

*Trainers Guide*

# MENTAL HEALTH AWARENESS TRAINING COURSE



Ministry of  
**JUSTICE**

*Mental Health is an area of health that is important to us all.  
It is crucial to our ability to lead a fulfilling life:*

## “THERE IS NO HEALTH WITHOUT MENTAL HEALTH”

*Life can be described as a continuum that we all move along – our mental health is better at some times than others. People with mental illnesses tend to move along the continuum more.*

### WHAT ARE THE AIMS OF THIS COURSE?

- To increase understanding of mental health issues.
- To contribute to your professional development.
- To complement other training, especially the ACCT course.
- To recognise the environmental pressures faced by prisoners.
- To allow you to respond effectively to a range of situations.
- To provide practical advice to prisoners in distress.
- To improve the quality of life of offenders.
- To enable you to manage offenders who are experiencing distress – and distinguish between the ‘worried well’ and those who have enduring diagnosed mental illnesses.
- To act as a reference source for you in the future.
- To make a contribution towards a more safely managed environment.
- To make a contribution towards a reduction in reoffending upon release.

## THE MENTAL HEALTH AWARENESS TRAINING PACKAGE INCLUDES THE FOLLOWING COURSE CONTENT;

- **INTRODUCTION NOTES**
- **TRAINING MATERIALS**  
inc; PowerPoint presentation and associated notes, further training modules
- **DELEGATES WORKBOOK**  
Extra modules included (But not in the trainers guide);  
Considerations for effective communication  
Active Listening  
Working with risk  
Embracing Equality & Diversity,  
Internal Sources of information  
Useful external organisations  
Glossary of Terms  
Who’s Who in mental health?

### HOW THE TRAINING WORKS?

This guide is intended to be used by a trainer(s) as a prison specific targeted development resource, supported by an employing organisation to train a group of staff.

Its flexibility means that it can be used to train anyone at a level who works in an organisation where they have personal contact with people who may demonstrate mental health problems, particularly those who are recognised as mentally disordered offenders.

Complementing the PowerPoint, further resources and activities in the delegates workbook will help participants to expand their understanding, remain positive and professionally robust in their interactions with people who have or may go on to develop a mental health problem over short or prolonged periods of time.

### UNDERSTANDING HOW THIS TRAINER’S GUIDE IS DESIGNED TO WORK

As you begin to look through this trainers guide and familiarise yourself with the material included you will see that the guide is spilt into a number of sections and modules.

#### TRAINER SECTIONS COMPULSORY TO INCLUDE IN TRAINING

#### TRAINER’S MODULES FLEXIBLE/ACCOMMODATE NEEDS OF AUDIENCE/TRAINERS DISCRETION

Within each section and module we have included trainer’s notes and further information to complement the relevant PowerPoint slides.

## SECTION 1

- Profile of the trainer
- Introductory notes
- Practicalities
- Aims and objectives of the session (trainer)
- Tips for the trainer

## SECTION 2

- Introductions
- Aims and objectives of the session
- Safety contract/ground rules

*The modules have been designed to provide 'pick and mix' type training. This has been done primarily to give the trainers and training ultimate flexibility and versatility to ensure delegates receive mental health awareness training which is appropriate and as diverse as the audiences needs in the time scale available to deliver it.*

### EACH MODULE CONTAINS;

- Core information
- Individual exercises and/or group exercises

Each separate sheet within the modules have; aims and objectives, length of time and materials required, as well as practicalities, suggested number of participants and further resources (if needed)

It is entirely your choice which modules and sub sheets you decide to use. All are provided with trainers notes to ensure you fully understand the relevant information and confident to deliver the training to the professional standards needed.

Suggested core modules include;

WHAT IS MENTAL HEALTH?

3 MAJOR GROUPS OF MENTAL DISORDERS

DEPRESSION

ANXIETY

SCHIZOPHRENIA

BIPOLAR DISORDER

BORDERLINE PERSONALITY DISORDER

ANTISOCIAL PERSONALITY

SUICIDE AND SELF HARM

EATING DISORDERS

YOUNG OFFENDERS

DUAL DIAGNOSIS (SUBSTANCE MISUSE)

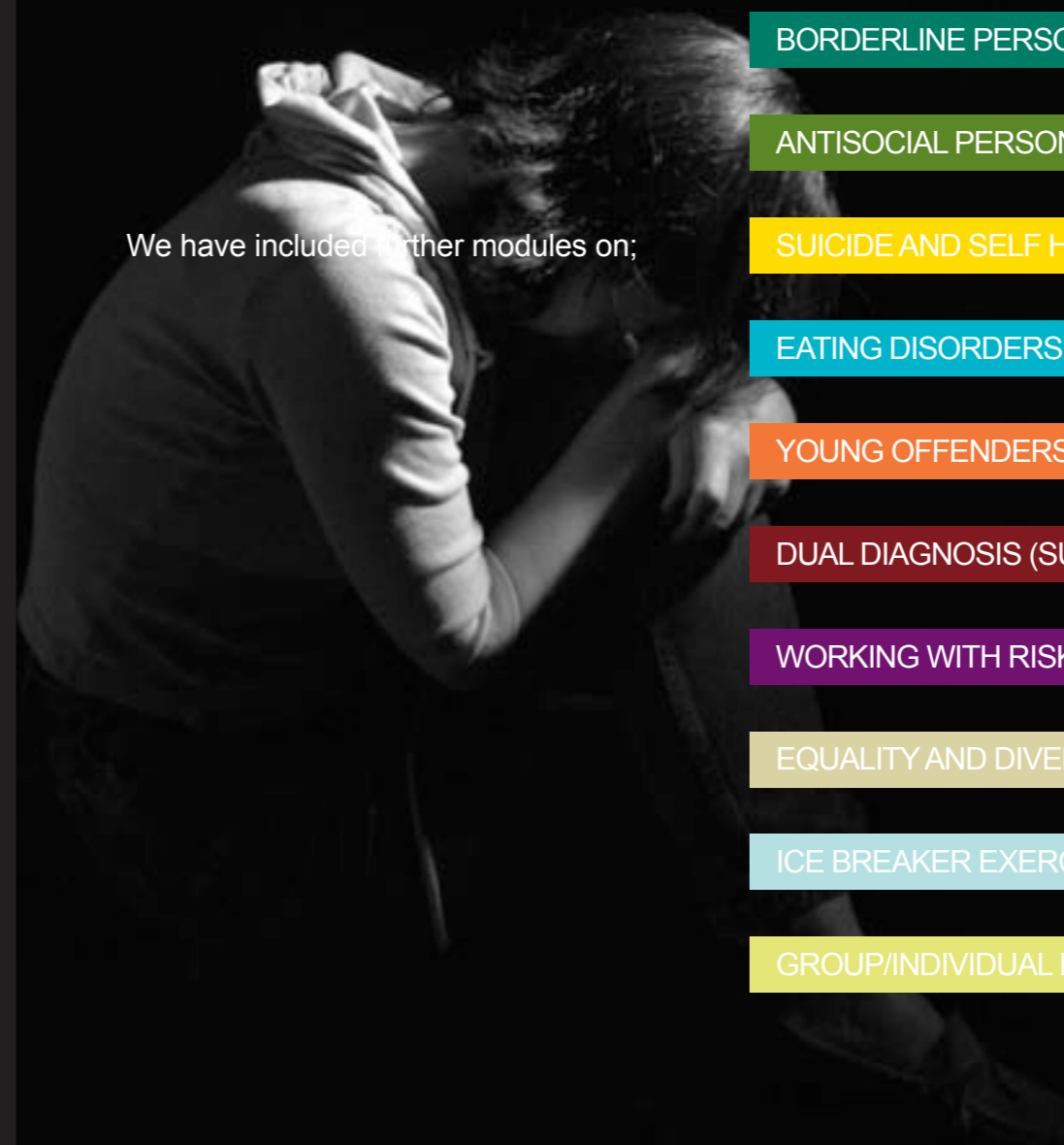
WORKING WITH RISK

EQUALITY AND DIVERSITY

ICE BREAKER EXERCISES

GROUP/INDIVIDUAL EXERCISES

We have included further modules on;



# SECTION 1

## PROFILE OF THE TRAINER

The material need not be run by a professional trainer, but it is desirable the course facilitator understands the subject well. It could be detrimental to the training if the trainer does not understand the issues around working with people experiencing mental distress.

### THE TRAINER IDEALLY SHOULD BE:

- A person who has experience of managing group dynamics
- A person who has an aptitude for managing others emotions in a safe and empathetic manner
- A person who has good interpersonal skills
- someone who has a high level of self awareness

### FOR THE TRAINING TO WORK WELL IT IS IMPORTANT THAT THE TRAINER RECEIVES:

- Managerial support
- Ring fenced time with a personal supervisor
- Ring fenced time to run the sessions

## ABOUT THE WORKBOOK

This guide is designed to compliment the mental health awareness PowerPoint and delegate's workbook.

The training is designed to offer flexibility for the trainer(s) to suit the specific needs of the audience.

## ABOUT THE AUTHORS

Raise! Is a 'not for profit' social enterprise which exclusively employs people with a diagnosed mental health problem - from directors to cleaners and, most importantly, trainers who are therefore able to inform from personal experience.

As such we are a distinctive organisation demonstrating that service users can run a commercial business. Through our courses we aim to educate many sectors of the community regarding mental health and to challenge misconceptions.

We have been involved in a large number of consultancy services including working for; CSIP, Department of Health and Hampshire County Council.

Although our offices are based in Hampshire, we deliver our training and consultancy services across the country.

*For more information about raise please visit our website – [www.raise.org.uk](http://www.raise.org.uk)*

## INTRODUCTORY NOTES FOR THE TRAINER

Please note that, before running any training session, you should fully acquaint yourself with the course materials and delegates workbook, so you are prepared for the responses of the group to the material.

You should also identify and arrange a support/supervision structure for yourself while you are acting in the role of the trainer.

Before embarking on the course, you need to decide how you will structure it, the length of time available to deliver the training and how you will close the training session

It may also be worthwhile ensuring there are support mechanisms in place for the group members to use outside of the sessions, and that the group members know these are available. These mechanisms should be the usual staff support/supervision systems within the organisation.

Be prepared to be led by the delegates on aspects of the material of which they have personal experience, whether as individuals or as a group.

## COMPLETION CEREMONY

At the end of the course you should make sure that the organisation acknowledges participants attendance at the training with a certificate/letter and/or record it in their personal development plans.

### AFTER THE TRAINING

At the end of the training, it would be useful for you to have some sort of summary session with your supervisor as part of the closure as your role as trainer.

At the end of the training, you should meet with the organisational managers that were involved in organising the training, in order to feedback the themes that emerged and the related implications for the organisation, alongside recommendations for the future in terms of training and support.

You can use the trainer's evaluation (Appendix 1) for suggested headings for this feedback to organisation managers.

## TIMINGS

3 Hour training session (2x 10 minute breaks suggested)

## VENUE

Preferably a suitably sized room, well lit and ventilated.  
It is suggested that the room be laid out informally in an open circular shape.  
Power points are necessary.

## NUMBER OF PARTICIPANTS

There is no minimum number of group participants.  
We suggest a maximum of 15-20 delegates to encourage group interaction, however if two trainers are available to deliver the training then the group size can be adjusted accordingly.

## MATERIALS

Laptop and Multimedia projector  
Visual audio DVD  
Flipchart paper and pens, Sticky Labels

## HANDOUTS

Delegate's workbook  
Attendance registers (Appendix 2)  
Evaluation forms (To be provided by your commissioning agency)

## PREPARATION

Trainers Working Programme  
Enough copies of group handouts

## AIM OF THE SESSION

- To set the scene for the training – Objectives & Course content
- To encourage positive participation in the session & effective learning
- To agree the group's boundaries in terms of:
  - Confidentiality*
  - Timings of session, Inc: breaks etc*

## TIPS FOR THE TRAINER

- The suggested flipchart and pens could be used in a number of ways:
- To record any queries that group participants raise, to ensure that they receive an answer before the end of the training
  - To record the agreed group boundaries
  - To 'car park' any issues that are raised during the training that would distract from a specific part of the session if answered immediately, but which require attention during the later part of the training
  - To record any themes which emerge from the session which you may like to feedback later to the organisational managers after the training course
  - To use in the group brainstorm *\*Case study and Group exercises*

# SECTION 2

## INTRODUCTION AND WARM UP (20mins)

- Invite each participant to state their name, job title and one word they associate with mental ill health.
- Do they have any expectations, concerns and/or worries from training session

*Further ice breaker exercises can be found at the end of the trainers guide*

## BOUNDARIES/SAFETY CONTRACT (10mins)

- Using the flipchart, agree a safety contract with the group. Remember that boundaries of confidentiality should be the same as those for a normal supervision. This is essential as some of the course content is highly emotive.
- Some examples of the safety contract relate to:
  - Timings of the training session; punctuality etc
  - Confidentiality of issues raised within the group
  - Use of bleeps/mobiles during the training (i.e.: only on vibrate/silent if mobiles need to remain switched on)
  - Respect & appropriate behaviour at all times within the group

## REFERENCE TO THE POWERPOINT

The PowerPoint presentation provides the main component for the mental health awareness training. The presentation, if viewed as notes pages contains extra notes for the training should you require them?

## ALL MODULES WITHIN THE TRAINER'S GUIDE CONTAIN;

Delegate's workbook  
Attendance registers (Appendix 2)  
Evaluation forms (To be provided by your commissioning agency)

## EXPLANATION OF DELEGATE'S WORKBOOK

The delegates' workbook is designed to compliment the training session. It should be reinforced that the delegate's workbook is a reference guide, to provide additional information, but could be used as part of each member of staff's personal development

## WHAT IS MENTAL HEALTH?

### “THERE IS NO HEALTH WITHOUT MENTAL HEALTH!”

What people understand by mental health and well being are influenced by age, class and gender, as well as people’s experiences, expectations and cultural and religious beliefs. Most definitions used by health and other professionals draw on the health definition of health drawn up by the World Health Organisation in 1948.

Mental health influences how we think and feel about ourselves, about our future and about others and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events. (Scottish Executive, 2004)

*The definition of mental health as a “positive sense of well being” challenges the idea that mental health is the opposite of mental illness.*

A key part of your role is to promote mental wellbeing, to recognise the ‘worried well’ and to enable early intervention to avoid mental distress. 90% of prisoners have at least one mental health disorder (ONS 1997). There will be a significant number of prisoners who will develop an illness such as those described in this training.:

### WHAT AFFECTS OUR MENTAL HEALTH?

*Mental Health is determined by socio-economic and environmental factors*

All of these can interact together to determine mental health and mental health disorders

There are:

- Many theories
- Different factors that cause different illnesses
- Many complex and related reasons:

### MENTAL HEALTH IS LINKED TO BEHAVIOUR

Mental, social and behavioural health problems may interact to intensify their effects on behaviour and well being.

## WHAT IS MENTAL ILLNESS?

*Mental illness is a term that describes a broad range of mental and emotional conditions. It impacts on the way a person thinks, behaves and interacts with other people.*

It may impact on the way a person thinks, behaves and interacts with other people.

Mental illness (or mental distress) is an umbrella term that refers to various psychiatric disorders. Just like physical illnesses they can vary significantly in severity and in the symptoms you may see.

Many people suffering from mental distress may not look as though they are ill while others may appear to be confused, agitated, or withdrawn.

Anyone can have times when they are mentally distressed – in fact it is thought that 1 in 4 of the general population will have a mental health problem at some point in their life.

However, there are particular stressors for offenders – physical isolation, social isolation, lack of purpose, guilt etc

*It is a myth that mental distress is a weakness in character and that offenders can get better simply by “pulling themselves together”*

Mental illnesses are real illnesses, as real as heart disease and cancer. They need and can respond well to treatment. As prison staff you can employ your observational skills to play a vital role in recognising mental distress.

In the past 20 years especially, psychiatric research has made great strides forward in the precise diagnosis and successful treatment of many mental illnesses.

Not too long ago mentally ill people were ‘warehoused’ in public institutions because they were disruptive or feared to be harmful to themselves or others. Today most people who suffer from a mental illness-including those that can be extremely debilitating such as Schizophrenia - can be treated effectively and lead full lives.

**“THERE IS NO HEALTH WITHOUT MENTAL HEALTH”**



## MENTAL ILLNESS IS NOT...?

### SCHIZOPHRENIA IS NOT...

- Split or multiple personalities (Officially known as Dissociative Personality Disorder)
- A Guarantee that the sufferer will be violent or dangerous
- Always a diagnosis for life

### BIPOLAR DISORDER IS NOT...

- Indicative that a person constantly swings from mania to depression and vice versa
- A guarantee that the mood swings are of a set duration, pattern and occur regularly (Varies from individual to individual)
- Always a diagnosis for life

### BORDERLINE PERSONALITY DISORDER IS NOT...

- Indicative of a disordered (faulty) personality
- A guarantee that the sufferer is manipulative or attention seeking in their behaviour
- Untreatable

### ANTI SOCIAL PERSONALITY DISORDER IS NOT...

- Diagnosable through standard mental health assessments (Heavily reliant on matching Diagnostic Criteria – DSM IV)

### DEPRESSION IS NOT...

- Easy to recover from without professional intervention, support and treatments
- Is not the same as low moods, or 'depressed' feelings that most of us can experience regularly as a result of daily events
- A guarantee that someone will express feelings of suicidal ideation

### GENERALISED ANXIETY DISORDER IS NOT...

- Is not the same as phobias, fears, stress or panic attacks
- Untreatable
- Is not a guarantee that someone will go on to develop other neuroses, including Obsessive Compulsive Disorder, Eating Disorders etc

*Although the symptoms of mental illness often can be controlled effectively through medication and/or psychotherapy, or may even go into remission, for some people the illness continues to cause periodic episodes that require treatment.*

*The term "mental illness" actually encompasses numerous psychiatric disorders.*

### COMMON DISORDERS INCLUDE: -

ANXIETY STATE

DEPRESSION

BIPOLAR DISORDER

PSYCHOSIS AND SCHIZOPHRENIA

PERSONALITY DISORDERS

SUBSTANCE MISUSE

Someone can experience a mental illness over many years. The type, intensity and duration of symptoms vary from person to person. They come and go and do not always follow a regular pattern, making it difficult to predict when symptoms and functioning will worsen, even if treatment recommendations are followed.

Consequently, some people with mental illness will need no support, others may need only occasional support, and still others may require more substantial, ongoing support to maintain their productivity.

## AIMS AND OBJECTIVES:

*This exercise is designed to encourage delegates to think about their own mental health and then apply the same principles to inmates they currently be working with.*

**INSTRUCTIONS:** This exercise is split in to two parts; A & B. Delegates can complete this exercise either individually, in pairs or in smaller sub groups according to the number of delegates and space available

### PART A

\*see attached handout

This will need to printed off in advance of the training session

1. Delegates are asked initially to think about what they do to maintain their mental health or improve it?
2. Delegates are asked to contrast what they do with the opportunities which are available to offenders to do the same...

*Examples – Physical exercise, relaxation, 'time out' etc*

- 10 minutes for delegates to complete the exercise
- 10 minutes for large group feedback

### PART B

\*see attached handout (MH continuum)

This will need to printed off in advance of the training session.

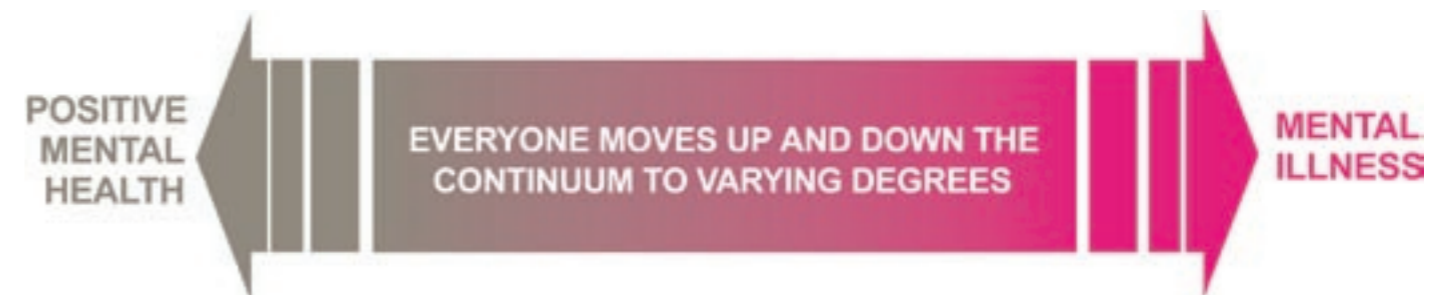
Delegates are asked to look at the handout and visually place themselves on the mental health continuum. \*They do need to disclose this if they do not wish to. And answer the following questions;

1. What factors are you aware of which could impact on your mental health?
2. Contrast what factors you are aware of with factors in prison which could impact on an offender's mental health.

*Examples – Stress, financial problems, unsympathetic colleagues, inadequate housing etc*

- 10 minutes for delegates to complete the exercise
- 10 minutes for large group feedback

## EXERCISE: PART A



### 0.1

What do you do to maintain your mental health or improve it?

### 0.2

Contrast what you do, with what opportunities are open to offenders to do the same...



## EXERCISE: PART B

*The Mental Health Continuum*

Mental Illness

Positive Mental Health

0.3

What do you do to maintain your mental health or improve it?

0.4

Contrast what factors you are aware of with factors in prison which could impact on an offender's mental health.

## OVERVIEW - WHAT IS MENTAL ILLNESS?

### *An explanation of mental illness and psychiatric disorders:*

*Mental illness is an illness that affects or is manifested in a person's brain. It may impact on the way a person thinks, behaves, and interacts with other people.*

The term "mental illness" actually encompasses numerous psychiatric disorders, and just like illnesses that affect other parts of the body, they can vary in severity. Many people suffering from mental illness may not look as though they are ill or that something is wrong, while others may appear to be confused, agitated, or withdrawn.

It is a myth that mental illness is a weakness or defect in character and those sufferers can get better simply by "pulling themselves up by their bootstraps." Mental illnesses are real illnesses-as real as heart disease and cancer-and they require and respond well to treatment.

The term "mental illness" is an unfortunate one because it implies a distinction between "mental" disorders and "physical" disorders. Research shows that there is much "physical" in "mental" disorders and vice-versa.

For example, the brain chemistry of a person with major depression is different from that of a non-depressed person, and anti depressant medication can be used (often in combination with psychotherapy) to bring the brain chemistry back to normal. Similarly, a person who is suffering from hardening of the arteries in the brain-which reduces the flow of blood and thus oxygen in the brain-may experience such "mental" symptoms as confusion and forgetfulness.

In the past 20 years especially, psychiatric research has made great strides in the precise diagnosis and successful treatment of many mental illnesses. Where once mentally ill people were warehoused in public institutions because they were disruptive or feared to be harmful to themselves or others, today most people who suffer from a mental illness-including those that can be extremely debilitating, such as schizophrenia --can be treated effectively and lead full lives.

# THE 3 MAJOR GROUPS OF MENTAL DISORDERS

## NEUROSES

Neurosis, also previously called a 'Neurotic Disorder', is a 'catch all' term that refers to any mental imbalance that causes distress, but, unlike a psychosis or some personality disorders, does not prevent or affect rational thought.

(I.e. Depression, anxiety Eating disorders, phobias etc)

## PSYCHOSIS

Psychosis is a generic psychiatric term for a mental state often described as involving a "loss of contact with reality." People suffering from it are said to be psychotic.

People experiencing psychosis may report hallucinations or delusional beliefs, and may exhibit personality changes and disorganised thinking.

This may be accompanied by unusual or bizarre behaviours, as well as difficulty with social interaction and impairment in carrying out the activities of daily living.

A wide variety of nervous system stressors, both organic and functional, can cause a psychotic reaction. This has led to the belief that psychosis is the 'fever' of mental illness—a serious but nonspecific indicator.

## PERSONALITY DISORDERS

Personality Disorders are a group of disorders characterised by the chronic use of mechanisms of coping in an inappropriate, stereotyped, and maladaptive manner.

Personality disorders are enduring and persistent styles of behaviours and thought, not atypical episodes. The personality disorders encompass a group of behavioural disorders that are different and distinct from the psychotic and neurotic disorders.

The official psychiatric manual, the DSM-IV (Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition), defines a personality disorder as "an enduring pattern of inner experience and behaviours that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."

Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances.

# DEPRESSION

## Trainers Guidance Notes

These notes are designed to compliment the PowerPoint presentations section on depression should you need to expand on it

Depression has been described as the 'common cold' of mental disorder, but its consequences can be serious.

The condition involves disturbances in mood, concentration, sleep, activity, appetite and social behaviour.

The individuals' thinking is dominated by themes of pessimism and hopelessness.

Quite often, depression is accompanied by very negative thoughts, decreased self esteem, self worth and self confidence.

## GROUP EXERCISE:

### Larger Group Brainstorm

#### 0.1

##### **You may like to ask the delegates at this point;**

- What effect negative thinking may have on an individual? Behaviour? Mood? Thoughts?
- What examples of language they can think of linked with negative thinking? "What's the point?" "Why should I bother?" "Everything is pointless" etc.

##### **STATISTICS**

- Depression is common affecting about 121 million people worldwide
- Depression is among the leading causes of disability worldwide
- Depression can be diagnosed and treated in primary care
- Fewer than 25% of those affected have access to effective treatments
- Over 25% of a GP's working week is taken up with patients who are experiencing mild-moderate depression and anxiety

#### 0.2

##### **You may like to ask the delegates at this point;**

- How do you know is someone is becoming depressed?
- What signs/symptoms would be apparent? Becoming withdrawn? Reduced/increased appetite? etc.

## Treatments for depression – medication:

### SSRI's (selective serotonin reuptake inhibitors)

These are the most commonly prescribed anti depressants. In layman's terms, SSRI's are used to combat low levels of serotonin and noradrenalin (Brain chemicals) Depending on the severity of the depression; the drugs and dosage will be different.

Examples are: Fluoxetine (Prozac),  
Paroxetine (Seroxat),  
Citalopram (Cipramil) and Sertraline (Lustral)

### MAOIs (monoamine oxidase inhibitors)

These are a powerful form of antidepressant. Particularly effective for Atypical depression \*see guidance sheet containing the different forms of depression

Because of their strength, they should be used as a last line of defence.  
Examples are: Phenelzine (Nardil)

### OTHER TYPES OF MEDICATION INCLUDE;

#### SNRIs (serotonin norepinephrine reuptake inhibitor)

These work best on depression with anxiety. They work on two neurotransmitters in the brain that play an important part in stabilising/ maintaining mood.

Examples are: - Venlafaxine (Most commonly used)

### OTHER TREATMENTS

#### TALKING

There are many different forms of talking therapies, but the most effective is

- **CBT** (Cognitive Behavioural Therapy),
- **Psychoanalysis**
- **Counselling**

**ECT** (electroconvulsive therapy)

### WHICH ONES ARE BEST?

Generally a combination of medication and other treatments provides the best support to patients.

## GROUP EXERCISES:

### Trainers Guide

**0.3** Split into groups to discuss the following statement and then nominate one person from each group to feedback to the whole group.

1. What distinguishes depression from a 'bad day'?
2. How would you know if a prisoner was just having a 'bad day' compared to suffering from a depressive episode?

### FACILITATOR NOTES:

- Ask the person how long he/she has been feeling like this. The main distinguishing factor is the length of time the person is feeling 'down' or 'having bad days'. Anyone may have days at a time of feeling down, irritable, tearful, lack of energy but if this continues for a few weeks and he/she feels like it every day then this is indicative of depression.
- It may be very difficult to determine the extent of the problem because he/she may not admit to what / how they are really feeling. The onset of depression may be insidious so that the person may not actually realise how ill he/she has become until they become very obviously depressed.
- There are likely to be physical symptoms associated with depression so ask how he/she is sleeping, appetite and energy levels e.g. change in sleeping patterns (unable to get to sleep or early morning waking), changes in eating patterns, weight loss (which may be very rapid), aches and pains, lack of energy or increased energy such as agitation (feeling fidgety), headaches. Ask how long this has been going on for.
- There will be mood changes so try to encourage the person to talk about how they are feeling. Mood changes associated with depression are hopelessness, worthlessness, tearfulness, guilt, negative attitude to self, suicidal thoughts, lack of concentration e.g. unable to take in even a couple of sentences of a book, social withdrawal (e.g. refusing to talk with his cell mate). Ask how long he/she has been feeling like this.
- Ask if he/she has been participating in their normal activities. They may say 'they can't be bothered' or participation may take a huge amount of effort.



## GROUP EXERCISE:

### 0.4 Split into 3 groups. **Group 1** to discuss and feedback to the group what phrases a prisoner might use if he/she was depressed

#### FACILITATOR NOTES:

- I can't be bothered, it's not worth it, it doesn't matter, I'm rubbish at everything, what's the point, it's no use, I can't go on like this, I'm useless at everything, everything I do goes wrong, I feel like killing myself, leave me alone, get lost, I don't feel like doing anything, it would be better for everyone of I wasn't here, I'd be better off dead.

### 0.5 **Group 2** to discuss and feedback to the group what body language the prisoner might display if he/she was depressed

#### FACILITATOR NOTES:

- Little or no eye contact when talking or eyes closed, slumped in chair, lying on bed all day, slow movements, slumped shoulders as if a huge weight was on them, mumbling, talking very quietly or not at all, taking a long time to respond to questions or forgetting what was asked
- Agitation e.g. unable to sit still, shuffling about on seat, foot tapping, walking about constantly in cell or other prison areas

### 0.6 **Group 3** to discuss and feedback to the group the type of behavioural changes might the prisoner show if he/she was depressed

#### FACILITATOR NOTES:

- Withdrawing from people they would normally socialise with e.g. at mealtimes or with cell mate, unwilling to see visitors
- Unwilling or unable to participate in activities e.g. daily exercise, lessons, prison work
- Lack of energy and enthusiasm for anything
- Unable to concentrate on even the simplest tasks e.g. reading books or completing their prison work
- Lack of personal care and hygiene
- Wakefulness at night or sleeping excessively
- Refusing meals or eating more
- Anger, irritability, tearfulness with officers, other prisoners etc
- Agitation e.g. unable to sit for any length of time, pacing their cell



## ROLE PLAY EXERCISE:

*(ideally this role play would follow on from exercise 2)*

### **Identifying depression in a prison setting:**

**Split into groups of 3-4 and each group develop a role play scenario (maybe based on any experiences to date?). Consider what questions the prison officer should ask to identify if the prisoner may be depressed**

Each group will then nominate one person to adopt the prison officer role, and nominate another to adopt the prisoner role (with body language associated with depression).

*Perform the role play with the other group members observing*

In each individual group, discuss what action could be taken by the prison officer to help the person

Each individual group nominates someone to feedback to the entire group what action could be taken to help the person

# ANXIETY

## Trainers Guidance Notes

*These notes are designed to compliment the PowerPoint presentations section on depression should you need to expand on it*

### RECOGNISING AN OFFENDER WITH ANXIETY

The differing ailments and their intensity will vary from individual to individual but some common signs are:

- Feeling worried a lot of the time and feelings of dread
- Feeling tired and having problems sleeping
- Difficulty concentrating
- Being irritable
- Tension and pains - stomach aches, indigestion and diarrhea
- Heavy, rapid breathing and heart palpitations – i.e. irregular heart beat
- Dizziness and fainting

### HOW TO HELP AN INDIVIDUAL WITH ANXIETY

- Assess each offender as an individual
- Refer the offender on to specialist help at any early stage
- Help the person to recognise that there is a real problem. Explain that asking for help does not mean they lack character. On the contrary, it takes courage to know when you need help. Help the offender to understand that they have taken a big step and encourage them.
- Never tell the sufferer they're over re-acting. Be assured that what they are feeling is very frightening and the sensations are real. By informing the sufferer they are over re-acting will only agitate and upset them and may even make the panic attack worse. BE SUPPORTIVE. Stay reassuring and let them know they will be ok
- Guide them to information that can help them with anxiety and panic attacks. The more the offender is educated about anxiety and panic attacks the less frightening the attacks often become, especially information that is written by former sufferers, it assures the sufferer they are not alone and they really can overcome it.
- Encourage relaxation through exercise and regulating breathing
- Listen - don't dominate conversations

### **Panic Attacks:** *are sudden feelings of terror that strike without warning*

These episodes can occur at any time, even during sleep. A person experiencing a Panic Attack may believe that he or she is having a heart attack or that death is imminent.

The terror that a person experiences during a Panic Attack is not in proportion to the true situation and may be unrelated to what is happening around them.

Most people who have Panic Attacks experience several of the following symptoms:

- A sense of terror and feeling a loss of control
- "Racing" heart, chest pains, feeling weak, faint or dizzy
- Tingling or numbness in the hands and fingers
- Feeling sweaty or having 'chills '
- Breathing difficulties

Panic Attacks are generally brief, lasting less than ten minutes, although some of the above feelings may last for a longer time. People who have had one panic attack are at greater risk for having subsequent panic attacks than those who have never experienced a panic attack. When the attacks occur repeatedly, a person is considered to have a condition known as Panic Disorder.



## GROUP EXERCISES

### 0.1 Split into groups to discuss the following statement and then nominate one person from each group to feedback to the whole group.

Think about a time that you felt anxious about something – how did you feel, what sort of events triggered it, did you have any physical symptoms, how long did it last?

### 0.2 Split into 3 groups. *Group 1* to discuss and feedback to the whole group what may trigger an anxiety disorder in a prisoner

#### FACILITATOR NOTES:

- There will be many potential triggers for anxiety in a prison setting e.g. claustrophobia, worry about their family, the future, financial problems, loss of control over daily activities, having to spend time with other people they may not like, lack of access to activities they would normally enjoy, concerns about physical health, unable to see friends or family regularly, fear of other inmates, bullying

*Group 2* to discuss and feedback to the whole group how the physical symptoms of general anxiety contrast to those associated with a panic attack

#### FACILITATOR NOTES:

- Physical symptoms of general anxiety are sweating, rapid and shallow breathing, dizziness, heart palpitations (you can feel your heart beating and it may be beating irregularly), fainting, indigestion, diarrhoea, stomach aches and sickness, difficulty speaking or change in voice due to constriction of the throat
- In a panic attack the symptoms described for anxiety are magnified and the person feels as if he/she is about to die or have a heart attack. They may experience a racing heart (feels as if their chest may explode), weak/dizzy/faint, tingling or numbness in hands and fingers, sweaty or chills, chest pains, breathing difficulties.
- In a panic attack, there will be a sense of terror or impending doom and he/she feels a total loss of control

*Group 3* to discuss and feedback to the whole group how a prison officer might help someone with an anxiety disorder/panic attack in a prison setting

#### FACILITATOR NOTES:

- Make sure they're in a safe environment
- Ask them what helps e.g. some people like support. Other sufferers may prefer to be left alone
- Support the sufferer – don't say they are over-reacting
- Be supportive and listen to what they say, try not to keep offering advice
- Reassure them they'll be OK, without brushing it off
- Try to help them to regulate their breathing e.g. some people find breathing into a bag helps
- Stay with them during a panic attack until it subsides
- Help them to learn more about anxiety disorder/panic attacks and relaxation techniques
- Find out what triggers their episodes and if there are any measures that can be taken to help them within the system



## ROLE PLAY EXERCISE

**Scenario:** *Pete shares a cell with Kevin who has recently been sent to prison. During the course of a conversation between Pete and prisoner officer Dave, Pete mentions that Kevin had a really bad 'turn' in his cell recently.*

- Split into groups and in each group nominate 1 person to be prison officer Dave, one person to play Pete, and one person to play Kevin (who has a number of personal problems outside of the prison and also suffers from claustrophobia)
- In role play, Dave must try to find out from Pete what has been happening to Kevin (Pete is willing to expand on what has happened e.g. Dave was very panicky, said he couldn't breathe, he was sweating and shaking and collapsed on the floor)
- In role play, Dave must then talk to Kevin to try and find out more about what has been happening to him
- Each group then discusses what steps could be taken to help Kevin and nominate one person from each group to feedback to the whole group

# BIPOLAR DISORDER

## Trainers Guidance Notes

Bipolar Disorder is a serious but treatable medical illness. It is characterised by extreme shifts in mood, energy, thinking and behaviour.

Bipolar Disorder is marked by periods of mania (highs), greatly elated moods, or excited states interspersed with periods of depression (lows).

### INDIVIDUALS BEHAVE DIFFERENTLY BUT MAY HAVE COMMON SIGNS SUCH AS:

- Euphoria or being 'high'
- Extreme hyperactivity
- Irritability
- Paranoia
- Depression

### THERE CAN ALSO BE LONG PERIODS OF STABILITY IN BETWEEN EPISODES.

- Individual's have their unique
- Assess each offender as an individual
- Refer the offender on to specialist help at any early stage
- Being aware that the times just after someone has been ill are the most dangerous in terms of suicide and self-harm
- Remember that offenders may not be able to work or comply with rules due to their illness.

### ENCOURAGE SELF-HELP SUCH AS THE OFFENDER:

Keeping a record of their illness, i.e. a Mood Diary – marking their mood from 0 to 10 where:

- 0 is endless suicidal thoughts, 'no way out', no movement, 'everything is bleak and it will always be like this' and
- 10 is a total loss of judgement, exorbitant spending, religious delusions and hallucinations
- Recognising early warning signs – i.e. emotions, behaviours and events that may lead to an episode of Bipolar
- Identifying triggers for their own unique pattern
- Concentrate on emotions and feelings

*Don't collude in grandiose ideas pattern of severity and duration.*

## GROUP EXERCISE:

### Larger Group Brainstorm

**Split into 3 groups** - Each group discuss how someone would behave if suffering from one of the symptoms of Bipolar Disorder in a prison setting

Group 1: **Mania**

Group 2: **Hypomania**

Group 3: **Depression**

Each group to nominate a spokesperson to feedback to the whole group for discussion

### BEHAVIOUR INDICATIVE OF MANIA:

- The person may not sleep or eat for days at a time
- Lack of personal care and hygiene because they will think it's just not important
- Extremely disruptive to cell mates and others because of hyperactivity (physical and in thoughts/vocal expression)
- Incoherent speaking because of the disorganised thoughts
- Frustration or anger because others cannot keep up with their thought processes
- Grandiose ideas expressed e.g. wanting to talk to the Prime Minister to discuss world affairs
- Unable to settle to anything requiring concentration

### EXPLAINING THE DIFFERENT TYPES OF BIPOLAR DISORDER

**BIPOLAR I** - where there has been at least one high, or manic episode, which has lasted longer than a week. Some people will only have manic episodes, although most will also have depressive ones. Some will have more depressive episodes than manic ones.

**BIPOLAR II** - There has been more than one episode of major depression, but only minor manic episodes – these are referred to as hypomania:

**RAPID CYCLING** - The manic and depressive episodes alternate at least four times a year and, in severe cases, can even progress to several cycles a day.

- Rapid cycling tends to occur more often in women and in Bi Polar II patients.
- Typically, rapid cycling starts in the depressive phase. Frequent and severe episodes of depression may be the hallmark of this event in many patients.
- This phase is difficult to treat, particularly since antidepressants can trigger the switch to mania and set up a cyclical pattern.

# SCHIZOPHRENIA

## Trainers Guidance Notes

**WHAT IS SCHIZOPHRENIA?:** A mental disorder that affects the way the offender's brain processes information. Someone experiencing Schizophrenia will not see or understand things in the same way as other people.

They may have difficulty experiencing appropriate emotions, acting in an appropriate manner or perceiving reality.

### SOME SIGNS YOU MAY NOTICE

#### 'More than normal' experiences e.g.

- Hallucinations
- Delusions
- Agitation
- Disorganised thinking – talking incoherently

#### 'Less than normal' experiences e.g.

- Slowness to move, think, speak or react
- Social withdrawal
- Apathy
- Difficulty in understanding things
- Poor memory

### THERE ARE DIFFERENT TYPES OF SCHIZOPHRENIA

**PARANOID TYPE:** delusions and hallucinations are present but thought disorder, disorganized behaviour and of emotional response are absent.

**DISORGANISED TYPE:** otherwise known as 'Hebephrenic Schizophrenia'. Where thought disorder and lack of emotions are present together.

**CATATONIC TYPE:** characterised by muscular rigidity and mental stupor

**UNDIFFERENTIATED TYPE:** psychotic symptoms are present but the criteria for paranoid, disorganized, or catatonic types have not been met

**RESIDUAL TYPE:** where positive symptoms are present at a low intensity only

### POSSIBLE RISKS

- 40% of people that have Schizophrenia will attempt suicide at least once.
- The result of these attempts is that between 10% and 15% of people with Schizophrenia have historically committed suicide.
- Males with Schizophrenia attempt suicide at a much higher rate than females; approximately 60% will make at least one attempt.
- Particular times that people with Schizophrenia tend to be suicidal include:
  - Periods when they are out of touch with reality (psychotic)*
  - Periods when they are very depressed*
  - In the first 6 to 9 months after they have started first taking medications, when they are thinking more clearly and learn that they have Schizophrenia and all the negative aspects that this brings*

### TREATMENTS FOR OFFENDERS WITH SCHIZOPHRENIA

#### Medication is the main treatment for Schizophrenia:

- Antidepressants - to relieve symptoms of depression
- Mood stabilisers - to moderate extreme mood changes
- Antipsychotics - to relieve symptoms of psychosis
- Benzodiazepines - for the relief of anxiety and as a sedative
- Talking therapies

### WHAT CAN YOU DO TO HELP ?

- Assess each offender as an individual
- Refer the offender on to specialist help at any early stage
- Make sure the medication the offender receives is closely monitored
- Remember that offenders may not be able to work or comply with rules due to their illness
- Concentrate on the offender's emotions and feelings
- Be very patient because for the offender their beliefs are very real
- Bear in mind that people who have schizophrenia can fully recover

**DON'T COLLUDE WITH ANY HALLUCINATIONS AND DELUSIONS**

# PERSONALITY DISORDERS

## Trainers Guidance Notes

**INTRODUCING THE CONCEPT OF PERSONALITY DISORDERS** *Relationships that we have with other people in our lives can be a great source of satisfaction – or dissatisfaction. This relates to both our personal and professional lives.*

This training focuses on the two sub groups of personality disorder delegates are most likely to come into contact with – Borderline Personality Disorder and Anti Social Personality Disorder

Nationally the profile of people with Personality Disorder has increased in the public eye, as has its presence within professional services; health and social care settings, the Police and Prison services. This is partly as a result of increased media attention, but it is also due to a professional recognition that there is a need to reduce associated risks, client distress and the inefficient use of resources.



### GROUP EXERCISE:

*The trouble with diagnosis*

*The use of the diagnostic term ‘Personality Disorder’ has been controversial. Why is this?*

*You may want to ask this as an ‘open question’ to the group to encourage interaction and participation.*

- One view is that an abnormality of personality distinct from the norm can and does exist, so there is a need to accurately describe and classify the phenomenon.
- Others argue that the assessment and diagnosis of personality disorders is subjective. Influenced by social and political agendas and personal interpretation and can be a response by health/social care systems to individuals with whom the system has failed to produce effective outcomes. (Dustbin Diagnosis)

However, there are a number of different schools of thought. These include:

- Personality disorder has genetic causes
- Personality disorder is caused by trauma during childhood
- Personality disorder is a physiological disposition towards difficulties with emotional regulation, exacerbated by childhood experiences
- Personality disorder has its roots in society’s need to label any ‘different behaviour’ as abnormal, or as a disorder

The symptoms of all Personality Disorders are long-lasting if not permanent and play a major role in most or all aspects of someone’s life.

- Self harm and emotionally dulling behaviours
- Emotions are unstable, intense, ever changing and long lasting
- Erratic way of living and trying to get some control over their lives in inappropriate ways
- Difficulties with interpersonal skills
- Impulse and reckless behaviour

*There are no conclusive statements relating to why some people develop Personality Disorders. Equally, the literature in this area is inconclusive and limited.*

# BORDERLINE PERSONALITY DISORDER

## Trainers Guidance Notes

### BPD OCCURS WITH OTHER CONDITIONS FOR APPROX. 50% OF SUFFERERS WITH:

- Schizophrenia and several types of Psychosis
  - Epilepsy
  - At least 50% of BPD offenders also suffer from Major Depressive Disorder, unstable mood regulation or both.
  - BPD also indicates a greater risk for angry, impulsive or violent behaviour.
  - As many as 38% of those with BPD have an Eating Disorder
- It is essential that each of these disorders is recognised and treated

### WHAT YOU CAN DO TO HELP

- Assess each offender as an individual.
- Refer the offender on to specialist help at any early stage.
- Don't promise things you can't deliver.
- Remember that offenders may not be able to work or comply with rules due to their illness.
- It is often the way that the risk of self harm and suicide can be decreased by observing and listening to the individual.
- Be aware that people may conceal their intent. Consider what they say but also their actions. It's important not to see someone purely in terms of their diagnosis.
- People with BPD can have very low self-esteem, and it can help them enormously if you can emphasise the positive parts of their personality.
- Maintain strict, clear boundaries.
- Please be patient – try to understand even if the offender doesn't!

### Reassure, Repeat and Reassure

### A GOOD WAY OF REMEMBERING THE MAIN ISSUES FOR SOMEONE WITH BPD IS;

- P** Paranoid ideas
- R** Relationship instability
- A** Angry outbursts, affective instability, abandonment fears
- I** Impulsive behaviour, identity disturbance
- S** Suicidal behaviour
- E** Emptiness

Individuals with BPD will often display impulsivity in at least two of many areas:

- Substance misuse
- Binge eating
- Excessive gambling
- Engagement in unsafe sexual practices
- Reckless driving

# ANTISOCIAL PERSONALITY DISORDER

## Trainers Guidance Notes

*Anti-Social Personality Disorder (ASPD) involves behaviour that manipulates, exploits and violates the rights of others. This behaviour is often criminal. To receive a diagnosis of ASPD a person must have exhibited certain behaviour during childhood.*

### SOME OF THE SYMPTOMS YOU MAY RECOGNISE IN OFFENDERS WITH ASPD;

- A lack of conscience
- Lack of remorse
- Feeling victimized
- Violating others e.g. property, physical, sexual, legal, emotional
- Physical aggression
- Lack of stability in work and home life
- Superficial charm and wit with a background of repetitive lying
- Impulsiveness
- Inability to tolerate boredom
- Disregard for society's expectations and laws
- A problem with forming relationships

### ASPD - ONE OF THE MOST DIFFICULT PERSONALITY DISORDERS TO TREAT

The effectiveness of treatment is largely unknown.

- Medications have not proved helpful. Often they are not taken regularly or are abused so they are not effective
- Group therapy has been shown to be helpful if the patient feels comfortable in the group setting. Individual therapy may be helpful if the patient develops a sense of trust with the therapist

# EATING DISORDERS

## Trainers Guidance Notes

*Eating disorders are real, treatable medical conditions which frequently co exist alongside other psychiatric disorders, such as depression, substance misuse, or anxiety disorders.*

### NORMAL EATING

Food is essential for life, for our health and development. Everyone has different eating habits – foods we like, how much we eat and when we like to eat.

Eating patterns will change, i.e. deciding to become vegetarian, adapting to a healthier diet as a result of ill health etc.

Under stress may lose appetite or comfort eat, but quickly return to usual eating habits.

### DISORDERED EATING

- Distorted pattern of thinking about food and size/weight.
- Food is used to cope with painful situations, feelings and stress.
- Preoccupied/obsessed with food; control or lack of control around food and eating.
- Eat too much, eat too little or use harmful ways to get rid of calories.
- Often friends and family that will notice the persons thinness or weight loss before the person admits to having anorexia

### EATING DISORDERS AFFECT:

- Anyone – regardless of age, sex, culture, race, disability, religion etc.
- Girls and women are 10 times more likely than boys and men to suffer from anorexia or bulimia.
- Becoming more common in boys and men
- More common in people who were overweight as children.
- Usually affects young women 15-25 although it also appears later in life and in men.

### STATISTICS

- At least 1.1 million people in UK have an eating disorder.
- 10 times higher in females than males
- 1% female suffer anorexia, 4% suffer bulimia
- 10% suffers are male
- 10% of people with an eating disorder will DIE
- Affecting children as young as 6
- 3.5 children in 100000 children, 18% are boys

### THE MAIN EATING DISORDERS ARE:

- Anorexia, Bulimia, Binge eating disorder, Compulsive Eating
- People also suffer other physical health problems including heart conditions and kidney failure.

## ANOREXIA NERVOSA: means 'loss of appetite for nervous reasons'

- It is more likely that the individual has lost the ability to allow themselves to satisfy their hunger.
- 10 to 20% suffers will die from complications related to anorexia. Anorexia kills more people than any other psychiatric disorder.
- Only about 60% will recover – with about a third making a full recovery
- Usually begins in teenager years, although it can start in childhood or later life
- 1 fifteen-year-old girl in every 150
- 1 fifteen-year-old boy in every 1000.

### SYMPTOMS:

- Restricting food/drink, sometimes to a dangerous level.
- Worrying about weight. Not able to stop losing weight
- Low self esteem
- Life feels out of control, need to control surroundings
- Focus on food – excessive dieting, starvation and exercise to control weight and food intake instead of feelings and emotions related to all areas of life.
- Ultimately, the disorder takes control and the chemical changes in the body affect the brain and distort thinking, making it almost impossible to make rational decisions about food. Exhaustion from starvation kicks in, and if untreated, often death occurs.

### TREATMENT OF ANOREXIA:

Involves 3 components:-

1. Restoring the person to a healthy weight
2. Treating the psychological disorders related to the disorder, and
3. Reducing or eliminating behaviours and/or thoughts that lead to disordered eating and prevent relapse

## BULIMIA: means 'the nervous hunger of an ox'

In reality the hunger is not a physical hunger. It's an emotional hunger.

- Bulimia was only recognised by doctors in 1979
- 2-3 times more sufferers of bulimia than anorexia
- Harder to recognise than anorexia as sufferers do not tend to lose weight as rapidly.
- Characterised by a cycle of binge eating followed by an immediate urge to get rid of the food by vomiting, taking laxatives, diuretics, diet pills, reducing food intake, exercising, etc in an attempt to stop weight gain from the binge.
- Most bulimics develop it in their late teens, early 20's however many successfully hide it for years.
- 4 in 100 women suffer bulimia at some point, fewer men
- 40% of bulimics have a history of anorexia
- Up to half of anorexics will also experience bulimia

### SYMPTOMS:

- Frequent weight changes
- Sore throat, tooth decay, bad breath, tear in esophagus

- Swollen salivary glands making the face rounder
- Poor skin condition and possible hair loss
- Irregular 'periods' or loss of interest in sex
- Lethargy and tiredness, muscle weakness, anemia, poor sleep pattern
- Dehydration, dizziness, headaches
- Constipation, diarrhea, pain, bloating, cathartic colon, gastric dilation/rupture
- Electrolyte imbalances – impacts on heart, kidney, liver, other organs
- Irregular heart beat, low BP, shortness of breath, chest pains
- Edema (swelling of hands and feet)
- Peptic ulcers and inflammation of pancreas
- Abrasions on back of hands and knuckles, light bruising under eyes and on cheeks, blood shot eyes, broken blood vessels
- Cardiac arrest and death

## BINGE EATING DISORDER

- Only recently recognised as an eating disorder in its own right (1992)
- It involves dieting and binge eating, but not vomiting or other methods of eliminating calories
- It is believed that there are more individuals who suffer with binge eating disorder, than with either
- Anorexia or bulimia nervosa.

### SYMPTOMS:

- Eating large amounts of food, rapidly, until uncomfortably full
- Not using any form of purging or compensation
- Feeling out of control around food – and when bingeing
- Secretive eating - hiding food or empty wrappers
- Weight gain or fluctuations in weight
- Attempts at various diets, believe life will be better if they lose weight
- Low self esteem, believing food is only friend
- Anxious and self conscious eating in front of others
- Feeling ashamed, depressed, disgusted or guilty after bingeing
- Loss of sexual desire
- Suicidal thoughts
- Poor sleeping habits
- Complications occurring as individuals usually overweight

## COMPULSIVE OVEREATING - *Binge eating compulsively*

- Feeling out of control when eating. Fear not being able to stop eating.
- Depression, low self esteem, constant need for love and acceptance
- Secretive eating patterns, hiding food
- Self punishment following compulsive eating
- Avoiding situations and activities – fear of eating in front of others
- Trying many diets but failing

- Believe they will be a better person if thin
- Feelings are based on weight and eating habits.
- Believe food is only friend.
- Poor sleeping habits

## COMMON TO ALL EATING DISORDERS

- ALL psychological illnesses
- ALL serious, and have physical dangers and complications.
- There is an underlying emotional issue, i.e. low self esteem, feeling worthless, need to forget feelings or events need to block out pain, anger and other feelings, need to block out people or situations, and a need to cope with a life that seems out of control.
- Sufferers are often self critical and self defeating “too stupid” or “too fat” “I don’t matter”.
- Need for acceptance and approval from others.
- ALL hold the believe that life will be better if they can lose weight.

## CAUSES OF EATING DISORDERS - *Genetics*

- Attitude of family members towards food, weight and academic results.
- Traumatic events – abuse, relationships, bereavement
- Social pressures – media, models, size zero, peers
- Puberty – change to body shape, relationships, responsibilities
- As body changes with age
- Depression
- Job – athletes or TV presentators, actors, actresses
- Control – feel unable to control life, so develop eating disorder in attempt to be able to control one aspect of life, food. But it's the eating disorder that has control.

## EATING DISORDERS AND MEN

- 10% of people with eating disorders are men
- 20% of these are gay
- Lack of recognition of eating disorders in men
- Its more difficult for men to access specialist eating disorder services, or be diagnosed, so often their illness is well established before treatment is offered.
- Culturally there is less pressure on men to be slim; however there is pressure to have well defined muscles including the 'six-pack' shape.
- Within the gay male community there are pressures to have 'body beautiful' and 'to be slim in order to get a partner', which may contribute to eating disorders, as well as the conflicts of their sexuality whilst growing up.
- Usually the onset of an eating disorder in men is triggered by situations such as:
- Childhood bullying/teasing, Overweight as child, Bodybuilding or specific occupations including ??

*To recover you need to have a genuine desire to get better. This may involve changes in lifestyle, behaviour and circumstances, exploring and resolving underlying emotional issues, and reshaping and defining attitudes to food and weight.*

#### RECOVERY:

Acknowledge and recognise you have a problem. Admitting this to you can take a long time.

- Tell someone - this is scary and full of uncertainty.
- Visit doctor – referral to therapist and dietician

Recovery is hard, long and emotionally difficult as you look at underlying causes of the eating disorder.

Realistic targets are essential so that recovery can be achieved, it can be disheartening to set massive targets which can not possibly be met.

It can take weeks or months for a person's body and mind to re-adjust once they start eating and drink regularly and healthily.

- To start with their body may bloat – may be frightening.
- There may be conflict between feeling hunger and feeling fat or fearing putting on weight
- The person may feel pressure from others to recovery faster.
- The persons coping mechanism – food, will be slowly disappearing, leaving emotional issues to be dealt with.
- Often mood swings and personality take a while to settle.
- Recovery is possible, however often needs professional help.
- For a long time the eating disorder has blocked out emotions. It's important to find a healthy way to deal with these emotions.

#### EXAMPLES:

- writing a journal - thoughts, feelings, fears, dreams
- drawing
- count to 10
- reassure self it will be ok
- build a tower with blocks and then knock it down
- talking in person or a helpline, and instant messaging
- listening to music or watching a movie
- playing an instrument
- watching sunset
- popping bubble wrap
- Relaxation
- Support groups

#### WHAT CAN YOU DO TO HELP?

- Assess each offender as an individual
- Refer the offender on to specialist help at any early stage
- Give the offender an opportunity to talk about their feelings
- Help the person to recognise that there is a problem. Explain that asking for help does not mean they lack character. Help the offender to understand that they have taken a big step and encourage them.
- Remember that offenders may not be able to work or comply with rules due to their illness
- Create an environment in which an offender is able to open up
- Remember that progress will take time
- Don't try to talk the offender out of his or her feelings. The feelings may be irrational, but you might try saying, "I'm sorry that you are feeling bad. What can I do to help?"
- Listen - don't dominate conversations

## YOUNG OFFENDERS & MENTAL HEALTH

*A young offender is someone who is aged between 18 and 20. However there are institutions for offenders as young as 13. It's important to remember that a mental illness may not be fully formed at this age and therefore will change in nature.*

### SOME SIGNS YOU MAY NOTICE

- High rates of neurotic symptoms, such as anxiety, depression, fatigue and concentration problems, are common.
- Suicide rates are high, and it has been found that up to 40% of new offenders had tried to commit suicide in the previous 12 months.
- 70 per cent of male sentenced young offenders had a hazardous drinking pattern compared with 51 per cent of female sentenced young offenders.
- Dependence on opiates such as heroin and methadone was reported by 23% of the women in the sentenced group, 21% of the male remand and 15% of the male sentenced group. Severe mental illnesses such as Schizophrenia are very rare but their prevalence rises in adolescence.

*It is important to stress that; Working with young offenders is NOT a simple situation - over 90% of young offenders have at least one, or combination of, the following: personality disorder, psychosis, neurotic disorder or substance misuse*

### WHAT YOU CAN DO TO HELP

- Assess each offender as an individual
- Refer the offender on to specialist help at any early stage
- Remember that offenders may not be able to work or comply with rules due to their illness
- Most have come from a disturbed if not abusive background so try to understand their point of view
- Over half of young people on a Detention and Training Order (DTO) have literacy and numeracy levels below their age.
- If they can have access to literacy and numeracy classes, there is a higher chance of them finding stable education and/or jobs once they are released.

## ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

*An increasing number of Young Offenders are diagnosed with this disorder. ADHD is a mental illness characterised by an impaired ability to regulate activity level (hyperactivity), attend to tasks (inattention), and inhibit behaviour (impulsivity).*

### WHAT CAUSES ADHD?

Until recently many professionals thought that ADHD only occurred as a result of poor parenting. The range of factors thought to cause ADHD today range from the biological such as genetics and brain damage during pregnancy to the environmental such as sensitivity to certain foodstuffs.

It is likely that the causes are actually bio-environmental, that is the result of an interaction between both biological and environmental causes.

Offenders with ADHD may appear to have difficulty interacting with others but this has more to do with their low self-esteem and their difficulty settling in a constructive way rather than an inherent problem with relating to others. People with ADHD can develop social and communication skills.

### WHAT CAN YOU DO TO HELP?

- Encourage any constructive hobby or interest the offender may have
- Encourage exercise to help with the frustration people with ADHD feel
- Remain patient

### IT'S IMPORTANT THAT THE LIKELY CAUSES OF THE ILLNESS ARE INVESTIGATED

These may be:

- Diet
- Environmental factors
- Chemical imbalances that may respond to drug treatments – e.g. Ritalin
- Behavioural traits

# SUICIDE AND SELF-HARM

## Trainers Guidance Notes

**Self Harm is a coping mechanism.** An individual harms their physical self to deal with emotional pain, or to break feelings of numbness by arousing sensation. Ways of harming include cutting, burning, bruising, scratching, hair pulling, breaking bones and ingesting poisonous substances.

**Suicide is a response to intolerable pain that appears to have no end.** When chosen, it feels like the only possible way out of pain. Suicidal people feel hopeless and helpless. They are wounded emotionally and mentally and cannot envision healing or surviving for as long as healing is anticipated to take.

### WHAT ARE THE SIGNS YOU SHOULD LOOK OUT FOR IN AN OFFENDER?

#### Self-harm:

- Covering up body even when warm
- Wanting to be alone
- Secretive behaviour
- Avoiding sporting activities that involve changing clothes

#### Suicide:

- Tidying up affairs e.g. making will, giving away prized possessions.
- Change in behaviour e.g. withdrawn, low spirited, severely agitated.
- Physical appearance, taking less care of themselves.
- Verbal threats such as “You’d be better off without me” or “Maybe I won’t be around anymore...”

**IT IS IMPORTANT TO REINFORCE;** *There is no such thing as a typical self harmer and there is no quick fix. Acts of deliberate self harm and suicide attempts do not necessarily involve an intention to die.*

## EXERCISE:



### Why Do People Self Harm? - How Can It Possibly Make Them Feel Better?

BY DELIBERATELY HURTING THEIR BODIES, YOUNG PEOPLE SAY:

IT CAN CHANGE THEIR STATE OF MIND, A WAY OF DEALING WITH PAIN

HELP THEM COPE BETTER WITH 'OTHER' PAIN THEY FEEL

PHYSICAL PAIN HELPS TO DISTRACT FROM EMOTIONAL PAIN

A CONSCIOUS SENSE OF RELEASE, ESPECIALLY FROM EMOTIONAL SCARRING

A 'WAKE UP' TO SITUATIONS OF NUMBNESS, WHEN THEY CAN'T FEEL ANYTHING

### SO WHAT IS SELF HARM?

- Self harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way.
- The vast majority of people, who self harm, keep their behaviour a secret, and this can often go on for a long time undetected. Self harm has a huge impact on everyday life.
- This often leads to extreme feelings of guilt and the burden of the secret is often hard to carry

### THE VICIOUS CIRCLE

People often start self harming to deal with their problems and feelings, but it soon often leads to other very serious problems. It can set up a pattern of very addictive behaviour, which can be extremely hard to break free from.

Because people often find release or even positives from self harm it can be difficult to envisage life without it.



## EXERCISE:

*In pairs, take 10 minutes to discuss the different ways in which people can self harm? You will be asked to return to the larger group where we will discuss your answers*

### SELF HARM CAN INVOLVE...

- Cutting
- Hair pulling
- Swallowing poisonous substances or objects
- Burning
- Scalding
- Banging or scratching one's own body
- Breaking bones

### MULTIPLE TRIGGERS...

*SELF HARM IS REGARDED AS A SYMPTOM, NOT THE CORE PROBLEM*

- Self harm masks underlying emotional and psychological trauma
- Isolation
- Academic pressures
- Suicide or self harm by someone close to them
- Low self esteem
- Poor body image
- Bullying, stress
- Family breakdown
- Triggers tend to be daily stressors as opposed to significant changes or events

### WHAT YOU CAN DO TO HELP?

- Assess each offender as an individual
- Refer the offender on to specialist help at any early stage
- Show understanding, care and concern for their injuries, be respectful
- Give time & support, encouragement to talk about underlying feelings or situations
- Be non judgemental, don't accuse or react with revulsion
- Remember to focus on the individual, not just the self-harm or attempted suicide
- Encourage the person to talk about their despair.
- Don't try to "jolly" them out of it.

### SUBSTITUTIONS TO SELF HARM

*Taken from the 'truth about self harm' National enquiry 2006*

Self Harmers have shared their most successful distraction techniques and substitutes:

- Using a red felt tip pen to mark where you usually might cut
- Hitting a punch bag or pillows or cushions to vent your anger and frustration, having a good scream into a pillow or cushion
- Rubbing ice across where you usually might cut, or holding an ice cube in the crook of you arm or leg
- All forms of exercise – these are really good at changing your mood and releasing adrenaline
- Making lots of noise, either with a musical instrument or just banging pots and pans
- Writing down negative feelings and making a point of then ripping it up
- Keeping a journal
- Scribbling on a large piece of paper with a red crayon or pen
- Putting elastic bands on wrists, arms or legs and flicking them instead of cutting or hitting
- Talking to someone with a sympathetic ear (not necessarily about self harm)
- Collage or artwork – doing something creative using your hands

# DUAL DIAGNOSIS

## Trainers Guidance Notes

*“Dual diagnosis” is a relatively recent term used to describe the concurrent existence of more than one kind of medical diagnosis:*

It does not specify disorders, it can apply to a person with any two conditions. It is often used to refer to the co-existence of mental health problems and substance (drug and alcohol) misuse. It can also include severe mental health problems, learning disabilities, mood disorders or Personality Disorders however here we look at substance misuse:

**IT IS IMPORTANT AS THE TRAINER TO STRESS THAT;** *If an offender is picked up early enough, then the outcome of recovery is generally good.*

*The difficulty often occurs when an individual doesn't have a severe enough mental health problem; for example, mild/moderate depression combined with alcohol/drug misuse. It is these types of offenders which can often 'slip through the net.'*

### OFFENDERS WITH SUBSTANCE MISUSE ADDICTIONS:

- Often experience worse psychiatric symptoms than those with mental illness only
- Generally have an increased use of services
- Are more likely to have social problems and are more likely to be homeless
- Are more inclined to be involved with the criminal justice system
- Often 'shunted' between agencies, making access to treatment difficult
- Have an increased risk of violent incidents (as victim and as perpetrator)
- Suffer increased incidence of drug related overdoses
- Are at a risk of possible prescribing problems due to drug interactions with prescribed medication
- Frequently do not comply with their prescribed medication.
- Have poorer physical health associated with mental illness and it is exacerbated by the substance misuse

- Those that can directly cause mental health problems (i.e. drug induced psychosis)
- Those that can aggravate or exacerbate mental health problems (e.g. cannabis – which can amplify the offenders mood)
- Those that offenders use to relieve mental health problems (i.e. Self medication, mental health services do not support this, generally agreeing only causes an exacerbation of symptoms)

While the relationship between mental illness and substance use is complex, it is generally accepted that this group of offenders suffers poorer health and social outcomes and offers challenges for health and social services.

*“I was pushed around like a tennis ball! The alcohol treatment centre staff said I had a mental illness & the mental health worker said I had a drink problem.”* An Offender

### TREATMENT FOR DUAL DIAGNOSIS:

The usual treatments for dual diagnosis clients are not always effective for a variety of reasons.

- There is currently no standardised treatment.
- Largely because it ranges across such a large number of problems and involves both substance use and mental health services.
- Medically orientated services can't always help people with 'multi-problems.' This often reflects the stigma that people with dual diagnosis face.
- People with the combination of dual diagnoses often have a lot of additional difficulties, which are not solely medical, psychological or psychiatric.
- More likely to come into contact with services when reached crisis point, with problems relating to social, legal, housing, welfare & lifestyle issues.
- They are not only drug users, but also mentally ill, which are two of the most stigmatised groups in society.

On the positive side, there are a number of treatment approaches that have benefited people with dual diagnosis, including various forms of counselling and drug treatment programmes. If the individual is picked up early then the outcome is generally good. However, the difficulty arises when the individual doesn't seem to have a severe mental health problem, for example minor depression with alcohol/substance misuse and end up 'slipping through the net.'

*“People thought I would be in & out of prison all my life. So did I. I couldn't see any other option. But when I was in HMP Stafford they had a drugs treatment programme and I got on to it. I have been clean & sober for 8 years now & have even trained as a counsellor, so I can help other prisoners to get out of the system & lead rewarding lives. Before, I never dreamed it would be possible to change.”* An Offender

### WITHDRAWAL:

The effects of withdrawal from illicit drugs can produce or mimic symptoms of mental ill health:

- Alcohol withdrawal can cause anxiety, insomnia, hallucinations (commonly visual) and clouded thinking
- Coming off stimulants (amphetamine & cocaine) often result in confusion, irritability & low mood. Can make people feel suicidal, provoking an attempt.
- Withdrawal from opiates can cause unpleasant physical side effects. Also, low mood, irritability

# GROUP EXERCISES

*appropriate for any module*

Please pick a famous, successful person from the attached list who, in an ideal world, you would like to be:

CELEBRITIES:	LEADERS:	SCIENTISTS:	AUTHORS:	ARTISTS:
Jim Carrey	Winston Churchill	John Nash	Graham Greene	Vincent Van Gogh
Frank Bruno	Alexandra the Great	Stephen Hawking	Samuel Beckett	Jackson Pollack
Stephen Fry	Richard Nixon	Isaac Newton	John Bunyan	Edward Lear
Sting	Menachem Begin	Sir Charles Darwin	Ernest Hemingway	Paul Gauguin
Ellen DeGeneres	Napoleon Bonaparte	Primo Levi	Victor Hugo	
Buzz Aldrin	Oliver Cromwell	Karl Paul Link	Henry James	
Linda Hamilton	Calvin Coolidge			

## AIMS AND OBJECTIVES – EXERCISE

This introductory exercise is designed to reinforce the Mental Health Continuum – Anyone can get a mental illness!!!

## TRAINERS INSTRUCTIONS

- 5 mins** Ask delegates to choose a famous person from the list provided on the delegate's handout
- 10 mins** Once everyone has chosen their famous person, you can inform them that for the duration of the course they now have a mental illness!!

You can either handout the list of famous people with diagnoses below or go through them verbally informing everyone which diagnosis they now have

CELEBRITIES:	DIAGNOSIS:
Jim Carrey	Depression
Frank Bruno	Schizophrenia
Stephen Fry	Bipolar
Sting	Bipolar
Ellen DeGeneres	Depression
Buzz Aldrin	Bipolar
Linda Hamilton	Bipolar

SCIENTISTS:	DIAGNOSIS:
John Nash	Schizophrenia
Stephen Hawking	Depression
Sir Isaac Newton	Depression
Sir Charles Darwin	Depression
Primo Levi	Depression
Karl Paul Link	Depression

ARTISTS:	DIAGNOSIS:
Vincent Van Gogh	Bipolar
Jackson Pollack	Depression
Edward Lear	Depression
Paul Gauguin	Depression

LEADERS:	DIAGNOSIS:
Winston Churchill	Depression
Alexandra the Great	Depression
Richard Nixon	Depression
Menachem Begin	Depression
Napoleon Bonaparte	Depression
Oliver Cromwell	Depression
Calvin Coolidge	Depression

AUTHORS:	DIAGNOSIS:
Graham Greene	Depression
Samuel Beckett	Depression
John Bunyan	Depression
Ernest Hemingway	Depression
Victor Hugo	Depression
Henry James	Depression

*Mental Illness doesn't mean you can't achieve in life!*

## INTRODUCTORY EXERCISES

### 0.1 LET'S GET LYRICAL

#### AIMS AND OBJECTIVES

This introductory exercise is a good ice breaker and useful to address some of the common myths and preconceptions about mental distress

#### TRAINERS INSTRUCTIONS

**5 mins** Ask delegates to brainstorm in the larger group and think of a song or a song title or the name of a singer or band that you associate with a mental illness or symptom or mood.

e.g. You Drive Me Crazy, Radiohead; The Only Way is Up, Borderline, Moody Blues, and Paranoia

*\* This exercise could be expanded on and lead on to the following;*

**10 mins** Ask delegates to brainstorm in the larger group and think of images/myths and stereotypes, words from the first brainstorm may portray?

*Where do these images come from?*

*Do they truly depict what is reality and what is not*

### 0.2 'DIAGNOSIS LABELS'

#### AIMS AND OBJECTIVES

This exercise could possibly be used at beginning of the training session and at end to measure differences in general Mental Health awareness so you can see

#### TRAINERS INSTRUCTIONS

**15 mins** Trainer to write a series of diagnoses on sticky labels and stick them on the backs of delegates while the delegates are standing.

Each delegate to then look at each others labels and say a word they associate with that diagnosis without using the word itself.

Each delegate then has to deduce what their label says.

## REFERRAL EXERCISE

*The key focus throughout the training should be to stress that staffs who work with offenders should not feel that they have to deal with mental distress and associated symptoms on their own.*

*It may be worth considering leaving a short slot at the end to focus on how staff can make a referral and who they should make their referral to – encouraging larger group discussion.*

#### FACILITATOR NOTES:

As the trainer, you should facilitate questions:

- Who did their referrals go to?
- Was there a single point of entry to mental health services?
- Are they aware of the care pathway?

## EXAMPLE OF SERVICES AVAILABLE FOR OFFENDERS

– Taken from the ‘wishing you well’ document

Although all of these services may not be available in every institution, a number of them will be. It is important to encourage delegates to refer on to the appropriate services.

<b>HOUSING SUPPORT:</b>	<ul style="list-style-type: none"> <li>• Nacro</li> <li>• Housing Advice Service.</li> </ul>
<b>EMPLOYMENT:</b>	<ul style="list-style-type: none"> <li>• Carter &amp; Carter</li> <li>• Outwork department</li> <li>• Jobs Bus</li> <li>• “Take Control” self-employment project.</li> </ul>
<b>LEARNING OPPORTUNITIES:</b>	<ul style="list-style-type: none"> <li>• The Adult Learning Centre</li> <li>• Outside College via Carter &amp; Carter</li> <li>• Open &amp; Distance Learning via The Signpost</li> <li>• Gymnasium</li> <li>• Workshop NVQs</li> </ul>
<b>PHYSICAL ACTIVITY:</b>	<ul style="list-style-type: none"> <li>• Healthy Living</li> <li>• Health Trainers</li> <li>• Gym classes</li> <li>• Fitness suite</li> </ul>
<b>INFORMATION ON MENTAL HEALTH:</b>	<ul style="list-style-type: none"> <li>• Health Trainers</li> <li>• Healthcare leaflets</li> </ul>
<b>TIME OUT AND CREATIVITY:</b>	<ul style="list-style-type: none"> <li>• Beauty appointments</li> <li>• Relaxation sessions</li> <li>• Acupuncture</li> <li>• Library</li> <li>• Poetry Group</li> <li>• Art classes</li> <li>• Fine Cell</li> <li>• Flower Shop</li> <li>• Massage</li> <li>• Chaplaincy</li> <li>• Association Room</li> <li>• Recreational Gym</li> </ul>
<b>DIET AND WEIGHT MANAGEMENT:</b>	<ul style="list-style-type: none"> <li>• Health Trainers</li> <li>• Healthy Living</li> <li>• Gymnasium</li> <li>• Eating Disorder Group</li> </ul>

<b>SUBSTANCE MISUSE:</b>	<ul style="list-style-type: none"> <li>• CARATS</li> <li>• Rehab Unit</li> <li>• Personal Officer</li> <li>• Smoking Cessation advice</li> <li>• Alcoholics Anonymous</li> <li>• “Drug &amp; Alcohol Awareness” course</li> <li>• Acupuncture</li> </ul>
<b>DEBT:</b>	<ul style="list-style-type: none"> <li>• Legal Services</li> <li>• ALC Financial Literacy course</li> <li>• National helpline (Tel: 0808 808 4000)</li> </ul>
<b>SUPPORT WITH CHILDCARE:</b>	<ul style="list-style-type: none"> <li>• Family visits</li> <li>• Visits</li> <li>• CVs</li> <li>• ALC parenting classes</li> <li>• Mothers Union</li> <li>• Childcare Resettlement</li> </ul>
<b>TALKING THINGS OVER:</b>	<ul style="list-style-type: none"> <li>• The Listeners</li> <li>• Samaritans</li> <li>• Counsellor</li> <li>• Chaplaincy</li> <li>• Personal Officer</li> <li>• Lifer Officer</li> <li>• Health Trainers</li> <li>• Psychology</li> <li>• Eating Disorder Group</li> <li>• Diversity</li> <li>• Independent Monitoring Board</li> </ul>
<b>CONFIDENCE AND SELF-ESTEEM:</b>	<ul style="list-style-type: none"> <li>• Counsellor</li> <li>• Psychology department</li> <li>• ALC courses</li> <li>• Healthy Living</li> <li>• Chaplaincy</li> <li>• Personal Officer</li> </ul>
<b>DOMESTIC ABUSE:</b>	<ul style="list-style-type: none"> <li>• Counsellor (info from Healthcare)</li> <li>• Samaritans</li> <li>• Personal Officer</li> <li>• Chaplaincy</li> <li>• National helpline (Tel: 0808 2000 247)</li> </ul>
<b>DIVERSITY:</b>	<ul style="list-style-type: none"> <li>• Hibiscus</li> <li>• Diversity Peer Support Workers</li> <li>• REAT Officer</li> <li>• Diversity Officer</li> <li>• Chaplaincy</li> <li>• Independent monitoring Board</li> </ul>

# APPENDICES

## APPENDIX (1): TRAINERS EVALUATION FORM

Course Title: Mental Health Awareness
Name:
Organisation:
Job Title:

### 0.1 Was the course pitched at about the right level for your delegates?

Too low     
  About right     
  Too high     
 (please tick)

### 0.2 Did you feel the course provided sufficient opportunities for learning in the following areas?

LEARNING OBJECTIVES	1	2	3	4
A Definitions of Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B Causes of Mental Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C Understanding of Neuroses, Psychoses and Personality Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D Difference between Psychosis and Neurosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E Insight into Depression, Anxiety and Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F Insight into Schizophrenia and Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G Insight into Personality Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H Understanding how Mental Illness is treated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I Knowing what you can do to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 0.3 Now please give your ratings on the following aspects of the course 1 = lowest score 4 = highest score (please tick)

	1	2	3	4
Encouraging delegate involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handouts/resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 0.4 Any other comments you wish to make about the content of the course?

### 0.5 Using what you've learned what will you do differently as a result of running this course/event?

### 0.6 Can you think of any other specific module that you would like to incorporate within the mental health awareness training?



Name:

Department:

Date of Training Course:

This Prison Specific Mental Health Awareness Course was:

- *Commissioned by the Department of Health's Offender Health Department*
- *Project Managed by Care Services in Partnership (CSIP) West Midlands*
- *Devised by Raise Mental Health Limited – [www.raise.org.uk](http://www.raise.org.uk)*