***Instructor Note:*** *This curriculum has been created as a minimum standard of training to be provided for jail staff. The instructor may supplement this curriculum as they desire; however, course material being removed is not authorized.*

# MENTAL HEALTH

## **5.1.0** **Unit Goal:** Summarize mental impairments and effective responses and the impact of individuals with mental impairments within the jail system.

A. An increasing number of incarcerated persons today have a documented diagnosis associated with a mental impairment. Jails have become homes to thousands of inmates who have mental impairments resulting in more severe symptoms and more disruptive behavior. Incarcerated persons, even those that do not have a mental illness, experience significant stress in the jail environment to include: separation from family and friends, lack of privacy, fear of assault, and boredom. These stressors are compounded for a person with a mental illness, often overwhelming the limited coping skills they do have, resulting in functional deterioration.

B. With the decrease in inpatient psychiatric beds and decline in the availability of community mental health services, people with serious mental illnesses frequently go without the treatment and services. When someone experiences a psychiatric crisis, or acts out as a result of symptoms of their illness, often police are the first-line responders, and jails and prisons are increasingly used to house and treat these individuals.

## **5.1.1 Learning Objective:** Define the term “Mental Health.”

1. Mental health is defined as: a person’s mental health condition with regard to their psychological and emotional well-being.
2. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.

Source: <https://www.mentalhealth.gov/basics/what-is-mental-health/>

## **5.1.2** **Learning Objective:** Define the term “Mental Illness.”

1. An illness, disease, or condition that either substantially impacts a person’s thought, perception of reality, emotional process or judgment, or grossly impairs a person’s behavior, as manifested by recent disturbance behavior.
2. Mental illness means an illness, disease, or condition, other than epilepsy, dementia, substance abuse, or intellectual disability, that:
   1. Substantially impairs a person's thought, perception of reality, emotional process, or judgment; or
   2. Grossly impairs behavior as demonstrated by recent disturbed behavior.

Source: [http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.571.htm#571.003](http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.571.htm)

## **5.1.3 Learning Objective:** List five prominent categories of mental illness.

Five Prominent Categories:

1. Mood Disorders
2. Schizophrenia/Psychotic Disorders
3. Dementias
4. Anxiety Disorders
5. Eating Disorders

## **5.1.4 Learning Objective:** Define a mood disorder.

A psychological disorder characterized by the elevation or lowering of a person's mood, such as depression or bipolar disorder.

## **5.1.5** **Learning Objective:** Identify prevalent behaviors associated with the two most common mood disorders encountered by jailers.

1. The two most common mood disorders encountered by jailers are:
   1. Depression
   2. Bi-Polar Disorder
2. Depression:
   1. Depression is a common, widespread disorder.
   2. Depression is a natural reaction to trauma, loss, death, or change.
   3. Major depression is not just a bad mood or feeling “blue,” but a disorder that affects thinking and behavior not caused by any other physical or mental disorder.
   4. A major depressive syndrome is defined as a depressed mood or loss of interest of at least two weeks duration accompanied by symptoms such as weight loss/gain and difficulty concentrating. Five or more symptoms are generally present during the same two-week period and are represented by a change from previous functioning. Depressed mood or loss of interest must also be included as a symptom.
   5. Other symptoms of depression:
      1. Prolonged feelings of hopelessness or excessive guilt
      2. Loss of interest in usual activities
      3. Difficulty concentrating or making decisions
      4. Low energy/fatigue
      5. Changes in activity level
      6. An inability to enjoy usual activities
      7. Changes in eating habits leading to weight gain or loss
      8. Changes in sleeping habits (sleeping more or less; an inability to fall asleep, or waking up early in the morning and not being able to go back to sleep).
   6. Depressive Disorders (Including Major Depressive Disorder):
      1. Depressive disorders are among the most common mental health disorders in the United States. They are characterized by a sad, hopeless, empty, or irritable mood, and somatic and cognitive changes that significantly interfere with daily life. Major Depressive Disorder (MDD) is defined as having a depressed mood for most of the day and a marked loss of interest or pleasure, among other symptoms present nearly every day for at least a two-week period. Suicidal thoughts or plans can occur during an episode of major depression, which can require immediate attention.
      2. MDD is thought to have many possible causes, including genetic, biological, and environmental factors. Adverse childhood experiences and stressful life experiences are known to contribute to risk for MDD. In addition, those with closely related family members (for example, parents or siblings) who are diagnosed with the disorder are at increased risk.
   7. Statistics:

6.6% of adults aged 18 or older had a major depressive episode (MDE) in 2014.

***Instructor Note:*** *It is the instructor’s responsibility to update statistics using the following source before presenting course material:* [*https://www.samhsa.gov/disorders/mental*](https://www.samhsa.gov/disorders/mental)

1. Bipolar Disorder:
2. A mental illness involving mania (an intense enthusiasm) and depression
3. Mania Phase may include:
   * 1. Abnormally high, expansive or irritated mood
     2. Inflated self-esteem
     3. Decreased need for sleep
     4. More talkative than usual
     5. Flight of ideas or feeling of thoughts racing
     6. Excessive risk-taking
4. Depressive Phase may include:
   1. Prolonged feelings of sadness or hopelessness
   2. Feelings of guilt and worthlessness
   3. Difficulty concentrating or deciding
   4. Lack of interest
   5. Low energy
   6. Changes in activity level
      1. Inability to enjoy usual activities
      2. Fatigue
5. An individual may quickly swing from the manic phase to the depressed stage.
6. An individual cannot maintain the level of activity normally associated with mania for a long period of time.

## **5.1.6 Learning Objective:** Define schizophrenia.

Schizophrenia is a brain disorder that impacts the way a person thinks (often described as a “thought disorder”), and is characterized by a range of cognitive, behavioral, and emotional experiences that can include: delusions, hallucinations, disorganized thinking, and grossly disorganized or abnormal motor behavior.

## **5.1.7 Learning Objective:** Identify the characteristics of schizophrenia.

A. The defining characteristic of schizophrenia and other psychotic disorders is abnormalities in one or more of five domains: delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms, which include diminished emotional expression and a decrease in the ability to engage in self-initiated activities.

1. These symptoms are chronic and severe, significantly impairing occupational and social functioning.

2. The lifetime prevalence of schizophrenia is estimated to be about 1% of the population. Childhood-onset schizophrenia (defined as onset before age 13) is much rarer, affecting approximately 0.01% of children. Symptoms of schizophrenia typically manifest between the ages of 16 and 30.

3. People with schizophrenia can experience what are termed positive or negative symptoms.

a. Positive symptoms are psychotic behaviors including:

1) Delusions of false and persistent beliefs that are not part of the individual’s culture;

2) For example, people with schizophrenia may believe that their thoughts are being broadcast on the radio.

3) Hallucinations that include hearing, seeing, smelling, or feeling things, that others cannot;

4) Most commonly, people with the disorder hear voices that talk to them or order them to do things.

5) Disorganized speech that involves difficulty organizing thoughts, thought-blocking, and making up nonsensical words; and

6) Disorganized or catatonic behavior.

b. Negative symptoms may include:

1) Flat affect:

a) Decreased emotional expressiveness

b) Diminished facial expression

c) Apathetic appearance

2) Disillusionment with daily life;

3) Isolating behavior

4) Lack of motivation

5) Infrequent speaking, even when forced to interact

4. As with other forms of serious mental illness, schizophrenia is related to homelessness, involvement with the criminal justice system, and other negative outcomes.

B. Role Play scenarios are available in the Appendix

Source: <https://www.samhsa.gov/disorders/mental>

## **5.1.8 Learning Objective:** Define dementia.

Dementia is an umbrella term used to describe a decline in memory or brain function that impacts an individual's daily life. This is different from the normal decrease in short-term memory most people experience as they age. Dementia is caused by changes in the brain which impact cognitive function, and it can be associated with a number of types of dementia many of us are familiar with such as Alzheimer's, Parkinson's, and Huntington's disease.

Source: <https://www.dementia.org/what-is-dementia>

## **5.1.9 Learning Objective:** Identify the symptoms of dementia.

1. Symptoms
   1. Memory Problems – Memory problems can relate to recent memory or memories of the past.
   2. Confabulation – Some people, who do not remember, make up facts to cover lack of memory. “Lying” is not done on purpose but is a part of the mental illness.
   3. Impaired Thinking – The person may be unable to complete simple tasks like dialing a phone or reading simple signs.
   4. Impaired Judgment – The person cannot properly evaluate the propriety of actions, and so, may act in socially inappropriate ways such as grabbing people, making off-color comments, urinating in the corner of a room.
2. When addressing symptoms in jail treat the individual as you would with any disability. Their inability to remember or follow directions is not intentional.

Source: Kentucky Department for Behavioral Health

## **5.1.10 Learning Objective:** Define anxiety disorders.

Anxiety disorders are a group of mental disturbances characterized by anxiety as a central or core symptom. Although anxiety is a commonplace experience, not everyone who experiences it has an anxiety disorder. Anxiety is associated with a wide range of physical illnesses, medication side effects, and other psychiatric disorders.

Source: <http://medical-dictionary.thefreedictionary.com/Anxiety+Disorders>

## **5.1.11 Learning Objective:** Identify the characteristics of anxiety disorders.

1. Anxiety disorders are characterized by excessive fear or anxiety that is difficult to control and negatively and substantially impacts daily functioning. Fear refers to the emotional response to a real or perceived threat while anxiety is the anticipation of a future threat. These disorders can range from specific fears (called phobias), such as the fear of flying or public speaking, to more generalized feelings of worry and tension. Anxiety disorders typically develop in childhood and persist to adulthood. Specific anxiety disorders include generalized anxiety disorder (GAD), panic disorder, separation anxiety disorder, and social anxiety disorder (social phobia).
2. Evidence suggests that many anxiety disorders may be caused by a combination of genetics, biology, and environmental factors. Adverse childhood experiences may also contribute to risk for developing anxiety disorders.

Source: <https://www.samhsa.gov/disorders/mental>

## **5.1.12 Learning Objective:** Define eating disorders.

Eating disorders are serious conditions related to persistent eating behaviors that negatively impact your health, your emotions, and your ability to function in important areas of life.

## **5.1.13 Learning Objective:** Identify common eating disorders.

1. The most common eating disorders are:
   1. Anorexia nervosa
   2. Bulimia nervosa
   3. Binge-eating disorder
2. Although eating disorders are classified under the five prominent categories of mental illness this form of mental illness has not significantly impacted jail populations as severely as the other four have.

## **5.1.14 Learning Objective:** Define the term substance use disorders /co-occurring disorders.

Substance Use Disorders **-** Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Source: <https://www.samhsa.gov/disorders/substance-use>

1. Co-occurring Disorders **-** The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. Co-occurring disorders were previously referred to as dual diagnoses.
2. According to SAMHSA’s [2014 National Survey on Drug Use and Health (NSDUH)](https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf), approximately 7.9 million adults in the United States had co-occurring disorders in 2014.
   1. People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated.
   2. The consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.

***Instructor Note:*** *It is the instructor’s responsibility to update statistics using the following source before presenting course material:* [*https://www.samhsa.gov/disorders/co-occurring*](https://www.samhsa.gov/disorders/co-occurring)

## **5.1.15 Learning Objective:** List the symptoms of substance withdrawal.

1. Emotional Withdrawal Symptoms
   * 1. Anxiety
     2. Restlessness
     3. Irritability
     4. Insomnia
     5. Headaches
     6. Poor concentration
     7. Depression
     8. Social isolation
2. Physical Withdrawal Symptoms
   * 1. Sweating
     2. Racing Heart
     3. Palpitations
     4. Muscle Tension
     5. Tightness in the Chest
     6. Difficulty Breathing
     7. Tremor
     8. Nausea, Vomiting, diarrhea

## **5.1.16 Learning Objective:** List the symptoms of substance withdrawal and associated risk factors related to substance withdrawal.

Alcohol and tranquilizers produce the most dangerous physical withdrawal. Suddenly stopping alcohol or tranquilizers can lead to seizures, strokes, or heart attacks in high risk patients. A medically supervised detoxification can minimize withdrawal symptoms and reduce the risk of dangerous complications. Some of the dangerous symptoms of alcohol and tranquillizer withdrawal are:

1. Grand mal seizures
2. Heart attacks
3. Strokes
4. Hallucinations
5. Delirium tremens (DTs)

Source: <https://www.addictionsandrecovery.org/withdrawal.htm>

## **5.1.17 Learning Objective:** Define psychosis.

Psychosis is an illness involving a distortion of reality that may be accompanied by delusions and/or hallucinations. These are most commonly seen in persons with schizophrenia, bipolar disorder, severe depression, or drug induced disorders. Physical circumstances can also induce a psychotic state. Potential conditions include: organic brain disorders (brain injury or infections to the brain), electrolyte disorder, pain syndromes, drug withdrawal, and closed head injuries.

Source: <https://medical-dictionary.thefreedictionary.com/psychosis>

## **5.1.18 Learning Objective:** Identify the two most common experiences related to psychosis.

* 1. Hallucinations are seeing, hearing, or feeling things that aren’t there, such as the following:
     1. Hearing voices (auditory hallucinations)
     2. Strange sensations or unexplainable feelings
     3. Seeing glimpses of objects or people that are not there; or distortions
  2. Delusions are strong beliefs that are not consistent with the person’s culture, are unlikely to be true and may seem irrational to others, such as the following:
     1. Believing external forces are controlling thoughts, feelings and behaviors
     2. Believing that trivial remarks, events, or objects have personal meaning or significance
     3. Thinking you have special powers, are on a special mission, or even that you are God.
     4. They are not being uncooperative; they are simply disconnected and unable to focus because of the noise in their heads. Coercive directives will not work and will only increase the confusion and distress. Simple directions, reassurance that they are in a safe place and compassion will always work better than coercion.

For individuals experiencing delusions and hallucinations, these experiences are real. There is poor processing of information and illogical thinking that can result in disorganized and rambling speech and/or delusions. It is not uncommon for a person hearing voices to hear two or more at a time. If you approach the person and start yelling at him, you are only adding to his confusion. Imagine having two or three people shouting at you all at once while an officer is trying to give you directions**.** This could cause the person to experience the fight or flight sensation.

***Instructor Note:*** *Discuss the issue of “fight or flight”*

See more at: [http://nami.org/earlypsychosis#sthash.FCeZMWOd.dpuf](http://nami.org/earlypsychosis)

Source: <http://nami.org/earlypsychosis>

Source: Kentucky Department for Behavioral Health

## **5.1.19 Learning Objective:** Identify characteristics of a person in psychosis.

A. Behavioral characteristics of persons in psychosis:

1. Inappropriate or bizarre attire

2. Body movements are lethargic or sluggish

3. Impulsive or repetitious body movements

4. Responding to hallucinations

5. Causing injury to self

6. Home environment:

a. Strange decorations (e.g., aluminum on windows)

b. Pictures turned over

c. Waste matter/trash on floors and walls (hoarding)

7. Unusual attachment to childish objects or toys

B. Emotional characteristics of persons in psychosis:

1. Lack of emotional response

2. Extreme or inappropriate sadness

3. Inappropriate emotional reactions

## **5.1.20 Learning Objective:** Define excited delirium.

A serious and potentially deadly medical condition involving psychotic behavior, elevated temperature, and an extreme fight-or-flight response by the nervous system.

Source: <https://leb.fbi.gov/2014/july/excited-delirium-and-the-dual-response-preventing-in-custody-deaths>

## **5.1.21 Learning Objective:** Identify the symptoms of excited delirium.

1. Aggressive, threatening, or combative behavior which gets worse when challenged or injured
2. Superhuman strength
3. Insensitivity to pain
4. Pressured, loud, or incoherent speech
5. Sweating or continuing to sweat after physical exertion has ceased
6. Dilated pupils / less reactive to light
7. Rapid breathing
8. High body temperature (105–113 degrees F.) - Subject will often disrobe due to profuse sweating and high body temperature.

## **5.1.22 Learning Objective:** Identify appropriate responses to excited delirium.

1. Notify Medical Staff - rapid chemical sedation can be lifesaving.
2. Remove physical restraints when feasible.
3. When using restraints, monitor the subject for positional asphyxiation.

Source: <http://mentalhealthdaily.com/2015/04/22/excited-delirium-syndrome-causes-symptoms-treatment/>

## **5.1.23 Learning Objective:** Define personality disorder.

A deeply ingrained, inflexible pattern of relating, perceiving, and thinking serious enough to cause distress or impaired functioning is a personality disorder. Personality disorders are usually recognizable by adolescence or earlier, continuing throughout adulthood, and become less obvious throughout middle age.

Source: <http://www.mentalhealthamerica.net/conditions/personality-disorder>

## **5.1.24 Learning Objective:** Identify the three most common personality disorders.

1. Paranoid:
   1. Tendency to interpret the actions of others as deliberately threatening or demeaning
   2. Foresee being in position to be used or harmed by others
   3. Perceive dismissive behavior from other people
2. Antisocial:
   1. Most commonly recognized in males
   2. A pattern of irresponsible and antisocial behavior diagnosed at or after age 18
   3. May have one or more of the following:
      1. History of truancy as a child or adolescent
      2. Starting fights
      3. Using weapons
      4. Physically abusing animals or other people
      5. Deliberately destroying others’ property
      6. Lying
      7. Stealing
      8. Other illegal behavior
      9. Unwilling to conform to society’s expectations of family and work
3. Borderline:
   1. Most commonly recognized in females
   2. May have one or more of the following:
      1. Unstable and intense personal relationships
      2. Impulsiveness with relationships, spending, food, drugs, and sex
      3. Intense anger or lack of control of anger
      4. Recurrent suicidal threats
      5. Chronic feelings of emptiness or boredom
      6. Feelings of abandonment

## **5.1.25 Learning Objective:** Identify the characteristics of personality disorders.

Those who struggle with a personality disorder have great difficulty dealing with other people.

* + 1. Tendencies may include being:
       1. Inflexible
       2. Rigid
       3. Unable to respond to the changes and demands of life
    2. Although they feel their behavior patterns are “normal” or “right,” people with personality disorders tend to have a narrow view of the world and find it difficult to participate in social activities.
    3. People with personality disorders usually will not seek treatment because they don’t think they have a problem.
    4. They may end up in the criminal justice system because their disorder may lead them to break laws and come to the attention of law enforcement (i.e., by theft, hot-check writing, fraud, etc.).
    5. They may use alcohol and illegal substances as a form of self-medication, due to the stress and the consequences of their behaviors. They often need treatment for chemical dependency or depression.

## **5.1.26 Learning Objective:** Define intellectual and developmental disorders and distinguish major differences between mental illness and intellectual and developmental disabilities.

1. Intellectual disability means significantly sub-average general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.
2. Developmental disability means a severe, chronic disability that:
   1. Is attributable to a mental or physical impairment or a combination of physical and mental impairments;
   2. Is manifested before the person reaches 22 years of age;
   3. Is likely to continue indefinitely; and
   4. Results in substantial functional limitations to areas of major life activities such as a lack of capacity for independent living.

Source: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm>

Source: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.591.htm#591.003>

## **5.1.27 Learning Objective:** Identify the characteristics associated with intellectual and developmental disorders.

A. Speech / Language

1. Obvious speech defects

2. Limited response or understanding

3. Inattentiveness

4. Vocabulary or grammatical skills lacking

5. Difficulty describing facts in detail

B. Social Behavior

1. Adult associating with children or early adolescents

2. Eager to please

3. Ignorance of personal space

4. Non-age appropriate behavior

5. Easily influenced by others

6. Easily frustrated or aggressive in response to direct questioning

## **5.1.28 Learning Objective:** Identify the differences between mental illness and intellectual and developmental disabilities.

1. Mental illness is unrelated to intelligence, while intellectual disabilities are associated with below-average intellectual functioning.
2. Mental illness develops at any point in one’s life, while developmental disability occurs before the age of 22.
3. There is no cure for mental illness, but medications can control symptoms. Intellectual disability involves permanent intellectual impairment. No medications can help.
4. Behavior is less predictable with individual with mental illness, while a person with intellectual and/or developmental disability behavior is consistent to a very specific functional level.

## **5.1.29 Learning Objective:** Define trauma.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

Source: SAMHSA

## **5.1.30 Learning Objective:** Define Post-Traumatic Stress Disorder (PTSD).

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault.

Source: <https://psychiatry.org/patients-families/ptsd/what-is-ptsd>

## **5.1.31 Learning Objective:** Identify causes of Post-Traumatic Stress Disorder (PTSD).

PTSD can occur after a traumatic event. A traumatic event is something terrible and scary that is seen, heard, and/or experienced, like:

1. Combat exposure
2. Child sexual or physical abuse
3. Terrorist attack
4. Sexual or physical assault
5. Serious accidents, like a car wreck
6. Natural disasters, like a fire, tornado, hurricane, flood, or earthquake

## **5.1.32 Learning Objective:** Identify symptoms of Post-Traumatic Stress Disorder (PTSD).

1. Behavioral symptoms:
   * + 1. Intrusive memories (Example: Being reminded of traumatic event by an everyday experience which may change how an individual reacts to the situation.)
       2. Avoiding reminders
       3. Trouble concentrating
       4. Emotional outbursts
       5. Hypervigilance
       6. Flashbacks
       7. Loss of interest in hobbies
       8. Withdrawal from others
       9. Reckless or self-destructive behavior
       10. Increased self-medication
2. Emotional Symptoms:
   * + 1. Anger
       2. Irritability
       3. Sadness
       4. Anxiety
       5. Hopelessness
       6. Guilt
3. Social Symptoms:
   * + 1. Becoming withdrawn, detached, or disconnected
       2. Loss of desire for intimacy, closeness
       3. Mistrust
       4. Over-controlling/overprotective behavior
       5. Argumentative
       6. Family violence may result

## **5.1.33 Learning** **Objective:** Identify triggers of Post-Traumatic Stress Disorder (PTSD).

1. High levels of stress may cause a breakdown in information processing, leading memories to be stored as physical or sensory cues.
2. Experiences associated with the original event(s) (e.g. emotions, smells, sounds, humidity, visual images, taste, people/objects that were present, etc.) may have the power to evoke memories of the event.

***Instructor Note:*** *In the most extreme cases, triggers can cause a person to have a “flashback” of the event. That is, they lose touch with their current environment and feel as if they were back in the traumatic situation (e.g., back in Vietnam, Iraq or Afghanistan). What could be triggers for someone? Seeing an empty box or broken-down vehicle near the roadway, smells of gasoline, police responses such as tactical deployments, etc.*

## **5.1.34 Learning Objective:** Define Traumatic Brain Injury (TBI).

TBI is a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

* 1. The severity of injury may range from a mild concussion to severe closed or open head injury.
  2. The injury may not be reported or diagnosed.
  3. TBI symptoms may not appear for months or years.

***Instructor Note:*** *A TBI can result in short- or long-term problems with functioning (e.g., daily activities, social functioning, work/school, etc.).*

## **5.1.35 Learning Objective:** Recognize and identify signs of Traumatic Brain Injury (TBI).

1. The most common Traumatic Brain Injury is a frontal lobe (front of head) injury, which may impact:
   1. Initiation
   2. Problem solving
   3. Judgment
   4. Inhibition of behavior
   5. Planning/anticipation
   6. Self-monitoring
   7. Motor planning
   8. Personality/emotions
   9. Awareness of abilities/limitations
   10. Organization
   11. Attention/concentration
   12. Mental flexibility
   13. Speaking (expressive language)
2. Behavioral symptoms that may accompany a Traumatic Brain Injury:
   1. Symptoms
      1. Irritability
      2. Aggression
      3. Paranoia
      4. Lack of restraint
      5. Anxiety
      6. Apathy/depression
      7. Insensitivity
      8. Egocentricity
      9. Lack of concentration
      10. Difficulty with memory
      11. Reckless decision-making
      12. Agitation
      13. Anger
      14. Lack of empathy
      15. Increased verbal and physical altercations
      16. Inappropriate or impulsive behavior/aggression or abusive language
      17. May appear to be resistant to authority
      18. Difficulty remaining focused
      19. May present as early dementia
      20. Subject may not remember, or respond well to, instructions or questions
   2. These symptoms can be de-escalated with skilled use of de-escalation strategies.
   3. Jail personnel may mistake individuals with brain injury for individuals under the influence of alcohol or other substance.

***Instructor Note:*** *What can staff do to de-escalate situations where subjects exhibit these symptoms? What would escalate the situation?*

## **5.1.36 Learning Objective:** Define delirium.

Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of your environment. The start of delirium is usually rapid — within hours or a few days.

Source: <https://www.mayoclinic.org/diseases-conditions/delirium/symptoms-causes/syc-20371386>

## **5.1.37 Learning Objective:** Recognize medical conditions in which delirium may present itself.

Delirium can often be traced to one or more contributing factors:

1. Severe or chronic medical illness
2. Changes in your metabolic balance, such as low sodium
3. Medication
4. Infection
5. Surgery
6. Diabetes
7. Water intoxication
8. High ammonia levels
9. Alcohol or drug withdrawal

## **5.1.38 Learning Objective:** Identify symptoms of delirium.

1. Primary symptoms include:
   1. Reduced awareness of the environment which may result in:
      1. An inability to stay focused on a topic or to switch topics
      2. Getting stuck on an idea rather than responding to questions or conversation
      3. Being easily distracted by unimportant things
      4. Being withdrawn, with little or no activity or little response to the environment
   2. Poor thinking skills (cognitive impairment) which may appear as:
      1. Poor memory, particularly of recent events
      2. Disorientation, for example, not knowing where you are or who you are
      3. Difficulty speaking or recalling words
      4. Rambling or nonsense speech
      5. Trouble understanding speech
      6. Difficulty reading or writing
   3. Behavior changes which may include:
      1. Seeing things that don't exist (hallucinations)
      2. Restlessness, agitation, or combative behavior
      3. Calling out, moaning, or making other sounds
      4. Being quiet and withdrawn — especially in older adults
      5. Slowed movement or lethargy
      6. Disturbed sleep habits
      7. Reversal of night-day sleep-wake cycle
   4. Emotional disturbances which may appear as:
      1. Anxiety, fear, or paranoia
      2. Depression
      3. Irritability or anger
      4. Sense of feeling elated (euphoria)
      5. Apathy
      6. Rapid and unpredictable mood shifts
      7. Personality changes

Source:<http://www.mayoclinic.org/diseases-conditions/delirium/basics/symptoms/con-20033982>

1. Refer to your departmental policy concerning detoxification protocols.

# DE-ESCALATION TECHNIQUES

## **5.2.0 Unit Goal:** Summarize barriers to de-escalation and techniques to overcome those barriers.

## **5.2.1 Learning Objective:** Define crisis as related to mental health.

Crisis: A situation in which:

1. The individual presents an immediate danger to self or others;
2. The individual's mental or physical health is at risk of serious deterioration; or
3. An individual believes that he or she presents an immediate danger to self or others, or that his or her mental or physical health is at risk of serious deterioration.

Source: ([25 TAC, Chapter 412, Subchapter G](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=303))

## **5.2.2 Learning Objective:** Discuss practices for de-escalation/communication techniques for the management of individuals in crisis.

1. Keys to Communication
   1. You will need to build trust and rapport to obtain information quickly and accurately. Use these three helping skills:
      1. Empathy is the ability to accurately describe the emotional state of another. Don’t confuse this with sympathy.
      2. Sensitivity comes from your understanding and commitment to staying with the person until the present crisis is resolved.
      3. Utilize objectivity and subjectivity in your communications.
         1. Use objectivity to make accurate evaluations.
         2. Use subjectivity to understand the pain the person in crisis is going through.
         3. Utilize active listening techniques.
   2. Promoting Communication
      1. Listening
         1. Listening is one of the most important skills used during a crisis de-escalation. Listening effectively establishes trust and allows you to understand information more thoroughly.
         2. To be an effective listener remember to:
            1. Recognize verbal and nonverbal cues.
            2. Avoid distractions.
            3. Note any extra emphasis the person in crisis places on words or phrases.
            4. Notice speech patterns and recurring themes.
      2. Clarification; It is important to remember that any statement not understood needs to be clarified. Nothing should ever be assumed. Some techniques to aid in clarifying:
         * 1. Rephrase the person’s statement in a way that encourages the person to clarify.
           2. Repeat key words. This focuses attention on particular thoughts and feelings.
           3. Admit confusion or misunderstanding of a statement and ask for clarification.
           4. Ask “open ended” questions to obtain better understanding.
      3. Dealing with silence: if faced with silence during a crisis situation, do not let the silence become discomforting, use it as a time to observe the person’s behavior.
   3. Respond Effectively
      1. Handle the feelings of the person in crisis with care and concern and treat the person’s feelings as legitimate.
      2. It is essential not to judge, give advice, or belittle the person during a crisis.
   4. Maintain Personal Space
      1. This is a crucial element for effective communication, and is different for every individual in crisis.
      2. Observe the persons reaction to proximity to create a comfortable space for effective communication.
      3. Maintain an appropriate distance to insure individual safety.
2. Basic Communication Guidelines
   1. Use short, clear direct sentences.
      1. Long, involved explanations are difficult for people with mental illness to handle.
      2. They will tune you out.
   2. Keep the content of communications simple.
      1. Cover only one topic at a time.
      2. Give only one direction at a time.
      3. Be as concrete as possible.
   3. Keep the “stimulation level” as low as possible.

High stimulation levels are painfully defeating for anyone who has suffered a mental breakdown.

* 1. If the person appears withdrawn and uncommunicative, allow time for them to acclimate to the situation and re-approach.
  2. Instructions and directions will often have to be repeated. Be patient.
  3. Be pleasant and firm. Make sure your boundaries are specific and clear.
  4. To increase the desired results, praise all cooperative behavior.
  5. Practice active listening. Use phrases like:
     1. Sounds like your feeling (angry, upset, and sad) - Is that right?
     2. You’re pretty (angry, upset, and sad) right now, aren’t you?
     3. I want to make sure that I understand what you are saying - are you telling me that you are…?
  6. Remember a person in crisis may be further agitated by intervention, even when they are necessary.
  7. Nonverbal communication speaks volumes. A cooperative and open stance may be more effective.

## **5.2.3 Learning Objective:** Recognize the concepts of the de-escalation paradox.

1. The difference between traditional inmate encounters and an encounter with an inmate who has mental illness is the need to be non-confrontational.
   1. Such a requirement to, in effect, shift gears is completely opposed to the way officers are routinely expected to control conflict.
   2. When responding to an emergency, officers are forced to make split second decisions about their safety and the safety of others.
   3. Those decisions are often based upon command and control tactics.
   4. The same command techniques used to gain control of a traditional inmate can escalate an encounter with an inmate with a mental illness into violence.
   5. An inmate with compromised coping capacity who is experiencing a crisis may have unpredictable behavior which can be mistaken for non-compliance with your commands.
2. Safety is compromised any time a jailer goes “hands-on” with a person. Jailers should use non-confrontational, verbal de-escalation skills to talk them down versus take them down.
   1. A non-confrontational approach gives you time to think, act, and understand the situation immediately in front of you.
   2. Reasons why command and control approaches can escalate a situation due to mental impairments:
      1. Disorganized thinking causes difficulty in reasoning and following simple requests.
      2. Hallucinations, where a subject is hearing or seeing things that are not there, can make the subject’s compliance to your commands difficult.
      3. Paranoid thoughts cause mistrust of others, including officers.
   3. Reasons for non-compliance are less about a power struggle and more about the brain disorder (i.e., condition and stressful life event).
3. Fostering a de-escalation mindset.
   1. Taking a less physical, less authoritative, less controlling approach to an individual with mental impairments may increase the probability of a safe resolution.
   2. Remaining alert and using empathy and patience will help frame your communication skills and increase the chance of a voluntary, peaceful resolution.
   3. It is important you appear calm, interested, confident, and resourceful.
4. Refer to your departmental policies for mental health evaluations.

## **5.2.4 Learning Objective:** Identify local resources and partnerships to assist with individuals in crisis and in need of supportive services.

The following resource guide has been developed to be provided resources for the students.

A list of mental health services, veteran resources, and peer support can be found at:

1. <http://www.dshs.texas.gov/mhsa-crisishotline/>
2. <http://tvc.texas.gov/Find-Your-Local-Office.aspx>
3. [http://milvetpeer.site-ym.com/page/MVPN\_PSC](https://urldefense.proofpoint.com/v2/url?u=http-3A__milvetpeer.site-2Dym.com_page_MVPN-5FPSC&d=CwMGaQ&c=ODFT-G5SujMiGrKuoJJjVg&r=lAmWlGP_Zs8cp56XlsRZqTtaDU2fUVcCMblDmbOmLBU&m=MVwhi3bt268w-soaBZakee1-GQ5aEkS8jLkNuu0YILQ&s=Aps_Z4dnbz1J2pXRdveq2qIMQdC0QFni25GkM4sg2Og&e=)

***Instructor Note:*** *The instructor shall provide a list of resources for your geographic area using the above-mentioned links.*

# SUICIDE

## **5.3.0** **Unit Goal:** Be able to screen for suicide risk and follow up with questions and actions necessary when an individual is identified as a suicide risk.

## **5.3.1 Learning Objective:** Discuss the seriousness of the suicide problem in jails nationally and in Texas.

1. National Statistics
   1. The suicide rate in local jails in 2014 was 50 per 100,000 local jail inmates. This is the highest suicide rate observed in local jails since 2000.
   2. More than a third (425 of 1,053 deaths, or 40%) of inmate deaths occurred within the first 7 days of admission.
   3. Almost half (47%) of suicides occurred in general housing within jails between 2000 and 2014.

***Instructor Note:*** *It is the instructor’s responsibility to update the statistics using the following source prior to presenting the material:* [*http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865*](http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865)

1. Texas statistics in county jails and lockups:

***Instructor Note:*** *It is the instructor’s responsibility to update the statistics by contacting the Texas Commission on Jail Standards*

* 1. 24% of suicides in Texas jails occur within the first 24 hours of incarceration.
  2. 27% of suicides in Texas jails occur between 2-14 days of incarceration.
  3. 20% of the suicides occurring in Texas jails involve victims who are intoxicated at the time of suicide.
  4. 31% of victims are found after more than one hour of observation.
  5. 93% of suicide victims in Texas jails use the hanging method for suicide.
  6. In 2012, 23 inmates successfully committed suicide in Texas jails.
  7. In 2013, 25 inmates successfully committed suicide in Texas jails.
  8. In 2014, 23 inmates successfully committed suicide in Texas jails.
  9. In 2015, 33 inmates successfully committed suicide in Texas jails.
  10. In 2016, the Texas Commission of Jail Standards implemented the suicide screening form and the State of Texas experienced 17 suicides.

Source: Texas Commission on Jail Standards

## **5.3.2 Learning Objective:** Explain common myths and accompanying facts about suicide.

1. **Myth:** People who make suicidal statements or threaten suicide don't commit suicide.

**Fact:** Most people who commit suicide have made either direct or indirect statements indicating their suicidal intentions.

1. **Myth:** Suicide happens suddenly and without warning.

**Fact:** Most suicidal acts represent a carefully thought out strategy for coping with various personal problems.

1. **Myth:** People who attempt suicide have gotten it out of their systems and won't attempt it again.

**Fact:** Any individual with a history of one or more prior suicide attempts is at much greater risk than those who have never made an attempt.

1. **Myth:** Suicidal people are intent on dying.

**Fact:** Most suicidal people have mixed feelings about killing themselves. They are ambivalent about living, not intent on dying and most suicidal people want to be saved.

1. **Myth:** Asking about and probing the inmate about suicidal thoughts or actions will cause him to kill himself.

**Fact:** You cannot make someone suicidal when you show your interest in their welfare by discussing the possibility of suicide.

1. **Myth:** All suicidal individuals are mentally ill.

**Fact:** Although the suicidal person is extremely unhappy, they are not necessarily mentally ill.

1. **Myth:** The rate of suicide is lower in a jail setting.

**Fact:** Jail suicides occur several times more often than in the general population.

1. **Myth:** Inmates who are really suicidal can be easily distinguished from those who hurt themselves but are just being manipulative.

**Fact:** Manipulative goals as a motive for self-injury are not useful in distinguishing more lethal attempts from less lethal attempts.

1. **Myth:** You can't stop someone who is really intent on committing suicide.

**Fact:** Most suicides can be prevented.

## **5.3.3 Learning Objective:** Be able to list risk factors and signs and symptoms of potential suicides.

1. Some situational and/or personal factors:
   1. First-time arrestee or insignificant arrest
   2. Committed heinous crime, one of passion, or a revolting sex crime
   3. Young inmate (anyone under 18, regardless of whether in adult court)
   4. Persons with high status in community
   5. Prior suicide by close family member or loved one
   6. Previously imprisoned/facing new, serious charges and long prison term
   7. Prior jail suicide or recent attempt by another inmate (i.e., a “copycat” situation)
   8. Harsh, condemning, rejecting attitudes of jailer or an authoritarian environment-regimentation
   9. Consistent or long term mental or physical pain and suffering
   10. No apparent control over future, including fear and uncertainty over legal process
   11. Isolation from family, friends, and community
   12. The shame of incarceration or over the offense
   13. Dehumanizing aspects of incarceration - viewed from inmate’s perspective or fears, based on TV and movie stereotypes, social stigma, etc.
   14. Recent, excessive drinking and/or use of drugs, or withdrawals
   15. Recent loss of stabilizing resources:
       1. Loss of spouse or loved one (for a young inmate; it could be a peer)
       2. Loss of job or expulsion from school
       3. Recent, pending, threatened divorce, separation, or break-up
       4. Rejection by peers (especially common among young inmates)
       5. Loss of home or land (e.g., farm or ranch)
       6. Business failure or other financial disaster
   16. Rape or the threat of it
   17. Current mental illness, poor health, or terminal illness
2. Segregation increases risk of psychological difficulties, especially in the mentally ill and juveniles.
3. Key times to observe signs and symptoms:
   1. At arrest and booking
   2. During transportation
      1. Sentencing court appearance
      2. Transporting to and from state correctional facilities
   3. First 24 hours of confinement
   4. Intoxication/withdrawal
   5. Waiting for high profile trial / sentencing
   6. Impending release
      1. Due to inmate being institutionalized and unable to function without the structure provided by a facility
      2. Fear of repercussions stemming from criminal organizations and associates retaliation.
   7. Holidays
   8. Darkness (or “lights-out”)
   9. Decreased staff supervision
4. Warning signs and symptoms:
   1. Talks about or threatens suicide
   2. Signs and symptoms of depression (the single best suicide indicator)
   3. Feelings of hopelessness or helplessness
   4. Extreme sadness and crying
   5. Withdrawal or silence
   6. Loss of or increase in appetite and/or weight
   7. Pessimistic attitudes about future
   8. Sudden changes in an inmates regular sleeping patterns
   9. Sudden change in an inmate’s mood or behavior
      1. Severe agitation or aggressiveness
      2. Expresses unusual or great concern over what will happen to them
      3. Begins packing and/or gives away belongings
      4. Has increasing difficulty relating to others
      5. Does not effectively deal with the present, is preoccupied with the past
   10. Loss of interest in people, appearance, or activities
   11. Excessive self-blaming
   12. Expresses or evidences strong guilt and/or shame over offenses
   13. Previous suicide attempts and/or history of mental illness
   14. May act very calm once the decision is made to kill themselves
   15. Speaks unrealistically about getting out of jail

## **5.3.4 Learning Objective:** Utilize the Screening Form for Suicide and Medical/Mental/ Developmental Impairments and the Continuity of Care Query (CCQ).

***Instructor Note:*** *Provide the Students with a copy of the required TCJS Screening form* <http://www.tcjs.state.tx.us/docs/ScreeningForm-SMMDI_Oct2015.pdf>

1. Basic Information
   1. The Screening Form for Suicide and Medical and Mental Impairments was revised to achieve three main goals:
      1. To create an objective suicide risk assessment with clear guidance for front-line personnel of when to notify superiors, mental health providers, and magistrates.
      2. To assist sheriffs to meet all statute requirements such as Code of Criminal Procedure §16.22.
      3. To be user friendly for the typical range of experience of a Texas county jailer.

Intake screening is the first step and is crucial to determine which inmates require more specialized mental health assessment. "Unless inmates are identified as potentially needing mental health treatment, they will not receive it."

*Attorney General Alberto R. Gonzales, Assistant Attorney General Regina Schofield, and Deputy Assistant Attorney General David Hagy – United States Department of Justice – Office of Justice Programs – National Institute of Justice – May, 2007*

* 1. The purpose of intake screening is for correctional staff to triage those who may be at significant risk for suicide; identify inmates who may be in distress from a mental health disorder/psychosis or complications from recent substance abuse; and assist with the continuity of care of special needs inmates.
  2. Per Minimum Jail Standard §273.5, an intake screening form must be completed on all inmates immediately upon admission into the facility.
  3. Additional screenings should be completed when staff has information that an inmate has developed a mental illness, or the inmate is suicidal at any point during an inmate’s incarceration. Any additional screening forms must be maintained in the inmate’s medical file.
  4. For counties that will create an electronic copy or import the form into their software package, all questions from this form must be present along with required notifications.
  5. For counties that will use a paper format, counties may insert blank space into the comments sections of the Word version of the form to create more writing space.
  6. The form should be completed by a trained booking jailer or medical/ mental health personnel.
  7. Fill out the form completely and in its entirety.
  8. If the inmate is unable to or refuses to answer questions, notify supervisor and place the inmate on suicide watch until a form can be completed. Notate the reason why the form cannot be completed. Complete a new form when the inmate is able to answer the questions.

1. 1st Section-Basic Information and Medical Information
   1. The first section consists of basic identifier information and medical information.
   2. All applicable boxes should be checked. Provide additional information where required.
   3. The below two medical questions require that a supervisor or medical personnel be notified if jailers receive a “yes” answer:
      1. Do you think you will have withdrawal symptoms from stopping use of medications or other substances (including alcohol or drugs) while you are in jail?
      2. Have you ever had a traumatic brain injury, or loss of consciousness?
   4. Medical personnel or supervisors should assess and take appropriate action.
2. 2nd Section-Self-Report Questions
   1. If the inmate is unable to answer questions, note the reason why, notify supervisor and place inmate on suicide watch until a form can be completed.
   2. Questions 1a-d are strong indicators of inmates at high risk of suicide. Any “yes” answer requires notification to supervisor, magistrate, and mental health immediately, and placement of inmate on suicide watch.
   3. However, if for any reason a jailer believes an inmate to be at risk of suicide regardless of the answer to 1a-d, the jailer should place the inmate on suicide watch and notify a supervisor.
   4. Inmates should only be removed from suicide watch after assessed by qualified mental health personnel.
   5. Questions 2-12 include questions about mental health symptoms and risk factors that warrant supervisor/magistrate notification. Self-report symptoms relate to possible psychosis, schizophrenia, bipolar disorder, depression, and PTSD. Question 11 also attempts to detect possible developmental disability.
   6. If a screener receives a “yes” answer, please ask follow-up questions to gain a better understanding of the symptoms.
3. 3rd Section-Observation
   1. Make careful observations of the inmate’s demeanor and appearance.
   2. Look for cuts to the wrist, impressions around the neck, or any other evidence of self- harm.
   3. Notate when applicable.
   4. A comment box is provided for any additional information that the screener believes is relevant, including an exact or CCQ match. This completed form will likely be viewed by magistrates and mental health professionals so additional information will be beneficial.
4. 4th Section-Notification
   1. A “yes” answer to most questions on the form will require notification to a supervisor, magistrate, or mental/medical personnel.
   2. Space is provided for each notification. Jailers shall notate when they make required notifications.
   3. In addition, magistrate notification shall include method of notification of either electronic or written notification. A completed copy of this form should be sent to the magistrate.
5. CCP §16.22 - EARLY IDENTIFICATION OF DEFENDANT SUSPECTED OF HAVING MENTAL ILLNESS OR INTELLECTUALLY DISABLED. (a) (1) Not later than 12 hours after receiving credible information that may establish reasonable cause to believe that a defendant committed to the sheriff's custody has a mental illness or is a person with an intellectual disability, including observation of the defendant’s behavior immediately before, during, and after the defendant’s arrest and the results of any previous assessment of the defendant, the sheriff shall provide written or electronic notice of the information to the magistrate.

## **5.3.5 Learning Objective:** Recognize potential hazards and risk factors associated with physical structures and assigned housing.

1. Potential hazards and risk factors associated with physical structures and assigned housing:
   1. Facility policies, procedures and post orders should clearly include suicide prevention guidance.
   2. Suicides most frequently occur in private spaces such as bathrooms, showers, mop closets, or cells.
   3. Important prevention measures include frequent rounds, not allowing inmates to cover windows, and establishing professional and meaningful relationships.
   4. Cells that are designated for inmates on suicide watch:
      1. Violent Cell--A single occupancy padded cell for the temporary holding of inmates harmful to themselves and or others. (TCJS 253.1 (34))
      2. Administrative Separation--The assignment of an inmate to a special housing unit, usually a separation or single cell, when staff determines that such close custody is needed for the safety of inmates or staff, for the security of the facility, or to promote order in the facility. (TCJS 253.1 (1))
      3. Single Cell --A cell designed to accommodate 1 inmate. The cell minimally contains 1 bunk, toilet, lavatory, table, and seat. (TCJS 253.1 (30))
   5. Place at-risk inmates in higher visibility cells.
   6. Monitor the clothing, bedding, property, and meals allowed for inmates on suicide watch.
   7. Supervision requirements of inmates on suicide watch:
      1. Observation shall be performed at least every 30 minutes in areas where inmates known to be assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior are confined. (TCJS 275.1)
      2. Supervision – Provisions for adequate supervision of inmates who are mentally disabled and/or potentially suicidal and procedures for documenting supervision. (TCJS 273.5 (5))
      3. Refer to departmental policy regarding supervision and documentation of Suicide Watch.
2. Behaviors to observe and document during a suicide watch:
   1. Is the inmate eating meals?
   2. Is the inmate sleeping normally?
   3. Inmate’s behavior when awake.
   4. Is the inmate attentive to personal hygiene?
   5. Does the inmate communicate appropriately with jailers and other inmates?
3. Refer to your departmental policy for discontinuing suicide watch and/or regarding the contacting of a mental health provider during and after business hours.

## **5.3.6 Learning Objective:** Identify methods for responding to a potentially suicidal inmate.

A. If you believe inmate is in danger of suicide, implement suicide prevention protocols and keep the inmate in a safe place.

1. Maintain contact

2. Address inmate by name

3. Don’t be reluctant to express your concerns about the inmate

4. Eye contact - Show concern, not disapproval or disgust

5. Try to keep the inmate’s sense of future positive

6. Focus on programs available to inmate, i.e., school, vocational training, substance abuse, etc.

7. Support from family and friends that care

8. Provide a feeling of control

9. Find something in their past to give them hope in the future

10. Help them discover a reason to live

B. What not to do:

1. Treating the inmate as non-person

2. Provoking or escalating the situation

3. Acting sarcastic, teasing, or making jokes about the situation

4. Using reverse psychology, such as challenging inmate to follow through with threat

5. Suggesting a more lethal method

6. Ignoring, discounting, or making unpleasant remarks about inmate’s feelings

7. Being afraid to ask direct questions about suicidal ideation

8. Accepting the inmate’s denial of suicidal ideation too quickly

9. Offering solutions or giving advice

10. Making promises that you cannot keep

11. Don’t try to make a diagnosis

12. Become angry, judgmental, or threatening

13. Never ignore the risk or threat – inmates can become suicidal at any point during incarceration

14. Suicide attempt #99 should be treated as seriously as #1!

***Instructor Note:*** *See Ashley Smith Video*

## **5.3.7 Learning Objective:** Explain methods for responding to a suicidal inmate.

A. Approaching a responsive suicidal inmate:

1. Remember that the inmate may attempt to have others kill them;

2. Remain calm;

3. Call for assistance;

4. Develop a plan and follow it: rushing to rescue increases the risk to all those who are involved;

5. Be alert;

6. Check out the situation; and

7. Ask the inmate to remove the means if time permits. This allows them to take action for their own safety. Ironically, taking the means away from them as a show of force can trigger a suicide.

B. Inmate attempting to hang self:

1. First jailer on scene will conduct visual assessment of inmate from outside cell to determine if inmate has article around neck and is attempting to hang self;

2. If possible, observe inmate’s hands for possible weapons;

3. First jailer on scene shall stay at cell front to observe and request backup and a medical response;

4. Once a minimum of two (2) jailers have arrived at cell, if possible, staff shall enter the cell;

5. Cut victim down immediately; avoid cutting the knot for investigative purposes, if possible;

a. One person should hold the body up

b. The other person should cut the noose with a readily available tool

6. Lay the inmate on the floor and remove the article around the neck;

7. Begin basic life-saving techniques, health care staff will assume the lead role in life-saving techniques assisted by jailer if necessary; and

8. Refer to department policy for first aid methods.

C. Unresponsive Inmate:

1. Conduct a visual assessment from outside cell to determine if inmate is either unconscious or experiencing a medical emergency;

2. First jailer on scene shall stay at cell front to observe and request backup and a medical response;

3. First staff on scene will observe inmate’s hands for any objects that may be weapons;

4. Once a minimum of two (2) jailers have arrived at cell, if possible, staff shall enter the cell;

5. Jailers will enter the cell with caution and be prepared to use force if necessary, but move quickly to secure the inmate; and

6. Begin basic life-saving techniques as applicable, health care staff will assume the lead role in life-saving techniques assisted by jailers if necessary.