRISON SERVICE

Mental Health Awareness

in custodial settings

Self-directed workbook

Name:

Establishment/Unit/Department

Offender Health Care strategies

Contents

TARGET AUDIENCE

This workbook is primarily for the use of staff that come into contact with offenders within the custodial setting. It is designed to provide skills in managing individuals who present with behaviour that may be the result of mental health difficulties. The workbook is not intended to enable the reader to diagnose or treat but will aid in the referral of offenders to the correct healthcare professional in the correct manner.

AIMS OF THE WORKBOOK

The aims of this workbook are to help the reader to:

- Develop an awareness and recognition of mental health and well-being
- Develop an understanding of how this may be influenced by culture, environment and upbringing
- Develop an understanding of how to refer an individual to the relevant healthcare professional
- Encourage participants to pursue further, available knowledge and training in managing mental health issues.

This workbook is not intended to equip participants with anything more than a basic awareness and understanding of the subjects involved. Participants will be expected to use this knowledge to only enhance the skills they already have in managing individuals within their own workplace. Anything other than this should be referred on to specialist services.

HOW TO USE THIS WORKBOOK

The workbook is divided into five modules and can be completed over an eight to twelve hour study period. It will take varying lengths of time to complete each module. It is advisable that a minimum of half-hour study sessions is applied if breaking the modules into smaller learning sessions.

Within each module there will be exercises reflecting upon acquired knowledge, your understanding of it and how you may apply it within your work place. The exercises will help give you a measure of your progress and understanding of the materials. There is no expected pass mark for the exercises, they are there for you to practice and measure your newly acquired knowledge. Further guidance regarding the exercises can be obtained from mental health professionals or those staff that have undertaken the **Two Day Mental Health Awareness Training** (Bournemouth University)

For each module you should:

i. read the module through

ii. complete the exercise in the text and at the end of each module

iii. revisit the module after doing each exercise

Individual Learning

The package is designed to enable you to undertake each module at your own pace. There is no requirement to achieve any academic standard other than an improved awareness of mental health.

Progressing and Further Follow On

A primary aim of the learning package is to stimulate participants' interest in mental health and a desire to seek out further and more in-depth knowledge with a greater respect for mental health awareness.

To achieve this there is a **two-day follow on package**. The two-day package constitutes a more formal and traditional delivery of its content, with the expectancy that a **healthcare professional** will deliver the core of information within a classroom setting. This package will provide a wider knowledge on the conditions likely to be presented, inclusive of risk assessment in respect of self-harm and suicidal intent, as well as the classical conditions of mental illness.

Portfolio Development

Increasingly within the custodial setting, there is an expectancy of a more informed approach in management of disturbed and difficult individuals. By utilising the skills and knowledge in these packages, you will be able to demonstrate how you are achieving this, contributing to transparency in your practice, providing protection and safety in your day-to-day management.

INTRODUCTION

Custodial Staff working in today's justice system are presented with many challenges in managing the daily needs of people under their care. This has become all the more significant when taking account of the increasing numbers of people coming into the system who are identified as experiencing current and continuing mental health difficulties.

One of the fundamental aims of this training package is to contribute to the development of a 'healthy' environment within the custodial community and other judicial settings. To achieve such an environment, consideration for the needs and concerns of staff alongside the needs of those in their care must be recognised. To achieve this, it is essential for staff to be properly equipped to recognise and manage the complex range of needs presented by those under their care.

Issues that will need to be addressed include:

- The effective identification and management of risk
- Developing an understanding of the effects of the working / living environment
- Achieving a reduction in confrontation and cycles of escalation
- Improving the understanding as to why individuals react and respond differently in similar situations
- How to provide a continuum of safety and security within the work place
- Achieving consistency
- Maintaining control and '**Being prepared for the unexpected**'.

Often mental health issues amongst offenders are further complicated by additional problems such as: alcohol and substance misuse, learning difficulties and issues around personality disorder. These will add to the complexity of the problems presented to you by individuals under your management.

This pack will provide you with an enhanced awareness of dealing with those offenders experiencing mental health difficulties. Once completed, it is recommended that you 'revisit' the pack at least every six months, to constantly 'check out' your progress.

MENTAL HEALTH DIFFICULTIES

Module Aims:

This module will help you develop a basic understanding of:

- Mental Health
- Some of the common influences and causes of mental health problems
- Stigma and mental health problems
- Types of mental health problems
- Factors that affect a prisoner's mental health

Mental Health

To understand mental health problems and illness it is important to have an understanding of what being 'mentally well' means. We all think we know what it is, although it can be very hard to define.

Exercise 1 *(Reflection time)*

Consider what you understand by the term 'mental health '. Write down below in one sentence how you would define your own mental health.

_____

_____

_____

The phrase 'mental health' tends to be used in a negative way. In reality mental health is a broad term that covers both healthy and unhealthy states.

It is necessary to think of a healthy mental health state as something which needs to be achieved and strived for within our daily lives. Each of us experiences changes in our mental health state, but for most of us, for most of the time, our mental health state is a healthy one.

We can all feel down, stressed and or anxious from time to time, but for most of us these periods are of short duration and so don't really become a problem.

Part of having a healthy mental state is being able to cope with daily stresses and strains of life. However, if you are continually facing difficulties at work and/or in your home life, even the healthiest of us will 'buckle' under the strain.

This module explores mental health and its definition. It provides comparisons for mental health in respect of how we interpret and measure it against the more straightforward and defined physical health.

REMEMBER:

This module is not intended to equip participants with anything more than a basic awareness and understanding of the subjects involved. Participants will be expected to use this knowledge only to enhance the skills they already

have, for management of individuals within their own workplace. Anything other than this should be referred on to specialist services (Module 5).

Influencing Factors on an Individual's Psychological Well Being

Mental health is an area of health that is important to us all. It is the core of our sense of being and is crucial to our ability to lead a fulfilling life.

One in four people are affected by a mental health problem at some stage in their lives though incidences tend to rise under certain circumstances: (DH, 1999).

It is not surprising then, that the incidence of mental ill health within settings such as secure environments is high.

Let's think a little more why people might develop a problem with their mental health.

There are a variety of reasons why our mental health state could become problematic to us. This could include:

- continual exposure to stressful environments, relationship problems, problems at work
- unemployment
- financial and money problems
- poor physical health, poor housing
- traumatic early life experiences, other traumatic experiences
- drug or alcohol abuse
- there is also some evidence that some people may have a predisposition to mental illness (e.g. a family history of serious mental illness).

We will look at these issues in more depth further into the module now consider the next exercise.

Exercise 2

Write five factors that you think help you to cope with the stresses of life.

How would you feel if you were unable to do the things that you have listed, and you were subject to extra stresses that made you feel more vulnerable? (Such as debt, bullying, loss of relationship).

Exercise 2 cont

How do you think this would affect your ability to cope?

How do you think this would affect your mental health?

To understand mental health problems and illness it is important to have an understanding of what being mentally well means. We all think we know what it is, although it can be very hard to define.

The following is an 'academic' definition' and is used in setting the scene.

Definition of Mental Health

'Our mental health is in a constant state of flux. It is ever changing, reflecting responses to the environment. It is intrinsically connected to our physical, emotional and social health' (Ironbar & Hooper)

In understanding this definition and applying it within a custodial setting, it is significant what influence it may have upon an individual's mental health.

Generally classification is dependent upon the perceptions of the person who is interpreting the behaviour, rather than the individual who is experiencing the illness.

It is a useful exercise at this point to look at comparisons between physical ill-health and mental ill-health.

PHYSICAL HEALTH COMPARED WITH MENTAL HEALTH	
PHYSICAL HEALTH PROBLEMS	**MENTAL HEALTH PROBLEMS**
Usually a reliable diagnosis	Sometimes an unreliable diagnosis
Objective marker (Blood test)	Assessment based on human judgement
Consistent World-wide	Culture can define
Prognosis usually known	Prognosis sometimes vague
Often clear onset and end	Often vague onset and end
Sick Role is usually acceptable	Sick role is often unacceptable
Treatment Voluntary	Treatment sometimes compulsory

The differences are further compared:

DIAGNOSIS

When you are physically ill a confirmation of the condition is reassuring, especially if it is further validated by physical tests such as blood test, scan, x-ray etc.

However, for a mental health problem, confirmation is based upon another's 'professional' judgement of your condition, without any objective physical markers (such as a blood test). Therefore the diagnosis can be imprecise and subjective.

CULTURE

The culture and the accepted norms the individual is living within at the time can define mental health, unlike physical health. However, physical health is consistent wherever you are within the world.

For example if a person had a headache in India, it would still be called a headache in Milton Keynes. However, mental ill health is culturally unique and is diagnosed against each culture's recognised norm.

PROGNOSIS

In many cases the prognosis in physical health is expected to offer a full recovery, (e.g. broken arm) whilst in mental illness it is harder to define.

In some mental illnesses it is not possible to talk about a 'full recovery', but better to discuss the illness in terms of life management and maintenance.

ONSET

Physical illness normally has a clear onset, and is time bound, i.e. the end of the illness is identified.

Mental illness is often vague in onset, i.e. it can be difficult to recognise when someone is beginning the illness, and it is often hard to predict or know or when the illness will improve.

SICK ROLE

It is usually more socially acceptable to be physically ill than mentally ill. It is more likely if you are an in-patient for a physical condition that you will have regular visits from family and friends.

If, however you suffer from a mental health problem or illness, it is more likely that your whole life and manner of being will be under question.

For example work colleagues may avoid you, because they fear 'making things worse'. There may be doubt expressed over your capabilities as a colleague, father, mother, friend etc.

Mental health problems can affect your ability to cope with the everyday stressors of life, and thus leave you very isolated from others.

TREATMENT

Generally, if you become physically ill there is a need to seek treatment as soon as possible, by either visiting the GP or attending the Accident and Emergency department.

With some mental health illnesses the person suffering may not feel that they are ill, and believe it is the 'rest of the world' that is out of kilter with them.

At times health professionals have to make the decision to 'treat' or manage the condition against the patient's wishes. At this time the Mental Health Act will be used.

It could be possible that a significant number of individuals who come under your duty of care may not possess the recognised coping strategies, or support frameworks, that you may have access to. This may be further complicated by the restrictions imposed upon them within the environment in which they are confined. When managing individuals showing signs of mental ill-health these are additional influencing factors which you should take into consideration.

Improving Mental Health Well-being

Factors that help to promote an individual's mental health are likely to be:

Health Protecting

- Regular access to exercise
- Opportunities to be creative
- Constructive activities and time out of cell
- Contact with supportive family and friends
- Freedom from fear of bullying and violence
- Opportunities to make choices and exercise control.

Factors that may have a detrimental influence on an individual's mental health:

Health Demoting

- Long bang up hours (within a prison/police cell\)
- A lack of meaningful activity
- Fear or reality of being bullied or victim of violence in jail
- Social isolation, lack of autonomy.

Causes of mental health problems

There is not one view about the influences upon mental health problems/illness. There those who would argue that many forms of mental health problems are linked to an individual's genetic and biological make-up whilst others would argue that an individual's environment has a primary influence. The likelihood is probably somewhere in between and there is a multiple of factors that impact upon mental well-being. For example, some individuals may be more vulnerable to mental health problems, which are triggered by stressful or traumatic events (prison/custody).

Below are lists of the factors that may impact upon an individuals mental ill health. His/her difficulties may be due to any one of these factors, or to a combination of them.

Difficult upbringing and early years

A difficult early life does not always mean that we will develop later mental health problems but may add to the risk of their onset. The following are factors in an individual's early life that may later impact on their mental health:

- Emotional, physical and or sexual abuse
- Neglect
- Overprotective parenting
- Insecurity for other reasons
- Being discouraged from sharing feelings
- Learned behaviour (from parent or carer with mental illness)

Stressful life events

Everyone will experience stressful events in their life and people will vary to the degree that these impact on their mental well being. The following are a common list of such events:

- Death of a significant other
- Moving house
- Loss of status (i.e. through unemployment)
- Relationship problems, separation, divorce
- Witnessing or participating in a traumatic event
- Failing physical health
- Loss of freedom (e.g. imprisonment)

Prolonged exposure to stress

Many of the issues listed in stressful life events may be experienced over a sustained period of time or may be repeated. This may add to the degree of difficulty an individual suffers and the risk and severity of any mental health problem.

Genes / biological factors

- Possible inheritance of genes that may predispose one to a risk of a mental health problem.
- Family history.
- Brain injury
- Chronic physical illness

Substance misuse

Alcohol and other substances sometimes can:

- Directly induce a mental health problem
- Aggravate or exacerbate a mental health problem
- Mask the underlying mental illness
- Provide a false picture where the behaviour may be influenced or masked by substance intoxification and will subside as the individual is stabilised.

Learning Difficulties

There is some evidence that a higher than average number of people with learning difficulties find themselves subject to the criminal justice system and held within custody. Staff working within these organisations should be aware that many of the reactions and behaviours displayed by people with learning difficulties are similar in nature to those displayed by people suffering from mental ill-health. The possibilities that an uncommunicative or disruptive offender has learning difficulties should always be considered and advice sought from education and health staff for confirmation or otherwise of this suspicion.

Learning difficulties are often confused with mental disorders. They are different from specific learning difficulties which usually refers to dyslexia or a similar problem that affects an individual in a more specific, limited way. People with learning disabilities usually have significantly impaired intellectual functioning. They may have difficulty with communication and understanding verbal instructions and risk being exploited by other prisoners. In a custodial setting they are at significantly increased risk of self-harm.

Types of Mental Health Problem

Mental health problems range from those that are mild and short term to those that are severe and long-term. The following section describes some of the most common forms of mental health problems and provides a brief description of each. This is not an exhaustive list and as said earlier you must always remain aware of the limits of your expectancies. **Use this information to recognise ill-health NOT to diagnose.**

Depression

Depression is a very common mental health problem, it can be relatively mild and short-lived, but for some people it is more severe and enduring. A person with depression may show some of the following signs;

- Socially withdrawn
- Poor appetite
- Problems with sleeping (difficulty in getting off to sleep, or waking early)
- Little energy and concentration
- Tearful
- Have a negative outlook on all aspects of their life
- Express a poor opinion of themselves (low self esteem)
- Complain of low spirits
- Difficult to engage with

People with Major Depression (They have symptoms severely and over a long period of time (2 weeks), have 20 times the rate of suicide of other people).

It is easy to think that only people who appear openly distressed or are quiet and withdrawn are at risk of hurting themselves. As a result the risk associated with difficult, un-cooperative individuals is often underestimated. The reports of the deaths of the 24 women who killed themselves during 2002 and 2003 showed that their depression and suicidal distress was more likely to be shown through aggressive and abusive behaviour than being quiet and withdrawn.

Anxiety

Anxiety is another common mental health problem. Feeling anxious at times due to events or circumstances is a normal response and is designed to protect us from danger or imminent threat. However, some people experience anxiety when there is no apparent cause. For others the anxiety becomes so severe and pervasive that (whether or not it has a cause) it interferes with their ability to maintain relationships with others, to hold down a job or do 'normal' things like go shopping or eat in a room with other people in it.

To assist you with the referral of an offender it is important to note that it is the 'severity of the symptoms and how much they interfere with the offenders life' that should be noted and passed tot he healthcare professional. A person with anxiety may show with some of the following signs;

- Agitation/restlessness
- May complain of various physical symptoms
  - Heart palpitations,
  - Breathlessness
  - Tremor, feel shaky
  - Stomach upsets
- Constant worrying

- Problems sleeping and resting
- Problems with concentration
- May express guilt feelings about the way they are

Anxiety and depression come hand in hand with the culture and environment of the custodial setting, and may be exhibited at some stage in various levels by both staff and those they care for. Mental ill health is not unique to offenders, it also affects staff and you should always be conscious of this within your working environment.

Anxiety is a normal response that we have all experienced sometime in our lives when coping in challenging situations, such as a job interview, or the first day in a new job.

A normal reaction to extreme anxiety is the FIGHT or FLIGHT response. In order to deal with a serious threat we may choose to stay put and 'fight'/cope with the situation or 'flight'/runaway/avoid the situation.

Anxiety problems may present in a number of ways, in addition to those above.

a) Panic attacks

These could be described as an extreme anxiety response, with no apparent cause. They can begin suddenly and are difficult to predict. The individual experiences a feeling of terror accompanied by difficulties in breathing, pounding sensation in the chest, sometimes accompanied by pain. People suffering a panic attack may feel faint or experience a sensation of unreality.

b) Obsessive-compulsive problem

Someone with this type of anxiety may feel a compulsion to think certain negative thoughts and to repeatedly perform certain behaviours. Examples being, repeated hand washing or continuous cleaning. These behaviours are repeatedly carried out in a ritualistic form to reduce the individual's levels of anxiety.

c) Phobias

Phobias generally involve the person in avoiding something that triggers anxiety in them. Phobias are seen as an unreasonable fear, for example being fearful of tiny spiders to the point of not entering a room just in case there may be one hidden. Phobias in their most extreme form can be very disabling for the person suffering from them because they can restrict their normal daily activities.

Exercise 3

Taking into account the issues highlighted above, what structures/support systems are provided for the offender to enable them to cope within the custodial setting.

List at least 5 which may have been used on:

a. an individual basis

b. group basis

Psychosis

Psychosis is a term that is used to cover several forms of severe mental illness. These include Schizophrenia, and Bi-Polar disorder (sometimes called manic depression).

Schizophrenia

Contrary to popular belief, Schizophrenia does not involve having a split personality. Schizophrenia affects how a person thinks, feels and acts. The person may have difficulty in distinguishing reality from what is imagined. They may express strange beliefs and ideas, with utter conviction. For example they may state that radio broadcasts are specifically focused on them. This type of thinking is known as delusional thinking. A person with this condition may have false perceptions in which they may state they can see, hear, smell, taste or touch things that others cannot. For example a person may have conversations with people/objects or creatures that you cannot see or hear. These symptoms are called hallucinations.

A person with Schizophrenia may appear:

- Distracted and not listening to what you say
- Talking to 'others' that you cannot see; appearing to respond to voices
- Disorganised speech patterns, i.e. not answering questions in a logical fashion
- Express strange or odd ideas
- Their emotional response may not fit the circumstances around them
- Swings in their mood
- Loss of concentration and motivation to do anything
- Sleep disturbance and agitation
- Social withdrawal

In some forms of schizophrenia the person may believe, unreasonably that others around him are out to harm him. This is sometimes called Paranoid Schizophrenia.

Psychotic disorders are strongly linked to suicide:

- 10+% of people with schizophrenia kill themselves
- 41% of offenders who reported attempting suicide in the past week had symptoms of psychosis inclusive of depression

There are several reasons for this:

- Voices sometimes tell the person to harm or kill themselves
- People with schizophrenia often attempt suicide in a 'well' period
- feelings of hopelessness can trigger the suicide
- risk is highest during in-patient stay and shortly after discharge

Bipolar disorder (Manic depression)

A person suffering from bipolar disorder may experience episodes of extreme elation and at other times episodes of depression.

A person who is elated (manic or hypormania) may show the following signs:

- Talking incessantly
- Rapid speech
- Constantly moving
- Interfering with other's personal effects
- Appear to need little sleep, drink or food

- Poor judgement
- Unrealistic understanding about their beliefs or their powers
- May be sexually disinhibited
- May be aggressive
- Easily distracted with poor concentration

During the 'depressive' part of the condition the person will show symptoms as previously described under depression. Bi-polar disorder is also strongly linked to suicide.

Dementias

Dementias are not forms of mental illness as such but are usually progressive conditions leading to loss of mental functions, and decline in physical ability. These are more common in older people.

Personality disorder

Personality disorders are not forms of mental illness but rather are patterns of thinking and behaving that are deeply ingrained and that are socially unacceptable. People believed to have personality disorder are overdeveloped in some areas (such as hostility and self-centredness) and underdeveloped in others (such as consideration for others, rational thinking and a sense of personal responsibility).

Personality disorder is a complex issue. There are several different forms of personality disorder. Although personality disorder is not in itself a mental illness, people with a personality disorder are more likely to also suffer from a mental illness than others. There are also strong links between personality disorder and suicide, and with self-harm as the statistics below show;

- 31% of people who kill themselves have a diagnosis of personality disorder and another mental disorder.
- 40-53% of adolescents and young adults who kill themselves have a diagnosis of personality disorder
- People with personality disorder have problems controlling their impulses – and often commit suicide in an impulsive, unpredictable way.

Furthermore, people with a personality disorder often have difficulty in coping with the stresses inherent in life – prison life. They may react by harming themselves. They may harm themselves, not in order to die but for other reasons – to reduce anxiety or escape from painful feelings, to punish themselves, to feel alive. It is essential to take these people seriously and not dismiss them as "attention seekers" or "manipulators". They may seriously injure themselves or die by accident.

Substance misuse

Substance misuse is not in itself, nor does it necessarily indicate, a mental illness. However, some substance misuse will induce mental illness or exacerbate existing ones. Additionally, they may mask an underlying mental illness. Dependence upon and withdrawal from certain drugs (opiates, crack, cocaine and speed) and alcohol are strongly related to self-harm and suicide. The strongest risk is associated with use and withdrawal from cocaine, crack and speed (either alone or in combination with opiates). This is because there is no substitute medication for these drugs and the symptoms of withdrawal include acute depression, agitation and suicidal tendencies.

It is highly likely the majority of individuals coming into your care survived in the community through a fairly chaotic lifestyle. With a high possibility of underlying mental health problems, self-medication by use of illicit substances, both as a necessity and by choice and a negligence or lack of priority where physical health is concerned will all be common factors.

Each individual you manage and are responsible for delivering a Duty of Care to will very rarely present to you with a straightforward set of single-issue problems. Let us look again at the definition of Mental Health:

'Our mental health is in a constant state of flux. It is ever changing, reflecting responses to the environment. It is intrinsically connected to our physical, emotional and social health' (Ironbar & Hooper)

As you can now see, most mental disorders increase the individual's vulnerability to self-harm and suicide. The chart below summarises this information in an easy form.

Summary of research into factors associated with suicide and self-harm.

VARIABLE	RELATIONSHIP	COMMENT
Person's current situation, thoughts and feelings		
Stress	Moderate	Losses can function as last straw
Emotional pain/distress (desperate to end distress; hopeless about things getting better)	Strong	Pain/distress experienced as unbearable (Even stronger in those who lack impulse-control)
Current suicide plan	Very strong	Planning indicates likelihood of carrying out intentions
Resources/support	Strong	Help, caring, friends, family, sense of meaning in life - offer major protection against suicide.
Person's past history		
Life stress	Moderate to strong	* Accumulated losses * "Damaged" life * Chronic illness * Decreased access to resources/support
Mood disorders (Major depression, manic depression)	Very strong,	Major depression shows strongest association; possible biological mechanism operating
Schizophrenia	Strong	For suicide; most often a response to distress of chronic illness itself
Substance abuse	Strong	For both suicide & self-injury; often have mental health problems also
Antisocial personality	Moderate to strong	Very strong for self-injury. Moderate for suicide
`Borderline' or `emotionally unstable' personality	Moderate to strong	Very strong for self-injury Moderate for suicide
Anxiety states Eating disorders	Minimal	
Previous suicide attempts and/or self-harm	Strong	In self: 35-66 times greater risk Mixed for impact of suicidal behaviour of others

Taken with permission from safer custody Group's ACCT case manager training.

Factors that may affect an offender's mental health

Managing mental health is never clear-cut or straightforward and within the custodial community, there are a number of influential factors that must always be taken into consideration within your management process.

Custodial settings are stressful environments. Offenders are held in a restrictive environment and have limited privacy, personal space and control over their day. They have limited and sometimes no contact with family and friends, and maybe exposed to bullying, or fear of bullying. At times often-in response to untoward incidents the regime can become even more restrictive

(lock downs), and intrusive (cell searches).

A significant number of offenders have lived in difficult social circumstances prior to their incarceration. Because of this they may be predisposed or already suffering from a mental health problem. For others the environment of the custodial setting itself may lead to the development of mental health problems.

Custodial and Criminal Justice staff will quite frequently encounter severe forms of mental illness that are rare in the general population.

In addition to a mental health problem, many prisoners will also have difficulties in terms of their personality, substance misuse, and a learning disability or difficulty.

The Stigma behind Mental Illness and Health

People with mental ill-health continue to experience prejudice and discrimination in every area of their lives, from finding somewhere to live, to getting a job. It is hardly surprising that many people with serious mental illness come to the attention of the judicial system.

It is important to recognise the harm negative attitudes can bring to the individual. Describing people with mental disorders as 'loony', 'barking', 'Muppets' or nuts' dismisses them as people not to be taken seriously, whilst the perception that they are dangerous; 'nonce' or 'psycho' can result in them being excluded from everyday activities.

People with a mental disorder need acceptance. Labels like these prevent true understanding. Many people believe that mental disorders are incurable. They may even view some treatments to be useless or harmful, even though in many cases they are proven to be effective.

Mental disorders are manageable, with most being treatable and as likely to respond favourably to medical and other treatments as in many physical illnesses. The stigma of mental illness can make it harder for sufferers to seek help and difficult for those responsible for their duty of care, to recognise and accept the behaviour shown.

People with mental ill health are sometimes viewed as weak, self-indulgent or as bringing on the problems themselves. Even those with a mental illness may believe they have themselves to blame.

People with mental ill-health need you to recognise that they are ill as much as people with physical complaints. 'Labelling' and 'categorising' a mental illness can be useful to help the individual and carers understand what is happening. However, the negative aspects of labelling of the illness can precede the individual's requirements, by 'lumping' them into a box, which does not necessarily meet their needs.

We must recognise and not overlook the positives of coming into a custodial setting: it is a place of safety, the individual is provided with consistency and direction, it may be likely that they are already known, having been well managed before. The bizarre behaviour they present with may be better accepted and recognised within this setting.

Exercise 4

Try to identify the positive & negative factors within the custodial setting which may reduce or enhance stigma associated with mental health or ill health.

List three positives and three negatives below:

POSITIVES

1. _____

2. _____

3. _____

NEGATIVES

1. _____

2. _____

3. _____

Cultural Issues

Different ethnic communities can have quite different understandings of mental health and a different language to describe it. This in itself can be described as a barrier to communicating effectively about a person's mental health.

Racism and bigotry are factors to be considered here. They can be both a cause of mental health problems and a factor in misunderstanding a mental health problem where there might be an alternative explanation.

Mental health problems are time, context and environment specific. In other words, we have to observe someone's behaviour over a period of time, and relate their behaviour to their cultural background and the context which they are in at the time. We can see extreme behaviours within the prison, which we can 'normalise' because of the environment within which we work. For example, levels of noise and shouting within prison wings can be viewed as the norm, and if the levels of noise during association is lower, you may suspect that something is about to happen.

Another example may be that of an Accident and Emergency department, the 'normal' expected behaviour of the patients and relatives is that of high anxiety and tension. However, that behaviour within a library setting would not be seen as appropriate.

Managing mental health is never clear-cut or straightforward and within the custodial setting there are many influential factors that must always be taken into consideration

REMEMBER:

This module is not intended to equip participants with anything more than a basic awareness and understanding of the subjects involved. Participants will be expected to use this knowledge only to enhance the skills they already have, for management of individuals within their own workplace. Anything other than this should be referred on to specialist services (Module 5).

If you require a greater understanding and a more in-depth knowledge then there is an opportunity to take up the **Two-Day Mental Health Awareness Package**. This is a more structured package, within a formal setting delivered by recognised mental health/Healthcare professionals.

To summarise, this module has defined what mental health/mental well-being may mean, knowing that this is an interpretation by many individuals either at a professional, specialist or lay person level.

You should now be able to:

- Provide a definition of mental health
- Recognise comparators of physical and mental health
- List the 6 Health promoting and 4 health-demoting factors
- List the four life stressors and describe their impact upon the individual
- Recognise how this is further complicated by the custodial setting.
- Have an awareness of the issues of Stigma in mental health

Linked to: Custodial Care Standard: CC0018; 019; 030- 034; 036-037.
National Occupational Standards Links to Health: MHA1, MHD1.1

OBSERVATION

Module aim:

This module focuses upon recognising your observational skills and relating them to identifying factors, which affect and impact upon a person's mental health. This may relate to:

- Monitoring the custodial environment
- Observing an individual without significantly influencing their behaviour (gaining a 'true' picture)
- Identifying group dynamics through passive observation, and
- Bringing together visual (sight), auditory (sound) and olfactory (smells) cues to make an assessment of a situation.

Areas and Types of Observation

Custodial Environments and Structure

Custodial Environments in this context are taken as meaning police cells, the courts, custody vans, prisons and other custodial establishments.

These structures are designed to maintain control, safety and keep order. However, they can often have the effect of removing a degree of choice and often encourage over dependence.

People are brought into this environment generally under duress, against their will and in significant distress. In contrast, experienced custodial staff can easily become 'attuned' to their environment, quickly integrating into the cultural demands and expectancies of their workplace.

A counter to this is the strong possibility of staff becoming desensitised to this unique environment and the impact it may have upon those newly entering it or experiencing the custodial setting for the first time.

To an outside observer or an individual new to this environment, it often presents as a foreign, intimidating structure and environment. Upon first contact it is a situation likely to instil fear, confusion and anxiety to those encountering it and this should always be a consideration, particularly where there may be underlying and ongoing mental health problems

- **The Cell environment**

  Prison / police cells can be claustrophobic and restrictive. They have been designed to facilitate observation and as such, they reduce the opportunity for personal space and privacy. They tend to be quite impersonal and initially present a sterile, foreboding environment. Added to this, cells may be shared with individuals who are strangers and unknown, adding to the anxiety, distress and insecurity of the occupants.

  In a number of instances being placed in a cell may invoke past memories of distress associated with similar environments such as inpatient hospital care, 'local authority care' or when a persons liberty was restricted in other ways, e.g. by an abusive parent.

- **Regimes**

  Working and living within the custodial environment the 'Regime' is the order, routine, processes and procedures, to ensure the establishment runs smoothly and securely. Such a regime may by necessity, impose rigid requirements on all those existing within in it.

  Often, untoward incidents require a rapid and dramatic response (such as 'lock downs' and cell searches), which can prove distressing to those involved.

  These influencing factors and the information discussed are part of the everyday fabric for staff working within a custodial setting.

However you should always be conscious of its impact upon an individual's behaviour and response, pressured by the expectancy for individual compliance. This may be complicated further when mental health difficulties and distress are an underlying factor.

Exercise 5

Taking into account the environmental factors we have reviewed:

Reflect back to being a new employee and your first experience of entering the custodial environment.

Can you remember what feelings this aroused?

- How did you feel?
- Who gave you support?
- What prepared you for this?

Relating to your own experiences, look at those under your care and write down five factors that may affect them on entering the environment

1. _____

2. _____

3. _____

4. _____

5. _____

The next section looks at types of observation

Passive and Active Observation

Passive Observation

These are skills performed by custodial staff each day. They are expected to be continually aware of what is going on around them by observing their environment, picking up on things that are not part of the routine or are not 'quite right', either with individual or group behaviour or changes to the environment. For example, prior to a planned incident large numbers of prisoners retire to their cells.

Active observation

This is a more structured and 'pro-active' or 'conscious' form of observation. This is normally directed at individuals and how they are engaging with their environment and the people who impact upon it. Whether that be as part of a structured interview or as to observing that individual in their everyday routine over a set period of time.

Where risk has been identified, the active observation may be part of the strategy for keeping the individual safe, as in the Risk Assessment Process i.e. **ACCT (Assessment, Care in Custody & Teamwork) and the F2052SH**. Observations under both the ACCT and F2052SH systems should be thought of as interactions, that is involving supportive conversations, except at night when the person is asleep. Supporting interactions form part of an overall plan of care and are not a stand-alone intervention.

Sensory Cues

Visual:

These are cues that can be seen. For example, the appearance of the prisoner, actions and behaviours, activities taking part in the immediate area, light levels, colours and shades.

Auditory:

Auditory cues relate to sound (or an absence of it). Important in this area are warnings from others, tone of voice, background noise, verbal content and the way this is delivered. Changes to the environment, general noise levels: 'calm before the storm'.

Olfactory:

The sense of smell is very powerful in preparing and dictating our response to a particular situation. Personal body odour, personal environment (cell) have an impact upon how we engage with and manage individuals on a daily basis and in negative circumstances may discourage staff from engaging with the individual.

Of all the five senses (the others being taste and touch), the three mentioned above are most likely to be used in every interaction with individuals. They are brought together and can help us make an accurate assessment of both the individual and the situation. They are particularly useful in identifying environmentally triggered patterns of behaviour that may not be immediately apparent, either to the person being observed or those who interact with the person on a regular basis.

Basic Observation Markers

Within the custodial setting when observing individual behaviour it is sometimes difficult to define 'what we see'. Below are some specific characteristics of behaviour that you may use in describing what you see:

- **Appearance**
  Clothing and dress, is it appropriate? (e.g. well groomed, dishevelled, over or under dressed). Is it appropriate to the environment (the residential unit/cell, gymnasium) and the individuals' activities at the time?

- **Hygiene**
  Levels of cleanliness can range from not enough or too much. Does the individual shower; wash his/her clothes. Do they do this to excess? Is this an issue with the individual where cleanliness takes on an excessive importance within their daily life?

- **Mood**
  Within the expectancies of the individuals' current circumstances, are they presenting in an appropriate manner? Are they elated, exceedingly happy or are they presenting with feelings of being depressed that exceed expectancies within consideration of circumstances.

- **Eye contact**
  Good; fleeting; non-existent? Is the emotional expression suited to the situation and topic?

- **Thinking Process**
  - Rational and logical, is it in common with presenting behaviour?
  - Consistent. Are they continually changing their story?
  - Confused and disorientated. Do they know who they are, where they are and why they are there?

- **Speech & Language**
  Normal pace, very rapid, slow and ponderous, monosyllabic (answering in single words?) Is this appropriate for the individual's educational and maturity level?

- **Memory**
  Ability to recall short term or long-term events? Constantly asking questions, particularly in areas one would expect them to know i.e. day of the week.

- **Attention and concentration**
  Easily distracted, hopping from one idea to another. Unable to complete a task.

- **Ability to Interact**
  Communication and development of relationships with others. Isolation, meddling, and/or argumentative. Can they relate to and build friendships/acquaintances with others?

Exercise 6

A prisoner comes into your work environment for the first time

- List the key observation markers you would normally look for as they come under your management.

_____

_____

_____

- What observation skills would you use to identify these markers?

_____

_____

_____

You should now be able to:

- Describe elements within the custodial environment, which may have an effect on a person's mental health and distress
- List the three types of observational cues used in most interactions
- Describe at least six basic observational markers.

Linked to:
Custodial Care Standard: CC002; 018; 030
National Occupational Standards Links to Health: MHA1, MHA4

COMMUNICATION

Module aim:

- How communication can be affected within a stress-causing environment.
- To enable a greater awareness of the importance of effective communication
- To recognise barriers that may be present or arise to prevent this being achieved.
- Recognise effective use of space, body language and active listening.
- It will highlight good practice in relation to communicating with distressed, withdrawn or disturbed individuals.

Effective communication, observation and 'thinking on your feet' are qualities you will use every day within a custodial setting

You must be able to:

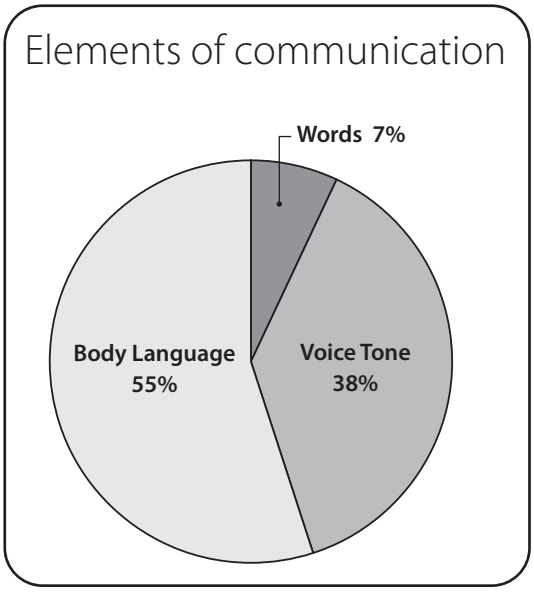
- Give clear instructions and check that they are followed.
- Conduct interviews.
- Deal with questions.
- Help with personal problems.
- Defuse potentially threatening situations.
- Resist attempts at intimidation or manipulation.
- Observe patterns and changes in offenders behaviour.
- Deal politely and professionally with members of the public.
- Be an effective part of a multi-disciplinary team.

These are some inter-personal skills (IPS) all custodial staff require.

Parts of Communication:

- Speaking
- Tone of voice
- Body language
- Watching
- Listening

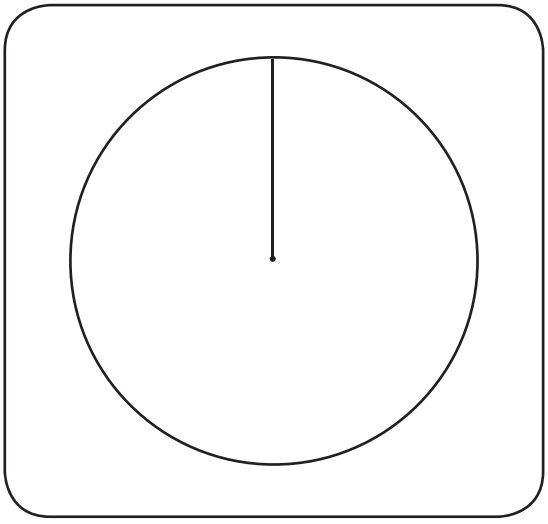
To communicate effectively you must be able to **speak clearly**, use appropriate **tone** and **body language**. Each of these elements contributes to effective communication, but try placing them in order of significance.



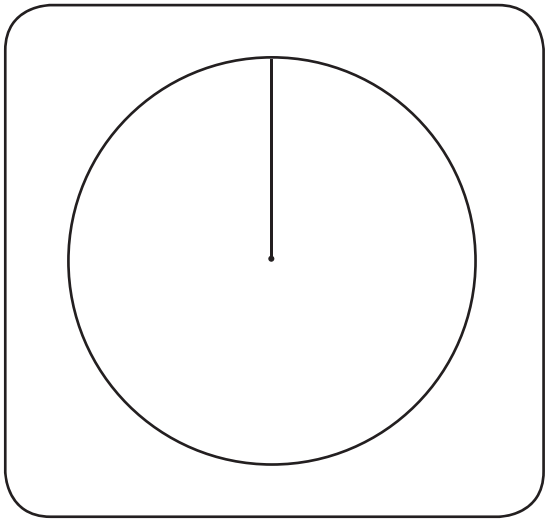
As seen in the diagram to the left the actual words used have only a minor impact upon what we are trying to convey, it is our physical presence and tone of voice that impacts most upon the person we are directing it at. Non verbal messages are the primary way that we communicate emotions.

Exercise 7

Person 1



Person 2



Using the blank diagrams above, take two people you know and using the elements of communication diagram, measure how they communicate, using the three elements, divide each diagram on a % basis:

1. Body Language
2. Voice Tone
3. Words

So it is vital to **listen and watch** when someone is talking to you.

Word

Word contributes just 7% towards getting your message across.

But language is powerful. Using critical, blaming, aggressive words can create a resistant and defensive attitude. But if you choose neutral words that normalise the situation you can begin to communicate effectively. The choice of words in any relationship makes a big difference to the people involved.

Degrees of formality

Most social interactions have a degree of formality – we use a different approach for royalty, senior managers, people we don't know, friends, family and children. These can range between.

Most formal **Formal** **Polite** **Informal** **Most informal**

Getting the degree of formality wrong can cause confusion or offence.

Words have two functions:

- Factual function (instructions, orders or information sharing).
- Emotional function (feelings, opinions or motives).

Choose your words with care and professionalism.

Tone

Around 38% of communication relies on tone, or how the voice is used. The use of appropriate tone and emphasis enables the receiver to effectively understand what is being sent to them.

Remember

When angry or excited, speech tends to speed up and get higher pitched.

When bored or depressed, speech tends to slow down and become monotone

When defensive, a person's speech is often abrupt

All these elements can be influenced by mental ill health and this always has to be taken into consideration

Non-Verbal Communication (NVC):

- NVC can be very powerful.
- It accounts for 55% of what is perceived and understood by others
- NVC means we are always communicating, whether we want to or not!!
- Communication is conveyed through facial expressions, as well as postures and gestures.

We use NVC a lot when communicating our emotions.

Facial Expressions

A face can light up with enthusiasm, energy and approval. It can also express confusion or boredom, and scowl with displeasure. The eyes are particularly expressive in showing joy, sadness, anger or confusion. However within mental health it is frequently common that facial expression does not always reflect the actual feelings or mood of the individual at the time.

Posture and Stance

Our body posture can create a feeling of warm openness or cold rejection. For example, when you face me, sitting quietly

with hands folded in the lap, a feeling of anticipation and interest is created. Arms crossed on your chest give a feeling of inflexibility. Gathering up your papers and reaching for your briefcase signals a desire to end the conversation. Within mental health body posture and its interpretation can be very subjective and whilst dealing with individuals with a perceived mental health problem you must always be conscious of personal space (see below) and aggressive stance.

Gestures

Gestures support communication by providing emphasis. Head nodding tends to reward and encourage and show active listening. Hand gestures are used to give illustrations of size and shape, pointing at objects.

People tend to indicate "I" with hand gestures toward themselves and "you " with hand gestures away from them selves. Again within mental health gestures that seem completely innocent to the user can be interpreted by the receiver as a negative or threatening action.

Personal Space

Personal space varies depending upon the relationship you have with the individual. Your own personal space is measured at 11/2 to 3 feet. Invasion of a person's personal space will increase anxiety. Where an individual is suffering from mental ill health these boundaries become distorted and have a greater significance to the individual.

Exercise 8

Now using your own experience, consider your work environment and the management of those under your care.

What factors do you think may affect personal space?

Write down 5 factors (environment), 5 factors (offender)

Which enhance or restrict personal space.

Environment	**Offender**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Listening Skills

Listening requires more than just hearing words. It requires a desire to understand, an attitude of respect and acceptance, and a willingness to open your mind and try to see things from someone else's point of view.

Verbal

Pay attention to the words and feelings that are being expressed.

Using reflective listening tools such as paraphrasing, reflecting, summarising and questions, to increase understanding of the message.

Non-verbal

Giving full physical attention to the speaker whilst being aware of their non-verbal messages.

Effective listeners avoid:

- Making judgements
- Interrupting to add their views
- Providing solutions or answers
- Asking leading and closed questions
- Letting their personal feelings get in the way.

Effective listening is about:

- Responding not necessarily solving
- Helping the other person to listen to themselves and find their own solutions
- Keeping calm and controlled

Levels of Listening

Ignoring

You are not consciously paying attention to what is being said.

You may hear some words but are not processing the information.

The non-verbal communication from a listener who is' ignoring' usually gives the game away, these include:

- Very little or no eye contact.
- Distracting actions such as looking out of the window

You may experience this action quite frequently when dealing with individuals with issues around mental health and will have to manage it to within the context it is presented.

Superficial Listening

'Going through the motions' is the most frequently used level of listening.

You may hear the words being said but only selectively process the information. You are more concerned with what your own reply will be once the speaker pauses. Your attention is not fully focused, some thoughts may be elsewhere 'It's nearly time for lunch, what shall I eat today'

The non-verbal communication may be convincing e.g. moderate eye contact, appropriate noises and nods of head.

An individual with mental health problems may appear to have reduced concentration levels and/or their attention may be distracted or divided. You should always be conscious of this possibility when they are interacting with others.

Content Level Listening

You are processing all the words rather than just hearing them. Sense is being made of the information. You need to listen at this level if you are to be effective in communicating. The non-verbal communication is far more convincing. And influential.

Empathic Listening

This is an active process to discern what a person is saying. It is a powerful tool for building relationships with the individuals under your charge.

By taking the time to listen, you show your commitment and give the message that they are people of value and worth. Empathic Listening is one of the best ways to strengthen trust and rapport with those in your care. Key elements in Empathic Listening include:

- Be non-judgemental.
- Give undivided attention.
- Listen carefully to what is said (focus on feelings, not just facts).
- Allow silence /time for reflection.
- Use statements to clarify messages.

When dealing with individuals' with ongoing or temporary mental health problems, applying these skills will assist you in building up any required trust. This may also enable the individual to feel more comfortable to be open and engaging.

The Importance of Consistency

If you send out different verbal and non-verbal messages at the same time, listeners may become confused. Inconsistency can also create a lack of trust.

When you send conflicting verbal and non-verbal information, the non-verbal information tends to be believed.

Consider the example of someone, through a clenched jaw, hard eyes and steely voice, telling you they are not angry. Which are you likely to believe, what you see or what you hear?

Exercise 9

Read the list of behaviours below and indicate by using arrows as to whether the impact upon communication will: increase (↑) /decrease (↓) /or stay the same (↔) when each of the behaviours is exhibited.

Behaviours	Increase	Decrease	Stay the Same
Quick or slow body movements			
Exasperated gestures			
Excessive fidgeting			
Staring silence			
Flashing or rolling eyes			
Smiling and receptive			
Arms crossed, legs crossed			
Slouching, hunching over			
Poor personal care			
Talkative and open posture			

Verbal Communication Barriers

Attacking Statements:

- Interrogating
- Criticising
- Blaming
- Shaming

Negative Messages:

- Moralising
- Preaching
- Diagnosing

Showing Power:

- Ordering
- Threatening
- Commanding

Other Barriers:

- Shouting
- Name Calling
- Refusal to Speak

Non-verbal Communication Barriers:

- Rolling eyes or avoiding eye contact
- Quick or slow body movements
- Closed posture, such as arms crossed
- Exasperated gestures
- Excessive fidgeting
- Staring silence
- Slouching, hunching over

Communication in an Interview Setting

A large part of the work Custodial staff perform is around gaining knowledge and information through interviewing individuals. Yet in the main, most staff develop these skills through observing others perform this task rather than practising themselves. This section will put those skills into a more structured format to enable you to carry out the process to achieve a more measured outcome.

When a person first comes into the custodial setting there is a requirement for a number of 1:1 interviews. This may be the only or best opportunity to engage with and carry out active observation on an individual and within that short period of time, gain enough knowledge to decide as to whether there is a requirement for further referral.

The interview structure:

1. Venue
2. Establish a Rapport
3. Consider Style of Questioning
4. Pick up Verbal Cues
5. Pick Up Non-Verbal Cues
6. Demonstrate Acceptance
7. Clarify Ambiguities
8. Recap Information.

Venue

When communicating effectively it is important to consider that the place you interview the individual offers a level of decency, respect and offers confidentiality.

Consider this: Would you like to have your appointment with your GP with the door open and the rest of the waiting room listening in?

Establishing Rapport

- Introduce yourself (use which ever name/title you feel most comfortable with)
- Ask what they would like to be called by e.g. formal, first name, and nickname
- Explain the purpose of the interview
- Indicate the length of time the process is likely to take
- What will be done with the information once you have finished?
- Explain the reason for taking notes.

Questioning Style

Open questioning: who; what; why and how. Reduce the possibility of the information channel closing down by allowing monosyllabic replies as in Yes & No. This can be avoided by not asking questions starting with 'can' or 'do'.

Pick Up Verbal Cues

Here you will look for:

- Statements of suicidal intent, 'I wont be here tomorrow'
- Statements that indicate hopelessness such as "it doesn't matter, nothing does".
- Talking in the third person as if there are 'others' in the room.

Pick Up Non-Verbal Cues

Here you will look for:

- Eye contact
- Body posture
- Attention span, are they able to concentrate on your questions
- Are they easily distracted?

Demonstrate Acceptance

The person you are interviewing may express a number of thoughts, emotions, feelings etc., which you may feel are/may be bizarre in nature, outside of normally expected responses and shock you as an interviewer. It is important to acknowledge these expressions as indicators of how that person is at the time, but to keep it within the context of the interview process.

Clarify Ambiguities

Ensure you understand everything the person is telling you. What your interpretation is of what they have said may not be theirs. Summarising will help clarify your understanding.

Summarise

This indicates that you have been listening to what the individual has been saying to you. Close off the interview with a summary of the information you have received. This is a good way of finishing the interview and keeping the process focussed on the end requirements.

This interviewing technique is used extensively as part of the process for measuring risk, particularly as part of the ACCT assessment process when identifying levels of self-harm behaviour and suicidal intent.

Exercise 10

Next time you interview an offender, consider using the structure specified above.

After the interview, write down what you thought was different about your approach and how you may have done things differently to further enhance the interview.

Summary

What is Effective Communication?

Remember that the whole point of language is as a means of two-way communication. You can transmit what you think is a clear message, but you have failed to communicate unless the listener understands it. By being aware of the factors that create problems for the listener, adapting your approach accordingly, and being patient, you will communicate more effectively and make your job easier

Effective Communication:

- **Is Two Way;**
- **Involves Active Listening;**
- **Reflects the Accountability of Speaker and Listener;**
- **Utilises Feedback;**
- **Is Free of Stress;**
- **Is Clear**

Cross culture communication

Many young people from ethnic minority groups brought up in Britain can use English well, but may choose not to.

Older generations may also be fluent English speakers but resent being spoken to in a slow, deliberate way and pretend not to understand.

Others may find their English deserts them in a stressful situation.

So don't jump to conclusions – adapt your approach to each new situation.

Imagine being confronted by a French police officer after a road traffic accident in France –this should give you some ideas about being helpful to others.

- Speak clearly, slowly and calmly
- Don't shout, it is intimidating
- If you have to repeat something, repeat it exactly, don't paraphrase.
- Use open questions rather than those expecting a Yes/No answer.

Try using "What is your son's name?" rather than "Is your son's name Rashid?"

Most people know "yes" and "no" and may say "yes" just to give you an answer.

Look for non-verbal signs of lack of understanding, like a fixed smile or a blank look.

Avoid jargon. This will be explained in more detail in module 5 (Referring On) where the importance of using Basic English in describing behaviour will be a significant part of the referral process.

Use simple words where there is a choice: 'end' instead of 'conclude', 'car' rather than 'vehicle' and 'before' rather than 'prior to the commencement of.

Keep your sentences short and simple

Use active rather than passive verbs e.g.

"The doctor will see you at ten o'clock."
not
"You will be seen by the doctor at ten o'clock."

Pictures or signs/mime can help someone understand what you are saying. If you need to leave a message it is better to leave a simple written note.

If you are dealing regularly with people from particular ethnic groups why not get a card prepared with the phrases you are most likely to use? Then you can try to say them yourself or just point to them.

You should now be able to:

- List the 5 elements of effective communication
- Recognise verbal and non-verbal cues in communication
- Be aware of and be able to apply effective listening skills
- Identify and list barriers to communication
- Apply Basic Interview skills and techniques in a structured format with expected outcomes.

Linked to:
Custodial Care Standard: CC002; 018; 019; 029; 030- 034; 036-037; 041
National Occupational Standards Links to Health: MHA1, MHA4

MANAGING BEHAVIOUR

Module aim:

From observing and recognising individuals in your care with identified mental health problems, this module aims:

- To provide basic skills in how to manage them appropriately
- To provide an awareness of different 'types' of behaviour, and how they can be affected by mental health, culture, and the environment
- To manage verbally and physically aggressive behaviour
- To manage individuals who are uncommunicative and/or in distress

Positive Strategies around Managing Offenders

Custodial staff deal, on a daily basis with individuals who challenge their position and present with behaviour that is intimidating and confrontational.

The person may be right or wrong but put aside your own feelings, stay un-emotive with the issues initially, this will enable you to maintain a position of control.

Listen carefully to what is being said and attempt to understand the view of the person.

Put yourself in the role of a 'third' person; arbitrate between yourself and the other participant in the discussion. Ask questions in order to find out exactly what the person means, i.e.

- What do those words mean?
- Why do you say that?
- How did I offend you?
- What did I do?
- When did I do it?

To create a situation of effective communication, whether the person is right or wrong, acknowledge their views and opinions. This approach will often calm the person and facilitate discussion that is more productive. It will create an atmosphere of collaboration and mutual respect. Take time to refer back to module 3 (Communication) and the skills described.

- You may be able to agree in principle and find an element of truth in what they say, or
- You can acknowledge that, based on their view of the situation, it is understandable that they are upset.

By now the person should be more settled. You will have re-established and resumed a calm and controlled environment and the way is prepared for feedback and negotiation.

Having taken control and calmed the situation you can express your views objectively, whilst acknowledging the differences in viewpoints. Base your statements on facts. Be constructive in any criticism and acknowledge their right to express their own feelings and opinions.

- Set limits and inform them of expected outcomes
- Inform them of expected response
- Maintain control
- Stay focussed
- Offer 'olive branch'.

Exercise 11

Think about types of behaviour you have encountered, or ones you have witnessed in which anger was present.

How can you be aware of what makes a specific individual angry?

Write down how you would normally respond, then consider the pointers discussed and consider whether you have used any of these in your experiences and if so did they work?

By recognising the main external or internal factors such as being in confinement or ongoing mental health problems, this understanding can assist in:

- Managing unreasonable behaviour
- Depersonalising situations
- Remaining objective and detached
- Recognise why this behaviour may be occurring

If we cannot rationally detach ourselves, we may become a factor of unreasonable behaviour.

Exercise 12

List the type of skills you display to effectively defuse an emotive situation?

Try to identify five skills you may have used or recognise.

1.

2.

3.

4.

5.

How do you combat emotional outbursts?

Compare your list with the pointers below. How many are the same or similar?

Below is a list of pointers to consider when dealing with situations where the individual is emotionally unstable:

- Adopt a non- aggressive approach
- Remain calm, professional and un-emotive
- Be aware of your own body language
- Be aware of your tone of voice
- Avoid being judgmental
- Call the individual by their name
- Try to get the individual to co-operate with you
- Make the individual aware of what could happen
- Do not talk aggressively
- Try to get the individual to think about what is going on
- Do not touch the individual
- Make the individual aware that you want to help

Exercise 13

How do custodial staff assist offenders to learn to manage their emotions?

Again consider your own skills and list some strategies you have used in addressing the question.

Recognising Emotional Instability and Its Impact

It is fair to say that it is impossible for staff to totally control the emotions of an individual in their care. However, staff being seen as good role models by being able to deal with their own emotions effectively may impact upon the behaviour of those under their care.

Those who come to the notice of the criminal justice system often have difficulty in controlling their impulses, behaviour and emotions. This has often been a factor leading to their initial arrest and then a period of imprisonment. Within prison this may contribute to incidents of self harm and violence.

It is critical that offenders learn that only they can manage their own emotions and that they must take responsibility for their own actions. It is important that you bear this in mind as we move through the next part of the module.

Strategy for Dealing with Prisoners' negatively expressed emotions

Being aware of individuals having identified 'Trigger Points' will be an advantage in managing and pre-empting periods of 'crisis':

- Staff recognise situations that are likely to arouse prisoners emotions/feelings
- Encourage the offender to recognise and avoid such situations whenever possible:
  - if you can't avoid a known problem/situation, be alert and ready
  - to intervene, reducing possibility of escalation
- Recognise when emotions are becoming unstable
- Intervene to maintain control of these emotions
- Consider your alternative options:
  - break the pattern with your own behaviour
  - Help the prisoner apply problem-solving skills
- Give an opportunity for the prisoner to reflect upon the incident
- Encourage healthy lifestyle and document unhealthy lifestyle developments.

Physical/Verbal Cues to Confronting Behaviour

Below are four indicators when an individual shows or expresses an increasing loss of control/calmness during an unstable situation:

1. Physiological Changes

- Change in colour (flushing or going pale)
- Apparent change in respiration (breathing fast)
- Sweating
- Dilation of pupils
- Shaking or trembling (of extremities, or of the whole body)
- Nervous tics, throbbing veins.

2. Choice of Words

- Increased use of swearing
- Direct or indirect statements of frustration (e.g. "This is really pissing me off", "You're not making any sense.")

3. Tone of Voice

- Raised voice
- Unnaturally 'controlled' voice
- Speaking through clenched teeth
- Long pauses, many sighs
- Change from normal tempo of speech (either much faster or slower).

4. Body Language

- Overall muscular tension
- Clenched fists, curled toes
- Clenched jaw
- Inappropriate eye contact (either refusal to make contact or excessive staring).

Some potential knock-on effects could be:

- Apathy and withdrawal

- Change in eating habits: loss of appetite or over eating
- Change in sleeping patterns: insomnia or non-stop sleep
- Continual depression
- Wide mood swings
- Giving things away
- Threats of suicide or a preoccupation with death
- Continual bouts of anger or paranoia

Exercise 14

What would you do if you noticed that an individual (colleague or offender) is not managing their emotions effectively?

Have you experienced this situation previously with this individual and if so how has this been managed?

Consider how this affected the staff/prisoners involved?

Using the information in this section consider how you may have been managed differently.

People are unconsciously affected by the behaviour of others. If a prisoner is angry and upset it is important that the member of staff dealing with that individual remains calm and attempts to deal with the situation in a calm and effective manner. It is important to remain calm and professional. As discussed within Module 3 (Communication) it is important to remain professional and emotionally uninvolved to increase the possibility towards a positive outcome.

Exercise 15

How would you demonstrate a calm and professional approach?

Compile a list of at least 5 factors that would contribute to your demonstration of the above:

1. _____

2. _____

3. _____

4. _____

5. _____

Below are some examples of appropriate management skills: compare these to the list you were asked to compile in the last exercise. Do they match the approach you would have taken?

- Exhibit a respect for the individual and
- An understanding of their circumstances
- 'Put yourself in their place'
- Your posture should be alert, but not tense
- Ensure direct eye contact
- Have your arms at your sides
- Put over that you are calm and unfazed
- Do not shout or yell
- Talk to the prisoner in a calm voice.

You should try to deal with this type of individual in a quick and effective manner. Your aim should be to control and manage the situation with the minimum of fuss reducing the possibility of negative outcomes.

We should always focus on the following areas:

- Tone of voice
- Choice of words
- Body language
- Mood of the individuals
- Time of day
- Underlying problem areas.

You should be aware of potential signs that can give you a clue as to what the problem is. The most important thing is that you remain focussed to your task and that is to defuse the situations without making matters worse.

Values, Standards and Norms

Our own cultural background and upbringing influence us, and it is from this that we set our own standards, develop our own values, and by which we usually measure others against. This can be recognised as our own value framework, the tool we measure both our own and others behaviours.

As individuals we are all influenced by prejudice within our everyday working lives. Prejudices are part of our make-up; they reflect our society and how in return it influences our thoughts and mindset.

As we develop we take on what are considered to be the cultural norms of our environment. We have a desire to 'fit in'. Whether that be an allegiance to your local football team or an association to your local political party. In doing so, we develop some level of prejudice against our perceived opponents.

Within context, this can be seen as 'healthy' and acceptable, that is, we have an insight and an awareness of our behaviour and its limited outcomes. When this awareness is not present is when our 'prejudices' become unacceptable and unhealthy.

Prejudices tend to be built upon emotions, with very little fact or information supporting the proffered theory and as long as we are conscious of this then we can manage our prejudices safely.

Reflecting upon this self-awareness and insight, you are also influenced by the moral and cultural standards in respect of your own community and its accepted 'norms'.

Therefore, it is important to understand the communities that the group/prisoners are taken from or have chosen to be separated from because of their actions.

These communities develop their own strategies for 'survival' where accepted 'norms' would be deemed immoral or criminal in the wider community. This can be recognised as an accepted sub-culture for their means of managing and surviving on a day-to-day basis.

The individual's background should always be acknowledged although the lifestyle should not be automatically accepted. This may be an opportunity for custodial staff to present themselves as a more acceptable role model without being judgemental of what had gone before.

Exercise 16

Study the list below and compare and consider both your own background and values with that of those under your care

- What types of community do the majority of your offenders come from?
- What is the sub-culture they base their values upon?
- How does this compare with your own?
- What are the accepted 'norms' in their community?
- How do they differ from your background?

Now write down a list of differences you may have identified based upon the questions asked.

There is always a requirement for a `consciousness' of cultural differences in the classical sense i.e. both in religious needs and differences and in racial needs and differences. Rastafarian, Islam and Christianity being examples of groups of individuals whose religious needs will differ both in how they practice and in the rituals required to achieve and apply this.

Chinese, East European and Afro-Caribbean are examples of minority races that you may commonly deal with on a day-to-day basis that may have specific needs above and beyond the norm. The use of language and the barriers identified, particularly where English is not a first language should be considered when interfacing and communicating with an individual where this has been recognised.

You should now be able to:

- recognise the main factors influencing:
  - conflict
  - emotional instability, and
  - volatility
- list six elements in enhancing a 'professional approach' to conflict
- be aware of and able to apply positive strategies in conflict
- Be aware of effective management skills in conflict.

Linked to:
Custodial Care Standard: CC002; 019; 029; 031- 034; 036-037.
National Occupational Standards Links to Health: MHA1, MHA4, MHA5, MHJ7.1

REFERRING 'ON'

Module aim:

This MODULE will provide you with guidelines on:

- **Who** to refer an individual to
- **When** to refer the individual
- **How** to ensure your referral has desired outcomes.

Who to and when to refer an individual is a dilemma many non-healthcare custodial staff often face. This module identifies the differing roles each professional within the health and social care services take, e.g. Mental Health In-reach services / psychiatrist, psychologist, CARATS, listener and other health care specialists. Others who may be of help are the Wing Listener, Suicide Prevention Co-ordinator or Chaplain.

This section also identifies good referral practice and suggests the information subset, which a referring agent may request from the officer / carer.

Who to Refer an Individual To

This will depend upon the structures within your own establishment and will vary from place to place. It will also depend on your own position and experience within the structure and the degree of urgency of the problem.

If you have concerns about a prisoner's mental health, it might be useful, in the first instance to discuss these with a colleague who also knows the prisoner. Obtaining their views will help you decide whether your observations are significant and may give pointers to further observation strategies.

You may also wish to obtain the views of others who have direct contact with the prisoner. Who else do you think might be able to comment?

- Pad mate
- Wing Listener
- Chaplain/faith advisor
- Probation worker/YOT worker
- Wing cleaner
- PEI
- Personal Officer
- Samaritans
- Psychologist

It is always worth sharing your concerns with the residential unit management team and asking them for advice on what to do. This should not be seen as passing the buck but as active sharing of information as we have already discussed.

If you feel that you need to refer the offender for the opinion of a mental health professional you should do so by the most appropriate route. In some prisons, all health referrals are 'triaged' (filtered) through wing based primary care staff and it may be that you should refer the offender to them. In some establishments the MHIRT (**Mental Health In-Reach Team**) are happy to take referrals from any member of staff but this can mean that you will not get a response as quickly.

The important thing is that you are aware of the **referral systems** in your prison and know **who** to refer to, **when** to do so and **how** to do so.

Exercise 17

What referral systems are used within your prison?

Write a list of services available to you within your work environment.

Can you identify a direct route for referral?

What are the contact details of each of these services?

The process of referral always involves some level of assessment and measurement of risk to be carried out. Within this process consideration has always to be made as to ensuring and maintaining safety of the individual. As well as managing the identified mental health issues, there may be a need for an alternative management pathway where issues of self-harm or suicidal intent are identified. Within the custodial setting this would trigger the **Risk Assessment process** to be activated ensuring identified levels for managing the risk and keeping the individual safe are put into place.

When to Refer an Individual

Again, the answer depends upon the circumstances. Much will depend upon your assessment of the severity of any mental health problems and the degree of risk posed to the individual or to others.

As is often the case, there is a balance to be struck between ensuring that a proper **assessment of mental health** is undertaken on individuals who give cause for concern and not diverting scarce resources unnecessarily.

Careful observation of the prisoner and recording of behaviour patterns will help you make up your mind on how urgent a referral is, as will sharing observations with other staff that have had contact with the individual.

If an individual is not thought to be at immediate risk to himself or others, it may be worth putting in place a period of **active observation** (Module 2 Observation) so that a much better record of behaviour can be made. In this case an informal discussion with the mental health team on what to look for and how to do this may be beneficial.

If you feel that an individual is an immediate or urgent risk, either due to issues around self-harm or underlying mental health problems, you should inform a senior member of staff and ensure that the offender is not left alone until a plan of care to keep the person safe is in place. In cases where risk is immediate and urgent, your priority must be to take action to ensure the offender and others are kept safe.. If your establishment does not have 24-hour health care cover, contact the Duty Governor or Duty Operational Officer and pass on your concerns as soon as possible.

How to Refer to Ensure Your Action Has the Required Outcomes

What do you feel that the purposes of referral are? What outcomes would you expect/want to see as a result of your referral?

The most important purpose of referral is to ensure that everything possible is done to prevent or reduce harm. This applies to both the individual being referred and to others who may be affected by their actions. In referring a person, you are asking for an opinion on what, if anything, is wrong with that person and advice on how they should be treated. In order to be able to provide an opinion or advice, the person being referred to will rely on a number of diagnostic factors. One of the most important of these, especially in mental health, is past history and observations.

When referring avoid using jargon or clinical terminology as this will not benefit the individual you have concerns about. Good practice centres on reporting the behaviour you see, not interpreting this behaviour!

i.e. not sleeping, waking up early, poor appetite, only eating a little, not engaging, spending long periods alone. This will be of much more benefit to the individual and to the 'specialist' being referred to rather than saying: I think he is depressed. Provide the Evidence.

Referral Skills Examples

Poor Practice:	**Good Practice**
'I've a fraggle that needs seeing.'	'I am concerned about an individual'
'This bloke is schitzo.'	'He is spending longer periods in his cell'.
'I have one who is depressed'	'they seem unusually withdrawn'
'we have one for the hospital.'	'She is staring into space for periods of time.'

To help get the required outcomes you seek, information passed on referral should include:

- Basic personal details (Name, Age, Prison Number etc.)

- Relevant offending history including offence and sentence
- Identified correct referral pathway
- Factors from formal risk assessments e.g. first night, cell sharing
- Personally observed behaviour causing concern, including frequency of events, levels of activity (over stimulated, agitated, aggressive, withdrawn, slowed down etc)
- Other reported behaviour – what, when, observed by whom
- Degree of concern you have – high, medium, low
- Immediacy of concerns – immediate, urgent, longer term.

Immediate or urgent referrals need not always be in writing but a written report should back up any verbal referral as soon as possible. This is not to make work but to ensure that you and others have a clear record of events should this need to be referred to in the future.

One outcome you might expect from your referral is feedback on what happened as a result and whether your concerns were justified. This will help you make judgements in future situations and assist in managing the person being referred. If you do not get feedback, contact the people referred to and ask for this, it is a legitimate expectation.

The individuals you manage on a day-to-day basis very rarely present with straightforward and uncomplicated problems that can be contained and resolved within the resources of a residential unit, without some support from other identified resources.

The individual's day-to-day problems that can be dealt with and managed as they are presented are likely to be custodial in nature and have risen as a result of being in prison.

The problems that need referral to healthcare are ones that are severe, interfere with the prisoner/trainee's ability to function normally in their everyday lives and/or lead to a risk of suicide or harm to self or others. It does not matter whether the problems are of recent origin or are long-standing.

List of Points of Referral and Defined Responsibilities

Primary Care Mental Health Teams

Normally, the first referral point in respect of mental health issues. It is the function of the team to carry out a further assessment and based upon the outcomes of this decide upon the need for further referral to the MHIRT.

MHIRT (Mental Health In-Reach Teams)

A cross discipline group of staff inclusive of mental health nurses, psychiatrists and social workers.

Prime responsibility: to manage and maintain individuals identified as suffering with acute and enduring mental illness.

Secondary Responsibility: To ensure continuum of care pre, post and during stay within a custodial setting, using an identified Care Programme Approach process that equates to management within the wider community.

C.A.R.A.Ts Team

To provide ongoing psychological support for individuals identified as having a current/past history of substance misuse and dependence. Working in partnership with the detoxification services both during and post-physical detoxifications, as well as working with individuals who choose to self manage their dependence.

Suicide Prevention Co-ordinator (SPC)

To oversee and co-ordinate the process of risk identification and management, in respect of self-harm behaviour and suicidal intent. Ensuring that when each individual risk is identified a process of individual safeguards; risk management and reduction

is activated by use of the ACCT process. You might contact your SPC if you wanted advice on how to manage an offender who you believe to be at risk of suicide or self harm.

You should now have an understanding of:

- how to refer to the correct agency, providing the correct information, achieving the required outcome
- the local resources available to you and how to access them
- the roles of specialist teams within your establishment and how they can be accessed and utilised in assisting you.

Linked to: National Occupational Standards Links to Health: MHA1, MHD1.2

GLOSSARY OF TERMS

Acute

Acute, in medicine, refers to an intense illness or affliction of abrupt onset.

Ambiguity

An identified uncertainty, things are unable to be seen clearly.

Anxiety

Anxiety is provoked by fear or apprehension and also results from a tension caused by conflicting ideas or motivations. Anxiety manifests through mental and somatic symptoms such as palpitations, dizziness, hyperventilation, and faintness.

Autonomy

Self-management and freedom of action

Bigotry

Not being able to tolerate the views of other people.

Crack

A very strong concentrated form of cocaine that is highly addictive

Cocaine

Used in medicine as a local anaesthetic or illegally as a stimulant substance

Cultural Differences

The recognised differences in customs and accepted 'norms' across different societies.

Custodial Staff

Any person working within an environment that requires managing individuals or groups of people within a confined and secure setting to maintain the safety of those individuals or the general public

Health Professional

Any person who has attained a level of competency that is academically recognised that enables them to deliver care within a health setting.

Hypomania

A mild degree of Mania presented as an elated mood that leads to faulty judgement and lacking the usual social restraints.

Learning Disabilities

Learning Disabilities occur when the individuals reading, math, or writing skills are substantially below that expected for age, schooling, and level of intelligence. Individuals with learning disabilities may become frustrated with their performance they may feel like failures they may develop behavioural problems. Special testing is always required to make the diagnosis of a learning disorder and to develop appropriate remedial interventions. Learning disorders should be identified as early as possible during school years.

Listener

A prisoner who has been trained by the 'Samaritan' organisation to provide a sounding board for other prisoners at times of crisis

Mania

An affective disorder characterised by intense euphoria, overactivity and loss of insight

Mental Health Act (1983)

Is the legislation that governs the compulsory admission and treatment of people with mental health problems. The Act was passed in 1983 and is currently under review. Please note that this act only applies to England and Wales. Other parts of the UK have their own legislation. The majority of patients will be admitted to hospital as informal patients, which means that they have voluntarily agreed to go. However, compulsory admission may be necessary when someone has such severe problems that they are a risk to their own health or the health or safety of other people, and they refuse to go into hospital. Admission can be arranged therefore under one of the following sections of the 1983 Mental Health Act and the person is detained 'on section' (or 'sectioned').

Mental Health

How a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions

Mental Illness

A disorder of one or more functions of the mind (such as emotion, perception, memory, or thought) which causes distress to the individual or others.

Paraphrasing

Express the meaning of. Give your interpretation of.

Pathway

Pathway, in terms of ill health and 'Care' is an identified 'route' that ensures individuals access appropriate care by the quickest and most appropriate way.

PEI (Physical Education Instructor)

Member of prison staff who manages physical therapy within prison

Present (To)

In terms of ill health it is the 'picture' of signs and symptoms seen on initial engagement.

Probation Worker

A person who supervises offenders, primarily upon the release from prison on licence but increasingly at the point of arrest and their 'offender pathway'

Prognosis

In terms of ill health it is the 'measure' of expected recovery from illness.

Psychiatrist

A medically qualified physician who specialises in the study and treatment of mental disorders

Psychologist (Clinical)

A person trained in the study of the mind who can assess and treat by use of certain therapies

Racism

The belief that each race has certain qualities and abilities giving rise to the belief that some races are better than others.

Samaritan

A member of an organisation who counsels those in distress either by phone or in person

Speed

A slang word used to describe amphetamine, a substance used as a stimulant

Suicidal Tendencies

A desire to take ones own life as a result of a fragile state of mind or as a habitual response to perceived adverse circumstances.

YOT (Youth Offending Team) Worker

A member of a team of multi-agency staff providing a service for the management of Young Offenders within the community.

REFERENCES.

Useful Internet Sites:

www.nta.nhs.uk

www.nacro.org.uk

www.ohcs.co.uk

www.youth-justice-board.gov.uk

www.youth-justice-trust.org.uk

www.mentalhealth.org.uk

www.bournemouth.ac.uk

Useful Organisations:

- MIND
- The Department of Health
- NIMHE
- NACRO
- Centre for Criminal Justice Policy and Research
- The Department of Prison Health
- Health and Social Care Advisory Service

Further References:

- The Future Organisation of Prison Health Care. DoH 1999
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- The Health and Care of mentally Disorder Offenders, 2003, The Centre for Reviews and Dissemination of Articles, York University.
- The mental Health Act 1983. www.direct.gov.uk
- Ironbar & Harper. The Journal of Psychosocial Nursing (1989)
- Gunn. J. Mentally Disturbed Prisoners. London The Home Office (1991)
- HMCIP. Suicide & Self-Harm in Prisons in England & Wales. London The Home Office (1991)

Notes

Notes

Notes

EVALUATION

The workbook that you have recently completed aims to provide you with an awareness of mental health. This evaluation sheet will help us to continually update the material and ensure that it meets the needs of its target audience.

Please take a few minutes to complete the questionnaire and return it to your Regional Mental Health Lead or Training Manager.

Establishment	Grade

	Please circle					
	Poor					*Excellent*
Layout						
Ease of use	1	2	3	4	5	6
Readability	1	2	3	4	5	6
Information						
Usefulness	1	2	3	4	5	6
Accuracy	1	2	3	4	5	6
Workplace specific	1	2	3	4	5	6
Exercises	1	2	3	4	5	6

Please use this section to make any comments regarding this workbook or Mental Health Training in general.

Many thanks for your help in ensuring this product is 'fit for purpose'. If you would like to be contacted further regarding MHAT then please add you details below.

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