

*Delegates Information Booklet*

# MENTAL HEALTH AWARENESS TRAINING COURSE



Ministry of  
**JUSTICE**



**90% OF OFFENDERS HAVE  
AT LEAST ONE MENTAL  
HEALTH DISORDER**

*(ONS 1997)*

## WELCOME TO YOUR MENTAL HEALTH AWARENESS COURSE

# SO WHY IS MENTAL HEALTH AWARENESS IMPORTANT?

### FOR YOU THIS COURSE CAN HELP TO:

- *Enhance your existing management and observational skills*
- *Increase your understanding of mental health issues*
- *Enable appropriate earlier intervention*
- *Make you more effective in your vital role*

### THIS COURSE WILL SUPPORT YOU TO HELP OFFENDERS:

- *Cope better with life generally*
- *Cope better with the issues that can result from being within the prison environment*

## INTRODUCTION

*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.



## HOW TO USE THIS BOOKLET

- Remember that this can be used as your reference – you can take it away with you to aid your personal development.
- This booklet accompanies a presentation that will be made by your trainer.
- At the front of the workbook is a table of contents so you can quickly find what you need. The separate modules are colour coded for your convenience e.g. Personality Disorders are green.
- Along with general information we also provide handy hints and tips (shown by the light bulb) along with interesting facts.
- At the back of the workbook is a glossary of terms and appendices for extra information.
- It's hoped that you will be able to apply the knowledge within this workbook and that you will reflect upon it in the future.

*There won't be time to cover all the material in this booklet.*

*Your trainer will go through with you the most relevant sections for your situation – it is a 'pick and mix' presentation.*

*However you have all of the training material so you can look through it later.*

## SO WHAT IS MENTAL HEALTH?

What people understand by Mental Health and mental wellbeing is influenced by a combination of their:

- Age
- Class
- Gender
- Personal experiences and expectations
- Ethnicity
- Cultural and religious beliefs

Most Health Care professionals use the definition of the World Health Organisation:

*“Health is a state of complete physical mental and social well-being and is not merely the absence of disease or infirmity.”*

*Health is a resource for everyday life, not for the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities”*

World Health Organisation

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

Mental Health influences how we:

- Think and feel about ourselves
- Think about our future
- Think about others
- Interpret events
- Are able to learn
- Communicate
- Form, sustain and end relationships
- Cope with change, transition and life events

*“Mental Health is the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own, and others dignity and worth.”* [www.scotland.gov.uk](http://www.scotland.gov.uk)



## EXERCISE

*Mental health in the prison environment brings its own difficulties - both for staff and offenders.*

**0.1** What do you do to maintain or improve your mental health?

## SO WHAT IS POSITIVE MENTAL HEALTH?

One commentator, D.W.Winnicott, wrote that: *“Health is more difficult to deal with than illness”*. Why might this be the case?

### POSITIVE MENTAL HEALTH IS ABOUT:

- Feeling in control
- Being able to make rational decisions
- Being in touch with our feelings
- Being able to form positive relationships
- Feeling good about ourselves
- Knowing how to look after ourselves

### POSITIVE MENTAL HEALTH CAN BE ACHIEVED IF INDIVIDUALS:

- Talk about their feelings
- Write things down
- Keep active
- Eat well
- Sleep well
- Keep in touch with friends and loved ones
- Get knowledge and take control
- Get professional help
- Improve coping skills
- Set realistic goals
- Keep an eye on personal stress
- Find a hobby
- Ask for help

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

McDonald and O’Hara (1998) identified ‘Ten elements of mental health promotion and demotion’ - i.e. factors that can help or hinder positive mental health:

| MENTAL HEALTH PROMOTION | MENTAL HEALTH DEMOTION    |
|-------------------------|---------------------------|
| self-esteem             | emotional abuse           |
| emotional processing    | emotional negligence      |
| self-management skills  | stress                    |
| environmental quality   | environmental deprivation |
| social participation    | social exclusion          |

## SO WHAT IS MENTAL ILLNESS?

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.

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"***

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

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

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.

## SO WHAT AFFECTS OUR MENTAL HEALTH?

*Mental health is determined by many complex and related reasons all of which can interact to determine the state of our mental health. There are many theories and different factors that enable us to positively maintain our mental health:*



- Family, friends, colleagues
- Employment
- Education
- Stable housing
- Sound finances
- Faith and religion
- Social activities - hobbies and interests
- Exercise and nutrition
- Cultural diversity



- Positive and optimistic thought patterns
- The ability to cope with stressful life events
- A sense of control over our lives
- Emotional support from family, friends etc



- This is what occurs naturally, within our brains, over which we have no control
- Mental Illness often occurs when various brain chemicals do not work effectively, working too much - or not at all.

***Which of the above are not available to offenders to maintain their mental health?***

**THE MENTAL HEALTH CONTINUUM:** *Everyone's mental health constantly fluctuates and moves up and down the continuum to varying degrees.*

*Where are you on the continuum at the moment?*

POSITIVE MENTAL HEALTH



MENTAL DISTRESS

## SO WHAT IS MENTAL ILLNESS NOT?

*There is a lot of stigma surrounding mental health...*

### **SCHIZOPHRENIA IS NOT...**

- Split or multiple personalities - that is actually known as Dissociative Personality Disorder
- A guarantee that the offender will be violent or dangerous
- Always a diagnosis for life

### **BIPOLAR DISORDER IS NOT...**

- An indication that a person constantly swings from highs to lows (mania to depression)
- A guarantee that the mood swings last the same length of time, follow the same pattern or even that they occur regularly. It varies enormously from individual to individual
- Always a diagnosis for life

### **BORDERLINE PERSONALITY DISORDER IS NOT...**

- A sign of a faulty personality
- A guarantee that the offender is manipulative or displays attention seeking behaviour
- Untreatable

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

- Diagnosable through standard Mental Health assessments

### **DEPRESSION IS NOT...**

- Easy to recover from without professional help, support and treatments
- The same as mild 'low moods' that all of us can experience regularly as a result of daily events
- A guarantee that someone will express suicidal thoughts

*Many people who suffer mental distress can fully recover and go on to lead fulfilling lives.*

### **GENERALISED ANXIETY DISORDER IS NOT...**

- The same as phobias, fears, stress or panic attacks
- Untreatable
- A guarantee that someone will then develop other illnesses e.g. Obsessive Compulsive Disorder and Eating Disorders

# 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 does not impact upon someone's sense of reality, e.g. Depression, Anxiety, Eating Disorders and Phobias.

## PSYCHOSIS

Psychosis, or being psychotic, is a generic psychiatric term for a mental state often described as involving a "loss of contact with reality." This loss of reality is the key difference with neurosis. It may last for short periods.

People experiencing psychosis may report hallucinations or delusional beliefs, and may exhibit personality changes and disorganised thinking. This may be accompanied by unusual or seemingly bizarre behaviours, as well as difficulty with social interaction and impairment in carrying out the activities of daily living. A wide variety of stress factors can cause a psychotic reaction.

## PERSONALITY DISORDERS

Personality Disorders are long lasting and persistent styles of behaviours and thought. Personality Disorders encompass a group of behavioural disorders that are different from the psychotic and neurotic disorders. People with Personality Disorders will behave in a certain manner because of their often distorted view of the world and how they see themselves. Because of these distortions they often find it difficult to conform to social norms.

*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. However with 90% of offenders thought to have a mental illness, there will be a significant number who develop an illness such as those described.*

**Mental Health**  
Prison Population 90%  
General Population 25%

Neuroses

Psychoses

Personality Disorders



# DEPRESSION

An example of a Neurotic Illness that is prevalent in prisons:

**DEFINITION:** *The World Health Organisation says - “Depression is a common mental disorder involving depressed mood, loss of interest, loss of pleasure, feelings of guilt, low self-worth, disturbed sleep, appetite, concentration and low energy”*

## SOME SIGNS YOU MAY NOTICE

- Persistent sad, pessimistic, anxious or empty feelings
- Feelings of guilt, worthlessness, helplessness
- Loss of interest in hobbies or activities
- Tiredness and loss of energy
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening or oversleeping
- Change in appetite and/or weight loss or weight gain
- Thoughts of death or suicide
- Physical symptoms such as headaches, digestive disorders, chronic pain

## WHAT IT IS NOT

Frequently it is not easy to recover from without professional help

## POSSIBLE RISKS

- Suicide
- Self Harm
- Reduction in self care

## WHAT YOU CAN DO TO HELP

- 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 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.
- Monitor possible suicidal gestures or threats. Statements such as “I wish I were dead,” or “I don’t want to be here anymore,” must be taken seriously. Depressed people who talk about suicide are NOT doing it for the attention. If the person you are dealing with seems to be suicidal, make sure that you open an ACCT document and refer to your designated manager.
- Remember that offenders may not be able to work or comply with rules due to their illness.
- Provide emotional support. You need to create an environment in which an offender is able to open up. Signpost to Listeners.
- What a person suffering from depression needs most is compassion and understanding. Telling an offender to “snap out of it” or “lighten up” will just make the matter worse. The best things to say are, “How can I help?”

Usually, depressed people lie about their depression, so if someone says, “Are you okay?” they will say “Yes”.

- Don’t try to talk a depressed person out of his or her feelings. Instead, you might try saying, “I’m sorry that you’re feeling bad. What would help you?” Ask if they have felt that way before and what has helped in the past.
- Depression is a disease so progress will take time.
- Step back every so often. You may become frustrated when your well-meaning advice and reassurance are met with sullenness and resistance.
- Get help from other professional agencies, talk to health care.
- Try to cheer them up, but don’t overdo it.
- Listen – don’t dominate conversations.
- Try to hold as much positive conversation as possible. Do not snap at the person. They cannot help the way they are feeling.
- Do not joke about the matter - this is serious!
- Be careful what you say and do to a depressed person.
- Don’t try to take on their problem all by yourself.
- Don’t be nosy. If they don’t want to discuss something with you, don’t try to force them to talk about it.
- **Knowledge can help both you and the offender!**

## POSSIBLE TREATMENTS

- Medication e.g. Anti-Depressants
- Talking Treatments – e.g. Therapy and Counselling
- Self Help – e.g. Relaxation and breathing exercises

## LIKELY CAUSES

- Medication e.g. Anti-Depressants
- Talking Treatments – e.g. Therapy and Counselling
- Self Help – e.g. Relaxation and breathing exercises

## AGE OF ONSET:

Most commonly starts between 25 and 44 years old

## HOW COMMON IS IT?

- In prisons: (Mixed Depression and Anxiety)  
Males: 19% and Females: 31% - Singleton, ONS 1997
- General population: 1 in every 6

## GENDER ISSUES

- Females are generally more likely to have all types of neurotic disorder

## ASSOCIATED CONDITIONS

- Post Traumatic Stress Disorder
- Anxiety
- Physical illnesses
- Phobias
- Psychosis
- Substance misuse
- Increased chance of having other Neuroses  
e.g. Obsessive Compulsive Disorder and Eating Disorders

## INTERESTING FACT:

Occurs disproportionately in the female prison population



*Did you know that there are different types of **Depression**?*

#### **MAJOR OR CLINICAL DEPRESSION**

Individuals seem disinterested in becoming involved in regular activities. The offender feels that they will always be in this hopeless state. Loss of appetite and weight loss are the norm.

#### **ATYPICAL DEPRESSION**

Atypical depression is different from Major Depression. The offender is sometimes able to experience happiness and moments of elation. Symptoms include fatigue, over sleeping, over-eating and gaining weight. Episodes can last for months, or the offender may live with it forever.

#### **PSYCHOTIC DEPRESSION**

Offenders tend to see and hear imaginary things and sounds, voices and visuals that do not exist. They are called hallucinations – where the offender imagines negative and frightening sounds and images.

#### **REACTIVE DEPRESSION**

This depression has more to do with severity of life stresses than inherited factors. Symptoms are typified by worry and anxiety, with problems getting to sleep rather than waking early in the morning.

#### **SEASONAL AFFECTIVE DISORDER**

A type of depressive disorder which is characterised by episodes of major depression which reoccur at specific times of the year – especially in Autumn & Winter.

#### **POSTNATAL DEPRESSION**

Can emerge for the mother at any time in the infants first year. Common symptoms are feeling very low and despondent, that life is a long grey tunnel and that there is no hope. Most sufferers complain of feeling tired and lethargic, or even quite numb. There can often be severe guilt about not coping or not loving the baby enough, or even being hostile or indifferent to their baby.

#### **DOCTORS ALSO DEFINE DEPRESSION BY HOW SERIOUS IT IS:**

##### **MILD:**

Some impact on daily life

##### **MODERATE:**

Significant impact on daily life

##### **SEVERE:**

Daily activities are almost impossible

*Listeners, health trainers and all staff throughout the prison can play a part in mental health promotion to offenders.*

# ANXIETY DISORDER

An example of a Neurotic Illness that is prevalent in prisons:

**DEFINITION:** A long term condition involving an excessive and persistent sense of apprehension

## SOME SIGNS YOU MAY NOTICE

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

## WHAT IT IS NOT

A mild illness that can be ignored

## POSSIBLE RISKS

- Panic Attacks
- Development of phobias
- Associated Mental Health problems including Depression

## WHAT YOU CAN DO TO HELP

- 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

**Knowledge can help both you and the offender!**

## POSSIBLE TREATMENTS

- Medication e.g. Anti-Depressants
- Talking Treatments – e.g. Therapy and Counselling
- Self Help – e.g. Relaxation exercises

## LIKELY CAUSES

Anxiety Disorders may result from a single event, or a complex combination of factors:

- A natural reaction to stress – “A fight or flight response”
- Social factors such as the offenders financial and family situation
- Genetics
- Physical causes
- Past traumatic events
- Drug misuse

## AGE OF ONSET:

Any age

## HOW COMMON IS IT?

- In prisons: (Generalised Anxiety Disorder) Males: 8% and Females: 11%
- General population: 3-4%

## GENDER ISSUES

- Of people with Phobias or OCD, about 60% are female.

## ASSOCIATED CONDITIONS

- Depressed Mood
- Somatic or Sexual Dysfunction
- Anxious or Fearful or Dependent Personality

## INTERESTING FACT:

Mixed Anxiety & Depression is the most common Mental Disorder in Britain at almost 9% of the population - *The Office for National Statistics*

*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.

# EATING DISORDER

An example of a Neurotic Illness that is prevalent in prisons:

**DEFINITION:** Eating disorders are often described as an outward expression of internal emotional pain and confusion. There are different types: Anorexia, Bulimia and Compulsive and binge eating

## SOME SIGNS YOU MAY NOTICE

### Anorexia (1%)

- Distorted perceptions of their weight, size and shape
- Behaviour which results in a marked weight loss
- A morbid fear of gaining weight or becoming fat
- Excessive exercising while starving themselves
- Stopping of periods for women

### Bulimia (4%)

- Bouts of eating followed by purging
- Distorted perceptions of their own weight, size and shape
- A powerful urge to over-eat, leading to binge eating and a resultant feeling of being out of control
- Compensatory behaviour such as; self-induced vomiting, misuse of laxatives, diuretics or other medication, fasting or excessive exercise
- A morbid fear of gaining weight or becoming fat

### Compulsive or Binge Eating

- Recurrent episodes of binge eating then a feeling of being out of control
- During a binge the person may; eat more quickly than normal, eat until uncomfortably over-full, eat large amounts when not hungry, tend to “graze” rather than eat meals, eat alone in secret, feeling disgusted and guilty with themselves.

## WHAT IT IS NOT

A fleeting problem that will just pass without help – it can have major, long term consequences for the persons physical health.

## POSSIBLE RISKS

- Heart failure / or other internal organs
- Tooth decay
- Infertility
- Osteoporosis

## WHAT YOU CAN 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

## POSSIBLE TREATMENTS

- Psychotherapy and counselling
- Specialist hospital treatment
- Medication – e.g. antidepressants

**With treatment about 60% of people can recover**

## LIKELY CAUSES

- Social pressure to be thin
- Emotional distress – a reaction to an illness, upsetting events etc
- Low self-esteem and social pressures to be thin
- Depression – so eat to eating with unhappiness
- A need to have control over their weight when they feel they 'have no control over rest of life'

## AGE OF ONSET:

Mid-teens onwards

## HOW COMMON IS IT?

- In prisons: 1 in 10 women, 1 in 100 men
- General population: 1 in 20 women, 1 in 200 men

## GENDER ISSUES

Women are 10 times more likely to suffer from an eating disorder.

## ASSOCIATED CONDITIONS

- Anxiety
- Obsessive Compulsive Disorder (OCD)
- Depression
- Self-harming

## INTERESTING FACT:

It is very common for an offender to suffer with more than one eating disorder.

A questionnaire used by doctors asks:

If you answer “yes” to two or more of these questions, you may have a problem with your eating. Please note this is not a guide to diagnose someone – that's a job for the health professionals!

- Do you make yourself sick because you're uncomfortably full?

- Do you worry that you've lost control over how much you eat?
- Have you recently lost more than 6 Kg (about a stone) in three months?
- Do you believe you're fat when others say you're thin?
- Would you say that food dominates your life?



# BIPOLAR DISORDER

An example of a Psychotic Illness that is prevalent in prisons:

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

## SOME SIGNS YOU MAY NOTICE

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 pattern of severity and duration.

## WHAT IT IS NOT

It is not a state of constant mania (highs) or depression (lows)

## POSSIBLE RISKS

- Suicide
- Extreme elation leading to ignoring basic bodily needs e.g. sleep/food

## WHAT YOU CAN DO TO HELP

- 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 from 0 to 10:
- 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
- Do not collude in grandiose ideas

## POSSIBLE TREATMENTS

- Medication such as Mood Stabilisers – e.g. Lithium
- Talking
- Self help – e.g. keeping mood diaries

## LIKELY CAUSES

- Genetics
- Stressful life events
- Emotional trauma

## AGE OF ONSET:

Symptoms often appear in late adolescence and early adulthood

## HOW COMMON IS IT?

- In prisons: Females: 1% and Males 1% - *Singleton, ONS 1997*
- General population: 1%

## GENDER ISSUES

Affects both males and females equally

## ASSOCIATED CONDITIONS

- Psychosis
- Self harm
- Eating disorders

## INTERESTING FACT:

Bipolar used to be called Manic Depression

*Did you know that there are different types of **Bipolar**?*



## 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

An example of a Psychotic Illness that is prevalent in prisons:

**DEFINITION:** 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:                 | 'Less than normal' experiences:           |
| • Hallucinations                                | • Slowness to move, think, speak or react |
| • Delusions                                     | • Social withdrawal                       |
| • Agitation                                     | • Apathy                                  |
| • Disorganised thinking<br>talking incoherently | • Difficulty in understanding things      |
|   | • Poor memory                             |

## WHAT IT IS NOT

Schizophrenia isn't about having a Split Personality

## 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*

## WHAT YOU CAN 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, 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

## POSSIBLE TREATMENTS

- 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
  - Self help and self help organisations

## LIKELY CAUSES

- Genetics – but no individual gene is responsible
- Stressful life events & social issues play an important role
- Drug and alcohol use can trigger a first episode  
- this is called drug induced psychosis

## AGE OF ONSET:

The peak ages of onset are 20–28 years for males and 26–32 years for females

## HOW COMMON IS IT?

- In prisons: Schizophrenia is 10 times more common than in the general population (*Fazel & Danesh, 2002*)
- General population: 1%

## GENDER ISSUES

Affects men and women equally

## ASSOCIATED CONDITIONS

- Self Harm
- Mood Swings - a type of Schizophrenia known as Schizoaffective Disorder is a combination of Bipolar & Schizophrenia

Did you know that there are five types of Schizophrenia?



### PARANOID TYPE:

Delusions and hallucinations are present but thought disorder, disorganized behaviour and 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.

# BORDERLINE PERSONALITY DISORDER

An example of a Personality Disorder that is prevalent in prisons:

**DEFINITION:** *It affects your view of the world and especially how you view yourself. The World Health Organisation says Personality Disorders are: "Deeply ingrained and enduring behaviour patterns manifesting themselves as inflexible responses to a broad range of personal and social situations."*

## SOME SIGNS YOU MAY NOTICE

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

## WHAT IT IS NOT

People with Boarderline Personality Disorder (BPD) are not manipulative- they just have overwhelming needs at times that need to be satisfied

## POSSIBLE RISKS

- 70 to 80 % of people with BPD self harm
- One in ten BPD offenders commits suicide

## 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**

## POSSIBLE TREATMENTS

- Medication
- Psychotherapy – particularly DBT - Dialectical Behavioural Therapy

## LIKELY CAUSES

- Some studies say that Personality Disorders may be inherited
- Environmental factors. Many people with Borderline Personality Disorder have a history of childhood abuse, neglect and separation.
- Between 40% and 70% of BPD patients report having been sexually abused
- Brain abnormalities. Some research shows changes in certain areas of the brain are a factor. In addition, certain brain chemicals that help regulate mood may not function properly

## AGE OF ONSET:

BPD is very common amongst adolescent and young adults with the highest rates at the ages between 18 and 35

## HOW COMMON IS IT?

- In prisons: Males: 14% Females: 20% - Singleton, ONS 1997
- General population: 2%

## GENDER ISSUES

Males with BPD are often sent to prison for violent outbursts resulting from a biological inability to control impulsivity.

## ASSOCIATED CONDITIONS

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.**

## INTERESTING FACT

Of all the different Personality Disorders only two Personality Disorders are associated with self-harm. One is BPD and the other is Antisocial Behaviour Disorder.

## A Mnemonic to describe Borderline Personality Disorder:

**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



# ANTI-SOCIAL PERSONALITY DISORDER

An example of a Personality Disorder that is prevalent in prisons:

**DEFINITION:** *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 SIGNS YOU MAY NOTICE

- 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

## WHAT IT IS NOT

A treatment that Health Care professionals find easy to treat

## POSSIBLE RISKS

- Homicide
- Suicide
- Frequent imprisonment for unlawful behaviour
- Alcoholism and drug abuse

## 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
- The primary motivation of the patient with Anti-Social Personality Disorder is to be right and to be successful. It is useful to work with this motivation, not against it
- This motivation may not be acceptable normally but it can offer a point from which to begin to build a rapport
- A key to treating people with Anti-Social Personality Disorder is to be flexible keeping in mind a variety of containment options

## POSSIBLE TREATMENTS

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.

## LIKELY CAUSES

- Genetic factors
- Child abuse
- An antisocial or alcoholic parent

## AGE OF ONSET:

Can't be diagnosed before 18 though often there is a history of similar behaviours before age 15 such as repetitive lying, truancy, delinquency, and substance abuse.

## HOW COMMON IS IT?

- In prisons: 49% of men and 31% of females - *Singleton, ONS 1997*
- General population: 13% of men and approx 1% of women

## GENDER ISSUES

Women are rarely diagnosed with ASPD

## ASSOCIATED CONDITIONS

- Alcohol and substance misuse
- Anxiety
- Depression
- Self-harm
- Eating disorders

## INTERESTING FACT:

Anti-Social Personality Disorder is also known as Psychopathic Personality or Sociopathic Personality Disorder. It is estimated that 35-55% of people with substance misuse problems also have symptoms of a personality disorder with the most prevalent being antisocial personality disorder.

*A common misconception about  
Anti-Social Personality Disorder...*



A common misconception is that Anti-Social Personality Disorder refers to people who have poor social skills. The opposite is often the case.

People with this disorder may appear charming on the surface, but they are likely to be aggressive and irritable as well as irresponsible in all areas of life.

# YOUNG OFFENDERS & MENTAL HEALTH

**DEFINITION:** *It's important to remember that a mental illness may not be fully formed at this young 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.

## WHAT IT 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.

## POSSIBLE RISKS

- Suicide
- Substance abuse
- Self harm
- Eating disorders
- Aggressive outbursts and inappropriate anger
- Drug induced psychosis

## 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.

*CAMHS, the Child and Adolescent Health Service promotes the mental health and psychological well being of children and young people. CAMHS teams provide support to young people and their families.*



## POSSIBLE TREATMENTS

- 10% of young men and 40% of the young women take some form of medication that acts on the central nervous system, such as sleeping tablets and anti-depressants
- Talking therapies

## LIKELY CAUSES

- Disturbed upbringing
- Physical and sexual abuse
- Peer pressure to become involved in illegal activities

## AGE OF ONSET:

The average age at which young people get involved in crime is 13 and a half for girls and 14 for boys.

There are early signs: a recent survey of 5-15 year olds found that:

- 5% exhibited aggressive and or anti-social behaviour
- 4% had emotional disorders such as anxiety or depression
- 1% were hyperactive

## HOW COMMON IS IT?

90% of young offenders have a mental health problem

## GENDER ISSUES

Almost 80% of young people in trouble with the law are male

## INTERESTING FACT:

There are currently 11,500 people under 21 in the prison system in England and Wales.

# ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

**DEFINITION:** *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

*ADHD creates a vulnerability to many other problems. Those particularly relevant to the justice service are an increase in alcohol and substance misuse (x6) and Conduct Disorder, leading to antisocial behaviour. Many people with ADHD also have Bipolar Disorder and specific learning difficulties.”*

Lancaster University

# SUICIDE AND SELF-HARM

**DEFINITION:** *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.*

## SOME SIGNS YOU MAY NOTICE

### 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...”

## WHAT IT IS NOT

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.

## POSSIBLE RISKS

- Habit forming, therefore risk of repetition
- Poisoning
- Broken bones and internal bleeding
- Mental disorders

## 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/situations.
- Be non judgemental, don’t accuse or react with revulsion
- 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.

## POSSIBLE TREATMENTS

- For most people, stopping self harming is a long, slow process. Opportunity to gradually build upon coping skills is paramount.
- Generally the recovery process begins with tackling the underlying problems that were causing the self harm or suicide attempt
- Learning new coping strategies or using ‘distraction techniques’ when the feeling to hurt themselves arises.
- Emergency help-lines, self help groups e.g. Listeners and sourcing other support networks.

## LIKELY CAUSES

- Emotional trauma
- Isolation
- Close relative has done the same
- Family breakdown
- Low self-esteem
- Alcohol and drug misuse
- Financial problems
- History of previous self-harming or attempted suicide

## AGE OF ONSET:

The average age of onset for Self-harming is 12

## HOW COMMON IS IT?

### Self-harm:

2% men and 8% women

More common in gay, lesbian, transgender communities;  
People with learning disabilities;  
People with Borderline Personality Disorder

### Suicide:

0.75% men and 0.25% women

## GENDER ISSUES

- Young Asian women are particularly more likely to self-harm and commit suicide.
- Because men are more likely to hit themselves or break bones, it is easier to pass off as an accident or that they have been in a fight.

## ASSOCIATED CONDITIONS

- Anxiety
- Depression
- Other mental health problems

## INTERESTING FACT:

Young people and adults will often feel very ashamed and guilty about self-harming and do not want to talk about it.

Before 1961 Suicide Act people in UK were sent to prison for attempting suicide.

## DUAL DIAGNOSIS

**DEFINITION:** “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:

### 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 specialised 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.

### THE SUBSTANCES CAN BE SPLIT IN TO 3 GROUPS:

- 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 and 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 they have reached a crisis point, with problems relating to social, legal, housing, welfare and lifestyle issues.
- They are not only drug users, but also mentally ill, which are two of the most stigmatised groups in society.

## 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 and cocaine) often result in confusion, irritability and low mood. Can make people feel suicidal, provoking an attempt.
- Withdrawal from opiates can cause unpleasant physical side effects. Also, low mood, irritability.

*"People thought I would be in and 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 and sober for 8 years now and have even trained as a counsellor, so I can help other prisoners to get out of the system and lead rewarding lives. Before, I never dreamed it would be possible to change."*

*An Offender*

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.'

## CONSIDERATIONS FOR EFFECTIVE COMMUNICATION

*Effective communication in a prison setting may pose particular difficulties to staff e.g. language barriers, suspicion, fear, anger and lack of engagement by the offender. Poor communication may result in confusion, misunderstanding, missed opportunities and increased risk.*

Better communication can be achieved through the efforts of all parties to anticipate and eliminate potential sources of confusion.

### IT HELPS TO CONSIDER:

- Why? - you need to know why they need your message
- What information do you wish to convey?
- Who is your audience? - think about situational or cultural influences
- What do you wish to communicate?
- How can you best communicate this and how might this be perceived?
- When? - is your communication relevant to that moment?
- Where? - will this affect the communication?

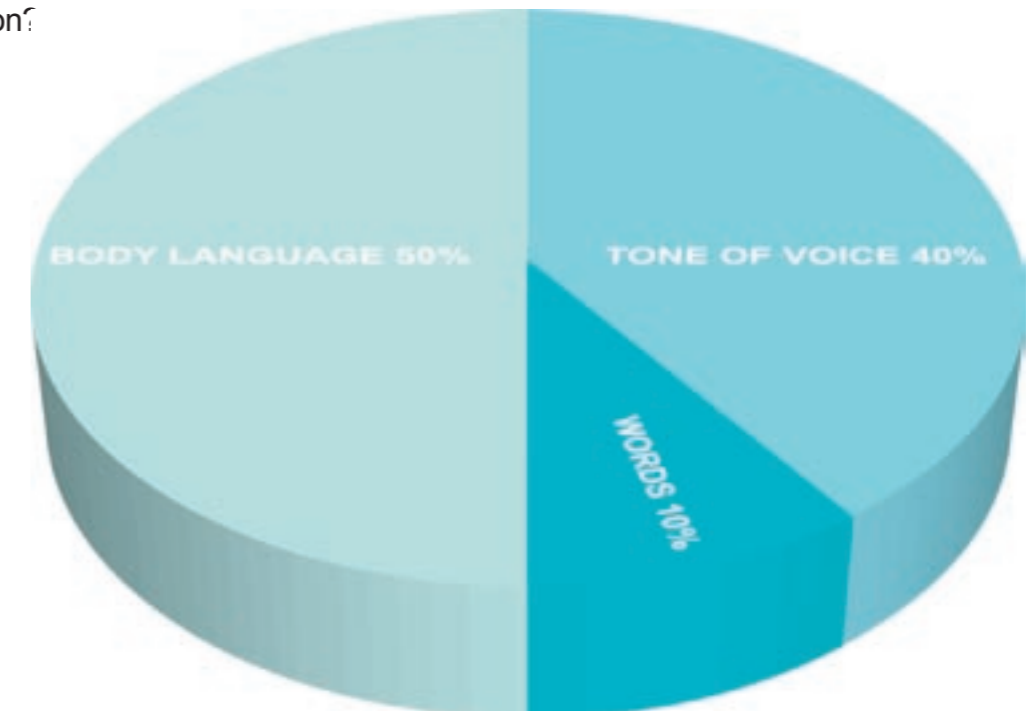
### ATTITUDE:

Your attitude is the first thing people pick up on in face-to-face communication. Just as laughing, yawning, and crying are infectious, attitude is infectious. Before you say a word, your attitudes can infect the people who see you with the same behaviour. Just by looking or feeling, you can be infected by another person's attitude, and vice versa.

Attitudes drive behaviour. Your body language is a result of your mental attitude. By choosing your attitude you get in that mood and send out a message that everyone understands, consciously or unconsciously.

### BODY LANGUAGE:

The way your message is conveyed...



## EYE CONTACT AND CULTURAL DIFFERENCES:

Eye contact is one of the most important non-verbal channels you have for communication and connecting with other people. “The cheapest, most effective way to connect with people is to look them into the eye.” This helps to answer a critical question when you are trying to connect – ‘Is he/she paying attention to what I’m saying?’

## SOME EXAMPLES OF CULTURAL DIFFERENCES:

In some cultures, looking people in the eye is assumed to indicate honesty and straightforwardness; in others it is seen as challenging and rude. Most people in Arab cultures share a great deal of eye contact and may regard too little as disrespectful. In English culture, a certain amount of eye contact is required, but too much makes many people uncomfortable. Most English people make eye contact at the beginning and then let their gaze drift to the side periodically to avoid ‘staring the other person out’. In South Asian and many other cultures direct eye contact is generally regarded as aggressive and rude.

**EFFECTIVE QUESTIONING:** *How you ask questions is very important in establishing a basis for effective communication. Effective questions opens the door to knowledge and understanding. The art of questioning lies in knowing which questions to ask when.*

### CHOOSING QUESTIONS:

Ask a specific question if you want to hear a specific answer. Open - as opposed to leading - questions are those that cannot be answered with a straight “yes” or “no”. Use open questions to gain insight into the other person’s character, and to invite a response that truly reflects what they feel rather than what they think you want to hear.

### GETTING RESPONSE YOU NEED:

#### An open question:

does not invite any particular answer, but opens up discussion or elicits a wide range of answers. Typically, open questions start with ‘Why’, ‘How’, ‘What’, ‘Tell me about ...’

#### A closed question:

is specific and must be answered with a yes or no, or with details as appropriate.

#### A fact-finding question:

is aimed at getting information on a particular subject.

#### A follow-up question:

is intended to get more information or to elicit an opinion.

### ASKING SEARCHING QUESTIONS:

Asking searching questions starts with challenging assumptions. If you do not check assumptions you cannot be good at asking searching questions. Don’t ask one or two questions and then rush straight towards a solution. With an incomplete understanding of the problem it is very easy to jump to wrong conclusions.

**ACTIVE LISTENING:** *It takes concentration and determination to be an active listener and hear what people are really saying. There are 5 key elements to active listening.*

### 1. PAYING ATTENTION

Give the speaker your undivided attention and acknowledge the message. Recognize that what is not said also speaks loudly.

- Look at the speaker directly.
- Put aside distracting thoughts. Don’t mentally prepare a rebuttal!
- Avoid being distracted by environmental factors.
- “Listen” to the speaker’s body language.
- Refrain from side conversations when listening in a group setting.

### 2. SHOWING THAT YOU ARE LISTENING

Use your own body language and gestures to convey your attention.

- Nod occasionally.
- Smile and use other facial expressions.
- Note your posture and make sure it is open and inviting.
- Encourage the speaker to continue with small verbal comments like ‘yes’ and ‘uh huh.’

### 3. PROVIDING FEEDBACK

Our personal filters, assumptions, judgments, and beliefs can distort what we hear. As a listener, your role is to understand what is being said. This may require you to reflect what is being said and ask questions.

- Reflect what has been said by paraphrasing. “What I’m hearing is...” and “Sounds like you are saying...” are great ways to reflect back.
- Summarize the speaker’s comments periodically
- Ask questions to clarify certain points. “What do you mean when you say...?” “Is this what you mean?”

### 4. DEFERRING JUDGMENT

Interrupting is a waste of time. It frustrates the speaker and limits full understanding of the message.

- Allow the speaker to finish.
- Don’t interrupt with counterarguments.

### 5. RESPONDING APPROPRIATELY

Active listening is a model for respect and understanding. You are gaining information and perspective. You add nothing by attacking the speaker or otherwise putting him or her down.

- Be candid, open, and honest in your response.
- Assert your opinions respectfully.
- Treat the other person as he or she would want to be treated.

# WORKING WITH RISK

**DEFINITION:** Risk is a measure of the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others.

## RISK ASSESSMENT INVOLVES:

- Gathering of relevant information
- Analysis of potential outcomes
- Identifying specific risks
- Historical information to anticipate future change

Risk management is about making plans, allocating tasks and acting upon them in the form of a duty of care. Positive risk-taking is weighing up the potential benefits and harms of exercising one choice of action over another, developing plans and deciding actions.

## PRINCIPLES

- Risk is dynamic, constantly changing.
- Risk can be minimised but not eliminated.
- Assessment can come from various sources but may be incomplete.
- Identifying risk carries a duty to do some thing about it.
- Joint care planning helps with assessment information gathering.
- Clear reasoning is required for defensible decisions.
- Risk-taking can engage positive collaboration with beneficial outcomes.
- Confidentiality is a right but can be avoided if an offender is deemed at risk.
- Organisations should be sensitive to the experience of offenders.

## RISK-RELATED ISSUES:

- Gut reaction and intuition
- Communication between services
- Confidentiality
- It is important to protect the rights of the individual however; material can be shared with relevant people. Seek guidance from managers on when and how to do this.
- Accountability and responsibility

## WORKING WITH RISK IN MENTAL HEALTH

- People do not wish to talk about risk.
- People will only tell you what they want you to know.
- People will only tell you what they think you want to hear.
- Talking about risk only increases the chance of it happening.
- It is too sensitive a subject that would test and break the trusting working relationship.

## GOOD PRACTICE GUIDANCE:

- Talk with people not at them.
- Dispel the fears associated with the myths and stereotypes.
- Promote equality, especially with Black and minority ethnic groups.
- Identify an individual's strengths.
- Offer appropriate support, reflection and guidance.
- Support people with their choices and link actions and outcomes when signposting with other service providers.

## WATCH YOUR LANGUAGE:

- De-stigmatise mental health issues, explain things carefully.
- Remember language is powerful and just by asking about risk you can create barriers.

## FOCUS ON ENGAGEMENT:

- Be aware of your communication style, be open and receptive.
- Be an active listener.
- Take expressions of risk seriously, but be careful not to take things at face value, make follow up enquiries.

Encourage people to talk about their perspectives and experiences:

- As victims not just perpetrators
- Through multiple experiences of loss (e.g. dignity, self-worth, personal liberties, independent means, social networks etc).
- Negative effects of service contact (e.g. side-effects of medication).

## DEVELOPING UNDERSTANDING:

- Preparation is the key.
- Watch how you phrase your questions.
- Be flexible with your responses.
- Learn to listen first.
- Pace the conversation.
- Plan for possibilities based on previous experience.
- Be equipped with a range of skills.
- Use team meetings and individual supervision for support.

## PARTNERSHIP AND COLLABORATION:

- Identify the most appropriate care and support for offenders.
- Do not over-protect people from failure, some risks are good.
- Where possible share knowledge and experience with others.
- Counterbalance negatives associated with risk through paying attention to the strengths/positives in people.



## EQUALITY AND DIVERSITY

In common with other public authorities, staff working with offenders should strive to extend the concept of equality to all of the following areas:

- Culture - particular days and times of days that may be of particular importance
- Interpersonal communication
- Discrimination
- Faith
- Equality and diversity
- The presumption of mental health
- Language and general communication

The benefits of promoting equality and embracing diversity are to:

- To remove any unfairness and disadvantage in service provision (institutional discrimination)
- To harness the knowledge and experience of stakeholders to make processes transparent and inform decision making
- It is quicker, simpler & cheaper to build disability equality into a projects design from the start
- Improves the chances of success and the



## INTERNAL SOURCES OF INFORMATION

Please add details to the table below that are relevant to you...

| TITLE:                          | NAME: |
|---------------------------------|-------|
| Health Care Contact             |       |
| ACCT Assessors                  |       |
| In Reach Team                   |       |
| Chaplain                        |       |
| C.A.R.A.T's team                |       |
| Suicide Prevention Co-ordinator |       |

## USEFUL EXTERNAL ORGANISATIONS

Mental Health can be a fascinating and rewarding subject to learn more about. It can make your job safer and easier as well as improving the lives of offenders.

Department of Health  
[www.dh.gov.uk](http://www.dh.gov.uk)

Sainsbury Centre for Mental Health  
[www.scmh.org.uk](http://www.scmh.org.uk)

Care Services Improvement Partnership  
[www.csip.org.uk](http://www.csip.org.uk)

Raise Mental Health Ltd  
[www.raise.org.uk](http://www.raise.org.uk)

MIND (Mental Health Charity)  
[www.mind.org.uk/](http://www.mind.org.uk/)

Offender Health  
[www.dh.gov.uk/en/Healthcare/Offenderhealth](http://www.dh.gov.uk/en/Healthcare/Offenderhealth)

# GLOSSARY OF TERMS

*Other forms of Personality Disorder:*

## **PARANOID PERSONALITY DISORDER**

The person with a paranoid personality disorder essentially has an ongoing, unjustified suspiciousness and distrust of people. Along with this they are also emotionally detached.

## **SCHIZOID PERSONALITY DISORDER**

A person with schizoid personality disorder has minimal social relationships, expresses few emotions (especially those of warmth and tenderness), and appears to not care about the praise or criticism of others. While they do not do well with contact in groups, they may excel when placed in positions where they have minimal contact with others.

## **SCHIZOTYPAL PERSONALITY DISORDER**

Schizotypal personality disorder is characterised by a lack of social and interpersonal relationships. This disorder also affects the way a person thinks and may come across quite eccentric in their behaviour. They often have magical thinking ('if I think this, I can make that happen'), paranoia, and other seemingly strange thoughts. They may talk to themselves, dress inappropriately, and are very sensitive to criticism.

## **HISTRIONIC PERSONALITY DISORDER**

Histrionic personality disorder is characterised by a person who is always calling attention to themselves, who are lively and overly dramatic. They easily become bored with normal routines, and crave new, novel situations and excitement. In relationships, they form bonds quickly, but the relationships are often shallow, with the person demanding increasing amounts of attention.

## **NARCISSISTIC PERSONALITY DISORDER**

Narcissistic Personality Disorder is a disorder in which a person has a grandiose (inflated) self-importance. They have preoccupation with fantasies or unlimited success, coupled by a desire for attention & admiration. They have an intolerance of criticism, and disturbed self-centred interpersonal relation. They are often described as being conceited, and generally have a low self-esteem as well. They act selfishly interpersonally, with a sense of entitlement over others.

## **DEPENDENT PERSONALITY**

Dependent personality is evident by passively allowing others to assume responsibility for major areas of one's life due to lack of self-confidence or lack of ability to function independently. While everyone is dependent on others in some parts of their lives, those with dependent personality disorder are dependent on almost all major areas of their lives, and view themselves poorly and good only through an extension of others.

## **AVOIDANT PERSONALITY DISORDER**

Avoidant personality disorder is where a person has an extreme fear of being judged negatively by other people, and suffers from a high level of social discomfort as a result. They tend to only enter into relationships where uncritical acceptance is almost guaranteed, undergo social withdrawal, suffer low self-esteem, but have a great desire for affection and acceptance. However, they do not want the affection as much as they fear the rejection.

## **OBSESSIVE-COMPULSIVE PERSONALITY DISORDER**

Obsessive-compulsive personality disorder is a decreased ability to show warm and tender emotions. Also a criterion for the illness is a perfectionism that decreases the ability to see the larger picture, difficulty doing things any way but their own and an excessive devotion to work, as well as indecisiveness. Essentially, everything must be just right, and nothing can be left to chance. Obsessive-compulsive personality disorder is different from obsessive-compulsive disorder and the latter must be ruled out.

## **DANGEROUS AND SEVERE PERSONALITY DISORDER (DSPD)**

The government first introduced the term dangerous and severe personality disorder in a consultation paper in 1999, which suggested how to detain and treat a small minority of offenders with mental disorders who pose a significant risk of harm to others and themselves. The term DSPD has no legal or medical basis. DSPD is thought to be an extreme form of antisocial personality disorder - the diagnosis most commonly associated with psychopathy.

## **Co-morbid:**

This pertains to two or more illnesses that occur together - for example Depression and Anxiety.

## **Para-suicidal:**

Para-suicide, sometimes called Deliberate Self-Harm, is when someone mimics the act of suicide, but does not end up killing themselves.

## **Self-Inflicted:**

This is an American term which means the same as Self Harm.

## **Manic Depression:**

Also called bipolar affective disorder until recently, the current name is of fairly recent origin and refers to the cycling between high and low episodes; it has replaced the older term manic-depressive illness coined by Emil Kraepelin (1856-1926) in the late nineteenth century. The new term is designed to be neutral, to avoid the stigma in the non-mental health community that comes from conflating "manic" and "depression."

## **Socio-economic:**

When we say this, within the context of this workbook, we mean the social background of the individual: be it, class, the area they come from, employability and generally the environment around them.

## **Interpersonal:**

A term meaning the relationship between people.

## **Impulse control and addiction disorders:**

People with impulse control disorders are unable to resist urges, or impulses, to perform acts that could be harmful to themselves or others. Pyromania (starting fires), kleptomania (stealing) and compulsive gambling are examples of impulse control disorders. Alcohol and drugs are common objects of addictions. Often, people with these disorders become so involved with the objects of their addiction that they begin to ignore responsibilities and relationships.

## **Dissociative disorders:**

People with these disorders suffer severe disturbances or changes in memory, consciousness, identity, and general awareness of themselves and their surroundings. These disorders usually are associated with overwhelming stress, which may be the result of traumatic events, accidents or disasters that may be experienced or witnessed by the individual. Dissociative identity disorder, formerly called multiple personality disorder, or "split personality", and depersonalization disorder are examples of dissociative disorders.

**Sexual and gender disorders:**

These include disorders that affect sexual desire, performance and behaviour. Sexual dysfunction, gender identity disorder are examples of sexual and gender disorders.

**Somatoform disorders:**

Somatoform disorder was formerly known as a psychosomatic disorder. This is where an offender may experience physical symptoms even though a doctor can find no medical cause for the symptoms.

**Grandiose:**

This is where an offender may have an exaggerated belief in one's importance, sometimes reaching delusional proportions, and occurring as a common symptom of mental illnesses.

**Dual Diagnosis:**

Dual diagnosis is a term that refers to patients who have both a mental health disorder and substance use disorder. The term "substance abuse" refers to substance use disorders that range along a continuum from abuse to dependence or addiction.

**Neuroses:**

Neurosis, also known as psychoneurosis or 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.

**Psychosis:**

Psychosis, in psychiatry; a broad category of mental disorder encompassing the most serious emotional disturbances, often rendering the individual incapable of staying in contact with reality

**Anhedonia:**

This is an inability to experience pleasure from normally pleasurable life events such as eating, exercise, and social or sexual interaction.

**Benzodiazepines:**

Are a class of psychoactive drugs considered minor tranquilizers with varying hypnotic, sedative, anticonvulsant, muscle relaxant and amnesic properties, which are mediated by slowing down the central nervous system. These medications are useful in treating anxiety, insomnia and agitation. These are short term meds, which can become addictive, so prescriptions are often in small supplies.

## APPENDIX

**WHO'S WHO IN MENTAL HEALTH?** *There may be many people involved in the care of clients experiencing mental illness - including medical professionals who prescribe medication and therapy. There are also support workers who can help offenders with everyday tasks to help them stay in the community.*

**IN REACH OR OUT REACH TEAMS**

These teams may include:

- A Social Worker
- A Community Psychiatric Nurse
- An Occupational Therapist or O.T
- A Psychiatrist
- A Psychotherapist
- A Clinical Psychologist
- A Counselor

**COMMUNITY PSYCHIATRIC NURSE (CPN)**

Community Psychiatric Nurses are registered nurses, trained in mental health and can:

- Talk about ways to cope - benefiting the offender
- Give long-term support
- Prescribe some medication

Community mental health nurses can specialise in working with older people, young people or people with drug or alcohol problems.

**COUNSELOR**

Counselors provide a 'talking therapy' where the client will be invited to talk about their thoughts and feelings; the counselor will then discuss ways of coping. Counselling can also be provided by:

- Community mental health nurses
- Psychotherapists
- Psychologists
- Social workers
- Occupational therapists

**PSYCHIATRISTS AND PSYCHOLOGISTS**

A psychiatrist mainly deals with the physical aspect of mental health, for example drug therapy. Psychiatrists often work closely with psychologists and counsellors, who

could discuss thoughts and feelings that an offender may be experiencing and work out coping strategies.

**SOCIAL WORKER (SW)**

Social workers can offer advice on practical matters; some social workers are specially trained in mental health and can offer counselling.

**APPROVED SOCIAL WORKER (ASW)**

Approved social workers have been specially trained and can carry out some tasks under the Mental Health Act (1983) such as recommending a compulsory hospital stay. Approved social workers also have a particular duty to look at alternatives to hospitalisation, for example by looking at the range of community care available that may allow the person with a mental illness to stay in their community.

**CARE COORDINATORS**

If an offender has different elements to his/her care, for example; seeing a psychiatrist, counsellor, doctor and social worker; they may have access to a care coordinator (sometimes known as key workers or case managers). This person will talk to all the different professionals and be a single person to talk, liaise and support the client concerned. Care coordinators will be a member of the community mental health team and will draw up a care plan with the client.

**CARE PROGRAMME APPROACH (CPA)**

Under this approach, all people with significant mental health needs should have a care plan, and a care coordinator to assess and arrange services for them.

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)*