

MENTAL HEALTH AWARENESS TRAINING FOR PROBATION WORKERS'



*West Midlands
Regional Development Centre*



COURSE AIMS

This workbook is part of a wider package to help increase your knowledge and understanding of some of the main mental health issues you may encounter as part of your role. One of the aims is to help to dispel some of the myths and stigmas that surround mental illness. The booklet provides information about some things you can do to promote mental health; therefore it is designed to help with all offenders not only those with mental illnesses.

The reading material does include introductory information on the types of illnesses you may encounter and how you can recognise them. A little extra knowledge can help both you and the offenders you work with. The aim is not to turn you into a mental health professional but to help you in this vital aspect of your role.

- To increase understanding of the issues relating to mental well-being and illness and some common psychiatric conditions.
- To enable you to feel more confident when dealing with offenders displaying signs of mental illness.
- To enhance your ability to observe, recognise and refer people you feel require support for their mental illness.
- To signpost mentally disordered offenders to appropriate services to enable earlier intervention.
- To help you to respond in a way that maintains the offender's dignity.
- To play a part in helping the offender to cope and to improve their quality of life.
- To help reduce stigma associated with mental illness.
- To make a contribution towards a more safely-managed working environment.
- To make a contribution towards a reduction in reoffending upon release and in the community.
- To contribute to your professional development in this field.



HOW TO USE THIS BOOKLET

- Ideally this booklet will be used in conjunction with a presentation made by your regional mental health awareness trainer.
- Participants are encouraged to reflect upon the learning material in future. The booklet can be kept and used as a reference manual.
- At the front of the workbook is a colour-coded table of contents so that you can quickly refer to the sub-section of your interest.
- The information represents a combination of contextual information on specific illnesses and potential responses to situations in simple, easy to understand terms.
- The learning material contains problem-based exercises to enable you to relate the material to your experience.
- Your trainer will go through with you the most relevant sections for your professional situation. It is unlikely that there will be sufficient time to cover all the material, however, other references and sources are provided for future reading.
- At the back of the workbook is a glossary of terms and appendices for extra information.

HOW DO WE DEFINE MENTAL HEALTH?

People understand the term 'Mental Health' in different ways, this is influenced by a combination of:

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

Mental health is often best understood in the wider context of health. A commonly referred to definition of 'health' is put forward by the World Health Organization:

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

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

World Health Organisation

Q.1 How would you define good mental health

Q.2 How would you define poor mental health?

We often find words to describe our physical state but seldom our mood or our thoughts.

Our mental health state 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.”



EXERCISE:

The ability to 'cope' with life's difficulties plays a massive part in our mental well-being.

Q.1 What 'coping mechanisms' do you use to maintain or improve your mental health?

Q.2 Do offenders always have the same access to those coping resources?
What might they do to help themselves cope?



WHAT IS POSITIVE MENTAL HEALTH?

WHEN OUR MENTAL HEALTH IS GOOD WE EXPERIENCE:

- **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

SOME FACTORS WHICH FACILITATE POSITIVE MENTAL HEALTH INCLUDE:

- Talk about their feelings
- Write it 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

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

WHAT IS MENTAL ILLNESS?

As human beings we all experience certain level of psychological distress. At times it can motivate us, at others we learn and grow through our experience. Equally, it is normal for our mood to drop or rise depending on our circumstances and environment.

Mental illness is an umbrella term that refers to various psychiatric disorders. Just like physical illnesses, it can vary significantly in it's the symptoms and severity. Psychological distress becomes a mental illness when it impacts upon the way a person thinks, behaves and interacts with other people in society.

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 experience mental distress – 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 (Mind, 2004). This doesn't always mean something severe like schizophrenia, it can mean something relatively mild like an adjustment reaction or generalised anxiety.

The prevalence of mental illness amongst offenders is much higher than that of the general population. Offenders are often at higher risk of developing mental health problems as they face particular stressors – social isolation, lack of purpose, lack of stimulation, and guilt.

“At anyone time one adult in six suffers from one or other forms of mental illness. In other words mental illnesses are as common as asthma”

(DH, 1999).

Mental illnesses are real illnesses - as real as heart disease and cancer. Like other long-term conditions they need and respond well to treatment. Some illnesses take a chronic course and service user's need to maintain contact with services over the long term. However, 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.

As a probation worker you can employ your inter personal and observational skills to play a vital role in recognising mental distress.

Q.1

Discuss with a neighbour what you think the causes of mental illness are.

WHAT FACTORS AFFECT OUR MENTAL HEALTH?

*Mental health is determined by **many complex and related factors** 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
- 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



- Our physical health
- Exercise and nutrition
- Mental illness often occurs when various brain chemicals do not working effectively, working too much - or not at all.

THE MENTAL HEALTH CONTINUUM: *Everyone's mental health constantly fluctuates. A person who suffers with schizophrenia can still enjoy good times with positive mental health. Equally, a person without a diagnosable mental health problem can still experience periods of poor mental health.*

Where would you place yourself on the continuum of mental health?

MENTAL DISTRESS

Everyone moves up and down the continuum to varying degrees

POSITIVE MENTAL HEALTH

“Good mental health is defined by more than just a lack of mental illness”

MENTAL ILLNESS AND STIGMA

Historically, a high degree of 'stigma' has surrounded issues relating to mental health

STIGMA CAN BEST BE DESCRIBED AS THREE THINGS:

- Ignorance
- Prejudice
- Discrimination (Mental Health Care)

It occurs when people are frightened or do not take the time to understand a group or individual. We know that stigma can negatively affect people's mental health state.

It can also affect people's life chances, for example, employment prospects are much worse for those experiencing severe mental disorders. Although commonly used to describe dangerous or unpredictable behaviour, expressions like mad or crazy are unhelpful in professional terms. As professionals we should aim to try and understand people's experiences from their perspective.

SCHIZOPHRENIA IS NOT...

- Split or multiple personalities - that is actually known as Dissociative Personality Disorder
- Mean 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)
- 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, over time most people gain control of their emotions.

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.

GENERALISED ANXIETY DISORDER IS NOT...

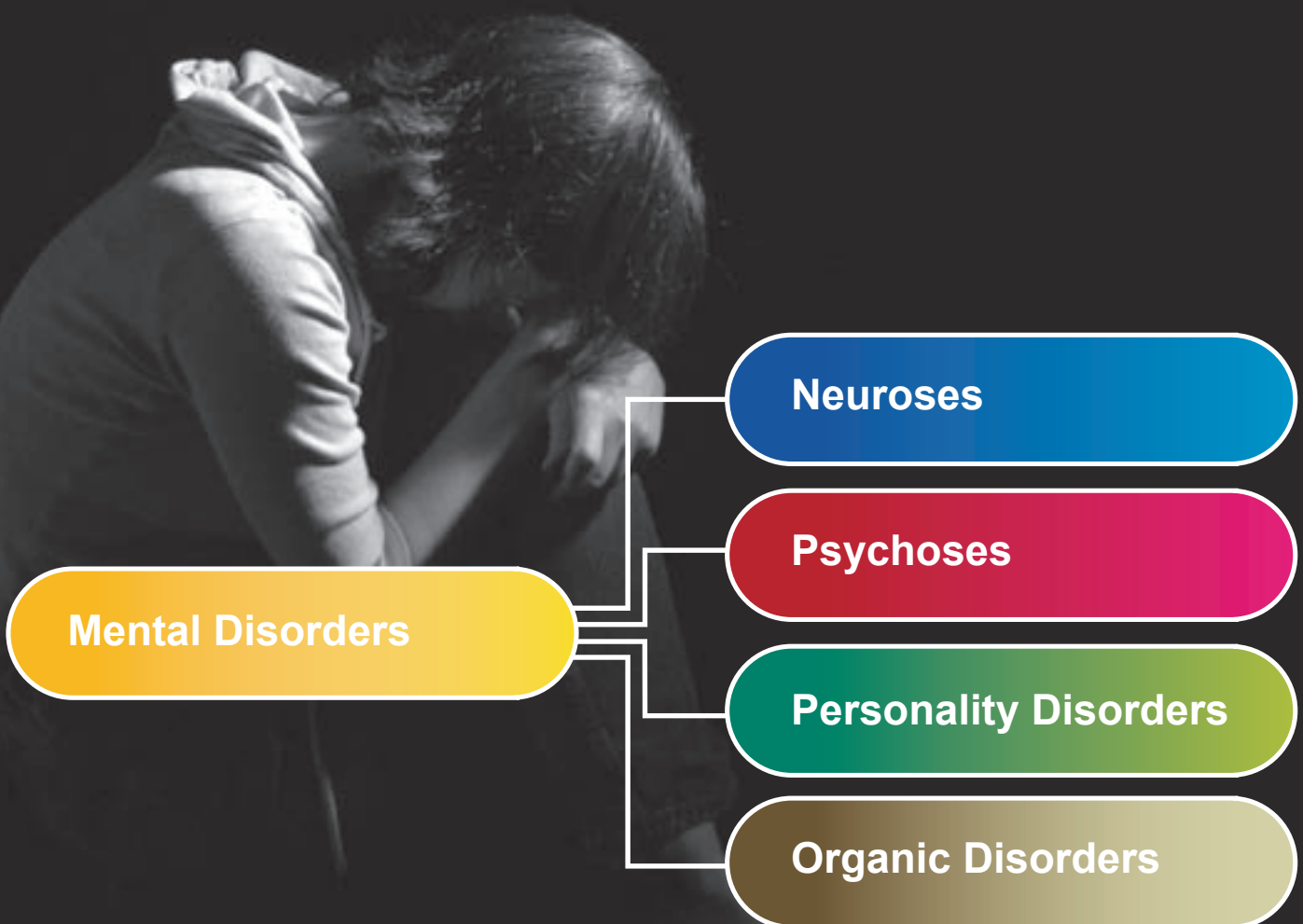
- The same as phobias, fears, stress or panic attacks
- Untreatable
- Necessarily going to develop other illnesses such as Obsessional Compulsive Disorder and Eating Disorders.

Most people who suffer mental distress fully recover and go on to lead fulfilling lives.

THE FOUR MAJOR GROUPS OF MENTAL DISORDERS

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.

A key part of your role is to promote mental well-being and to facilitate early intervention to help avoid more serious mental distress. Offenders and ex-offenders experience higher rates of mental illness compared to the general population. In 1997, Singleton and co workers generalised that 90% of offenders in prison were thought to have a diagnosable mental illness. Many of them will be at the milder end of the mental health continuum. A significant number have existing illnesses or develop an illness such as those described below.



NEUROSES

Neurosis is a 'catch-all' term that refers to any functional mental imbalance that causes distress but does not impact upon someone's sense of reality. Anxiety is generally at the root of the distress; examples include depression, generalised anxiety disorder, eating disorders and phobias.

PSYCHOSIS

Psychosis is also a generic term for a range of perceptual disorders. The individual mental state is described as being 'detached from reality'. It can last for short or long-term episodes.

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.

PERSONALITY DISORDERS

Personality Disorders are long lasting and persistent styles of behaviours and thought. Personality Disorders encompasses a group of behavioural disorders that are different from the psychotic and neurotic disorders. People with Personality Disorders 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.

ORGANIC DISORDERS

Organic Disorders are another school of dementia - inducing illnesses caused by damage to the brain tissue. Some examples include, Alzheimer's disease, Creutzfeldts-Jakob's disease, Traumatic brain injury, Parkinson's Disease and Huntington's disease.

THE OFFENDER WITH ANXIETY

DEFINITION: *Anxiety can be described as a short-term or chronic condition involving intense feelings of fear, worry and apprehension, sometimes associated with specific objects or events. Anxiety is a common form of mental distress experienced by offenders.*

SOME SIGNS YOU MAY NOTICE

Physical symptoms include:

- discomfort in your abdomen (tummy)
- diarrhoea
- dry mouth
- rapid heartbeat or palpitations
- tightness or pain in your chest
- shortness of breath
- dizziness
- needing to urinate more often than usual
- difficulty swallowing
- shaking

You can also get psychological symptoms, which can include:

- sleeping difficulties (insomnia)
- feeling worried or uneasy all the time
- feeling tired
- being irritable or quick to get angry
- being unable to concentrate
- a fear that you're 'going mad'
- feeling not in control of your actions, or detached from your surroundings.

POSSIBLE 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'
- A response to separation or loss
- Genetic predisposition
- Past traumatic events
- Social factors such as the offender's financial and family situation
- Personality factors
- Drug misuse

POSSIBLE RISKS

- Panic Attacks
- Development of phobias
- Self-harm
- Physical health problems, e.g. stomach ulcers.
- Drug and alcohol use and misuse
- Associated Mental Health problems including Depression

POSSIBLE TREATMENTS

- Medication
- Counselling and talking therapies
- Self-help – e.g. relaxation exercises

AGE OF ONSET:

Any age

HOW COMMON IS IT AMONGST OFFENDERS?

Using research by Singleton and colleagues on the prevalence of neurotic disorder amongst prisoners:

Males remand: 59%; male sentenced: 40%.

Females remand: 76% and female sentenced: 40%.

(Singleton, ONS 1997)

ASSOCIATED CONDITIONS

- Low mood
- Physical health complication
- Other anxiety related conditions

SOME THINGS YOU CAN DO TO HELP:

- Treat each offender as an individual, try not to make judgements about their comments and behaviour.
- Be aware of your verbal and non-verbal communication skills. Try and gain the offender's confidence by behaving in a professional, empathetic manner.
- Express your concerns to the Offender Manager, where possible, refer the offender to primary care services as soon as practicable.
- Rationalise negative thoughts by pointing out their good points. Help the person to understand that there is a genuine problem and that care services will be able to help with it.
- Try to be supportive and offer reassurance. Avoid ill-thought-out comments like telling the sufferer they're over-re-acting, as this may make them feel worse.
- Guide them to self-help 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.
- Provide timely information on healthy living, e.g. reducing nicotine and caffeine intake, eating a balanced diet and getting some exercise.
- Encourage relaxation through exercise and regulating breathing.
- Listen - don't dominate conversations.
- Try not to reinforce negative statements such as 'I can't cope any more'. Reassure them that it is okay to cry and encourage them to express their feelings, in a safe and confidential space.
- Listen out or gently probe for suicidal thoughts and feelings.
- Avoid interpersonal situations in which you don't feel comfortable. Discuss particular cases with colleagues.

Mixed Anxiety and Depression is the most common Mental Disorder in Britain at almost 9% of the population (The Office for National Statistics) It is a highly treatable condition.

PANIC ATTACKS occur in a small percentage of people with acute anxiety. They often manifest as 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 disproportion 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.

Q.1 What are the physical and psychological effects of anxiety?

Q.2 How can we recognise it?

OFFENDERS WITH DEPRESSION

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

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 somatizations, such as headaches, digestive disorders, chronic pain

POSSIBLE CAUSE

- Loss – liberty, family, employment
- The effects of the criminal justice system
- Family history of mental illness
- Stressful life events
- Physical illness or disability – chronic illness such as heart disease, stroke, or diabetes
- Personality – certain personality traits such as low self-esteem
- Substance misuse – such as alcohol, nicotine and illegal drugs

POSSIBLE RISKS

- A reduction in self-care
- Vulnerability
- Physical illness
- Self-harm

POSSIBLE TREATMENTS

- Medication e.g. anti-depressants
- Counselling and talking therapies
- Self-help – e.g. relaxation and breathing exercises
- Exercise

AGE OF ONSET:

Most commonly starts between 25 and 44 years old

HOW COMMON IS IT?

- Using research by Singleton and colleagues on the prevalence of mixed anxiety and depression amongst prisoners:
Males remand: 26%; sentenced 19%.
Female remand: 36%; sentenced 31%.
- (Singleton, ONS 1997)
- General population: Almost 10%
- (Mind, 2004)

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

SOME THINGS YOU CAN DO TO HELP

- Treat each offender as an individual, keep an open mind about their issues and try not to make judgements about their words and behaviour
- Raise your concerns with the Offender Manager, you may wish to refer the offender on to primary care services at any early stage for medical interventions.
- Use your listening skills – try not to dominate conversations.
- Demonstrate empathy and trustworthiness to help win their confidence. Sometimes it's worth saying that you will treat the discussion as confidential unless you feel they are at risk or someone else is at risk of harm.
- Express concern a person suffering from depression needs compassion and understanding. Telling an offender to 'get over it' or 'lighten up' will just make their situation worse. If you ask closed questions like, 'Are you okay?' they will simply respond with closed answers like 'Yes'. It's better to ask open questions like 'Tell me how you are feeling', or, 'What sort of things help when you feel this way?' Don't try to minimise or talk a depressed person out of his or her feelings.
- 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 a trained professional is informed as soon as possible.
- Often probation workers worry about saying the wrong thing and causing more upset. However, often individuals want to talk about their situation and feelings.
- Provide emotional support. You need to create an environment in which an offender is able to open up.
- Remember that depression is a disease, often with no identifiable start and end point; progress will take time.
- Remember that offenders may not be able to work or comply with rules due to their illness.
- Where possible try to introduce an element of stimulation by encouraging simple activities, such as, go for walks, reading a newspaper, talking about neutral subjects.
- Don't try to take on their problem all by yourself. Make use of supervision sessions where possible.
- People with depression tend to like space to think about issues. If they don't want to discuss something with you, don't try to force them to talk about it.

Depression occurs disproportionately with all offenders, notably in the female population. Older people coming into contact with Criminal Justice services are particularly vulnerable to depression.

These are the most common forms of Depression:

REACTIVE DEPRESSION

This depression relates to a prolonged exposure to life stressors. Symptoms are typified by sadness, worry, anxiety, and with problems getting to sleep. This type of depression responds well to changes in lifestyle and to anti-depressant medication.

SEASONAL AFFECTIVE DISORDER

A type of depressive disorder which is characterised by episodes of major depression which recur at specific times of the year – especially in late autumn and winter and ending in spring.

DYSTHYMIA

is a mild to moderate form of depression that persists over the long term. Some individuals with this condition have fewer symptoms than those with major depression, however the symptoms can last longer and develop more slowly. Sometimes people with dysthymia also experience major depressive episodes.

MAJOR OR CLINICAL DEPRESSION

represents a combination of symptoms that interfere with the ability to work, sleep, eat and enjoy once-pleasurable activities. Individuals get little satisfaction out of life and seem uninterested in becoming involved in usual activities. Hopelessness, pessimism and low energy are common features which may result in missed appointments.

PSYCHOTIC DEPRESSION

This is a severe form of depression in which the individual can occasionally experience delusions and hallucinations, as well as a severely depressed mood. It's often a very frightening condition with specific risks attached.

POSTNATAL DEPRESSION

Can emerge at any time in the infant's 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 - even being hostile or indifferent to your 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 become very difficult.

CASE STUDY: Severe Depression

You have been allocated as the offender manager for Darren, a 42 year old divorced man, who is well known to local mental health services. He has been diagnosed with severe depression and came into contact with criminal justice services some time ago, after a situation arose in which he made threats to kill a local bank employee. In brief, his father's house was repossessed and a short while later he died of cardiac problems. Darren has a very fixed opinion that the bank staff are responsible for his father's death.

After a period of assessment, Darren was admitted to a medium secure mental health unit. In due course, he was discharged under a CPA to multi-disciplinary team care, on a community-based section of the Mental Health Act; MAPPA arrangements have been put in place.

Historically, Darren has a 16 year history of severe depression. His wife divorced him nine years ago, taking custody of his two children, saying she could no longer cope with his moods. He has little contact with his children, which is a source of regret. He now lives alone; his self-care is poor and his flat is very untidy. Darren admits to smoking cannabis and drinking several large cans of strong lager every day. He is overweight and says he survives on take-away food. He is on anti-depressant medication.

When he turns up for his appointments, his appearance is dishevelled and his demeanour sad. Darren is very difficult to engage, sometimes he utters just a few words, often just staring into space. At other times, he appears agitated and launches a tirade of bitterness, sometimes directed at staff. Some staff have expressed concern about his welfare; they suspect he may do something dramatic.

Q.2 How would you begin to engage with Darren?

Q.3 What are the main concerns about Darren?

THE OFFENDER WITH EATING DISTRESS

DEFINITION: *‘At first, it was such a relief not to worry about anything else. The eating disorder started as a coping mechanism to help me avoid my other problems. But, in the end, it became the biggest problem of all.’*

Mind website

HOW CAN IT BE DEFINED?

Eating distress (or eating disorders) is relatively common. Anorexia and bulimia are amongst the most common forms and can lead on to other complications. Eating disorders should be treated as serious conditions. They are often described as a method of dealing with internal emotional pain and confusion. Eating distress affects women more than men however, ten percent of sufferers are men.

The main types are:

- ANOREXIA NERVOSA** In many cases ‘eating’ comes to represent everything that is bad or negative to the individual. This can include feelings that aren’t expressed adequately. Not eating, and weight loss, can become that individual’s only way of feeling safe.
- BULIMIA NERVOSA** is an illness defined by food binges, or recurrent episodes of significant overeating, that are sometimes accompanied by feeling out of control. Individuals use a variety of methods, for example, vomiting or laxative abuse, to prevent gaining weight.

RISKS FACTORS

- Being young and female
- Having been previously obese
- Personality disorder
- Having an accompanying severe psychological disorder
- Having a dysfunctional relationships

SOME SIGNS YOU MAY NOTICE

ANOREXIA

- Distorted perceptions of their weight, size and shape
- Denying they feel hungry
- 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

- Bouts of eating followed by purging
- Discoloured teeth
- Distorted perceptions of their own weight, size and shape
- A powerful urge to overeat, 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 offender 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, and feeling disgusted and guilty with themselves.

POSSIBLE 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 cope with unhappiness
- A need to exert control over their diet when they feel they have little control over rest of life'

POSSIBLE COMPLICATIONS

- Heart failure and failure of other internal organs
- Infertility
- Tooth decay
- Lowered immunity
- Osteoporosis

POSSIBLE TREATMENTS

- Counselling or talking therapies
- Behavioural plans
- Specialist hospital treatment
- Medication

AGE OF ONSET

Mid-teens onwards

GENDER ISSUES

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

ASSOCIATED CONDITIONS

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

It is very common for individuals to suffer with more than one forms of eating disorder.

Q.1

How would you define eating normally, is this the same for everyone?

THE OFFENDER WITH BIPOLAR DISORDER

DEFINITION: *Bipolar Disorder (used to be known as manic depression) affects both males and females equally. It 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

Individuals have their own unique pattern of severity and duration; there can be long periods of stability in between episodes.

POSSIBLE RISKS

- Suicide
- Vulnerability to exploitation
- At risk of further offences
- Extreme elation leading to ignoring basic bodily needs such as hydration and diet
- Social problems
- Increased risk of accidents

POSSIBLE TREATMENTS

- Medication
- Talking therapy
- Social skills training
- Self-help activities
- Advocacy groups

POSSIBLE CAUSES

- Genetic predisposition
- Stressful life events
- Emotional trauma

AGE OF ONSET:

Symptoms often appear in late adolescence and early adulthood

ASSOCIATED CONDITIONS

- Psychosis
- Self-harm
- Eating disorders
- Drug and alcohol misuse
- Poor self-care

WHAT THINGS CAN BE DONE TO HELP?

- Try to keep an open mind without judging the offender too quickly. At times their thoughts and ideas are likely to be instable or unrealistic.
- Express your concerns to the Offender Manager; where appropriate refer the offender on to specialist help at an early stage, as medical intervention will be required
- Find out whom to contact in the event of severe mood change.
- Talk to your client to try and find out what his or her triggers are. Find out what usually happens to them when they are unwell.
- Recognising early warning signs to mood change: emotions, behaviours and events that may lead to an episode.
- Be aware that the times just after someone has been ill are the most dangerous in terms of suicide and self-harm
- Remember that offenders with bipolar mood disorder may not be able to work or comply with rules due to their illness.
- Encourage self-help tools, such as, keeping a record a mood diary.
- Encourage the offender to comply with their medication regime, look for signs that they are not taking it.
- Concentrate on emotions and feelings
- Don't collude in grandiose ideas

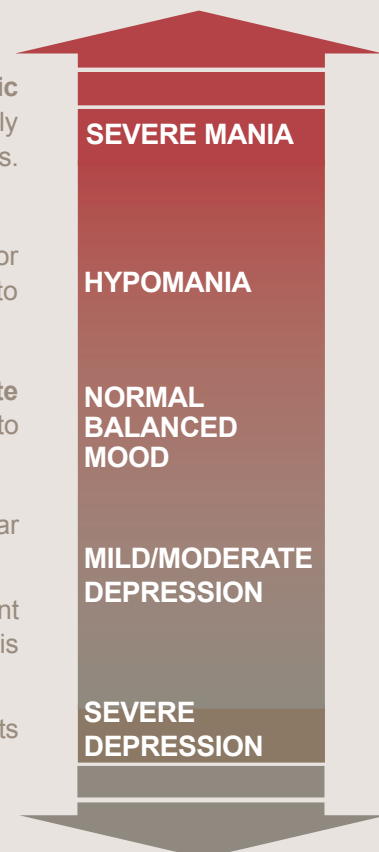
THERE ARE DIFFERENT TYPES OF BIPOLAR

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 Bipolar 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.



THE OFFENDER WITH SCHIZOPHRENIA

“Schizophrenia is a severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions. It can impair functioning through the loss of an acquired capability to earn a livelihood, or the disruption of studies”. (W.H.O. 2009).

Schizophrenia is a ‘perceptual disorder’ meaning there is a problem between sensing the external world and interpreting the normal world. It generally begins in late adolescence or early adulthood and affects approximately one in one hundred people. Schizophrenia is varied and it affects people very differently at different times in their lives. The majority of cases are treated effectively although some people experience chronic problems that persist into later life.

Schizophrenia is ten times more common in prison populations (Fazel & Danesh, 2002). Probation staff may not realise that the behaviour of a client has been gradually changing. Recognising these changes can be particularly difficult if the illness develops in young offenders’ as it is a normal time for some changes in moods and behaviour.

SOME SIGNS YOU MAY NOTICE

‘More than normal’ (Positive experiences)

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

‘Less than normal’ (negative experiences)

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

TYPES OF HALLUCINATIONS

Hallucinations are difficult to understand as they occur outside of the normal parameters of reality; they should be taken seriously by the professional.

AUDITORY HALLUCINATIONS / HEARING

These are the most common type, these often consisting of critical voices or other background noises.

VISUAL HALLUCINATIONS / SEEING

These are more common in organic illnesses or when a person is withdrawing from alcohol, these involves seeing people or objects such as, insects.

TACTILE HALLUCINATIONS / FEELING

Linked with organic disorders and some physical health complications, a person may describe feeling insects beneath the skin.

OLFACTORY HALLUCINATIONS / SMELLING

Quite rare among people with functional mental illnesses, may be linked to other symptoms or illnesses

GUSTATORY HALLUCINATIONS / TASTING

More likely to be associated with other neurological problems.

WHAT IS A DELUSION?

Delusions are very strong ideas or belief based on a false interpretation of external events. There are different types of delusions; some of the main ones include: persecutory delusions, ideas of reference, grandiose delusions, and religious delusions.

THOUGHT DISORDER: This may be described in a number of ways such as disorganised or chaotic thinking. For example, a person's thoughts may jump from topic to topic or conversation may be difficult to follow. A person with schizophrenia may also feel that thoughts are being put into or removed from their minds.

CATATONIC BEHAVIOUR: This bizarre form of behaviour is comparatively rare by today's standards. It can present in different ways but mostly involves remaining in a particular position for varying lengths of time.

NEGATIVE SYMPTOMS

These cover a range of very different presentations and symptoms, which can include being difficulty concentrating, withdrawn and feeling apathetic. Negative symptoms can result in people neglecting their diet and themselves. They may not get involved with typical activities and can appear preoccupied with their own thoughts. Negative symptoms can also lead to difficulties with education, which can contribute to troubles with employment. For criminal justice workers as well as families and carers, the negative symptoms are often the most difficult to deal with. Persistent negative symptoms may lead to feelings of isolation and depression and can cause long-term disability.

POSSIBLE RISKS

- People diagnosed with schizophrenia are more at risk of suicide

POSSIBLE TREATMENTS

- Medication is the main treatment for schizophrenia.
- Talk Therapies.
- Self help and voluntary and community organisations
- Advocacy

LIKELY CAUSES

- Brain biology
- Genetics – inherited pre dispositions
- Stressful life events & social issues play an important role
- Drug and alcohol use can trigger a first episode - this is called drug induced psychosis

ASSOCIATED CONDITIONS

- Self Harm
- Anxiety
- Depression
- Disrupted moods

WHAT STEPS CAN YOU TAKE TO HELP

- Discuss your concerns with the Offender Manager; try to work within the wider network of care.
- Get as much information you can by reading any previous reports or information on the offender before any scheduled meeting.
- Look at information on triggers for relapse or aggression.
- Approach the person with an open mind - try not to prejudge them based on previous encounters with other mentally disordered offenders.
- If you suspect an individual's mental state is slipping liaise with their mental health worker.
- Encourage the offender to comply with the medication they are prescribed.
- Remember that offenders with schizophrenia may find it difficult to follow or comply with instructions due to aspects of their illness.
- Handle delusions or strong beliefs with sensitivity even if they seem unrealistic. Try not to dismiss their beliefs or collude with them.
- Retain a sense of optimism, most people with schizophrenia successfully recover from their illness.

CASE STUDY: Engaging people with Schizophrenia

Dwaine is a 36 year-old man with a long history of schizophrenia. He has lived at home with his parents most of his life. Dwaine is unemployed and attends a day centre four days a week where he sees a Community Psychiatric Nurse (CPN). He regularly receives a depot injection every two weeks.

Dwaine presents as a quiet, often-distant man. He is observed talking to himself under his breath and is easily distracted from conversation and activities. He watches television several hours per day and smokes heavily. He has some very fixed ideas about his status, believing he is an important person, commanding a high amount of standing. This is often the source of friction with carers and other service users.

When he becomes unwell arguments happen in the family home. These arguments have become violent and Dwaine's father has had to go to A&E on three occasions over the past two years. His parents

are in their late sixties and feel a bit stuck with the situation. They realise they are unable to manage his aggression but are worried about his ability to cope in other accommodation. This leads on to feelings of anxiety and guilt.

In the most recent incident the police were called. Once again Dwaine had been violent and his father needed hospital treatment. On this occasion the police took him to the station in handcuffs and charged Dwaine with violent conduct. Eventually, the courts took a sympathetic view but Dwaine was charged and given a probation order.

Explaining to Dwaine that he won't be able to move back to the family home will be a difficult task. In the short term, alternative accommodation needs to be found and clearly some plans need to be put in place to help Dwaine manage his situation and behaviour.

Q.1 List some possible short-term actions for Dwaine's immediate future.

Q.2 What skills would you use to begin to engage with Dwaine?

Q.3 What other professionals do you think you need to work with in this situation?

PARANOID TYPE: delusions and hallucinations are present but thought disorder, disorganized behaviour and lack of emotional responses 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.



THE OFFENDER WITH A PERSONALITY DISORDER

DEFINITION: *Our personality characteristics make us who we are as individuals. They are a representation of our mental, emotional and social characteristics.*

A personality disorder can be described as a cluster of “deeply ingrained and enduring behaviour patterns manifesting themselves as inflexible responses to a broad range of personal and social situations.”

(World Health Organisation)

The effects of Personality Disorders are enduring if not permanent, and have a major impact on the most or all aspects of the individual's life. They are thought to be caused by a combination of the individual's genetic make up, their childhood experiences and learned behaviour.

Statistically, personality disorders are common; perhaps understandably over offenders with personality disorders are over represented within criminal justice services. Returning to our mild, moderate and severe model of disorder, we can say that many people with personality with mild personality disorder function relatively well in society. However, more severely disordered individuals are more

likely to come into contact with all public services, particularly health and criminal justice services.

Many studies show that people with other forms of mental illness, like schizophrenia also have a personality disorder. Equally, some people with severe personality disorders can experience disruptions in perception and psychotic phenomena.

There are several types of personality disorder as can be seen in the table below. Borderline Personality Disorder is the most common form found with female offenders while Anti Social Personality Disorder the most common in males. We will focus on these two examples to enhance our learning on the subject.

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

BORDERLINE PERSONALITY DISORDER

DEFINITION: *Borderline Personality Disorder is also referred to as 'Emotionally Unstable Personality Disorder'. It is more common amongst adolescents and young adults with the highest rates between the ages of 18 and 35. People with BPD are often regarded as manipulative but at times experience overwhelming needs that have to be satisfied.*

SOME BEHAVIOURS YOU MAY NOTICE

- Efforts to avoid feelings of abandonment or being left alone
- Self harm and other emotionally dulling behaviours
- Unstable and intense emotional states, others describe feelings of loneliness and emptiness
- Unstable, often intense, relationships
- Poor sense of self, can result in poor self-image
- Expressions of anger,
- Impulsivity, could result in substance misuse, binge eating
- Reckless behaviour, such as dangerous driving
- Paranoid ideas

POSSIBLE TREATMENTS

- Medication
- Group therapy
- Therapeutic communities
- Counselling

POSSIBLE CAUSES

- Some studies report that Personality Disorders may be inherited
- Environmental factors; many people have a history of childhood abuse, neglect and separation.

HOW COMMON IS IT?

Using research by Singleton and colleagues on the prevalence of personality disorders amongst prisoners:
Males remand: 23%; sentenced 14% Females: 20% General Population: 2% (*Singleton, ONS, 1997*)

ASSOCIATED RISKS

- Males with BPD are often sent to prison for violent outbursts resulting from an inability to control impulsivity.
- At least 50% of BPD offenders also suffer from depressive disorder.
- Eating Distress
- Self harm and suicide

WHAT YOU CAN DO TO HELP

- Try not to pre-judge the offender on the basis of their diagnosis.
- Show them that you are trustworthy and dependable.
- Treat them equitably; don't promise things you can't deliver
- Raise any concerns with your Offender Manager. Together you can decide whether to refer the offender on to specialist help if you are concerned about any potential risks
- Avoid colluding with any strong ideas, particularly about other staff members
- In terms of verbal communication adopt a strategy of providing reassurance, repeating information, finishing with more reassurance.
- Maintain clear boundaries.
- Observe for signs of vulnerability and exploitation.
- 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.
- Be patient
- Take account of your own psychological safety; be prepared to deal with your own feelings of professional powerlessness.

CASE STUDY: Personality Disorder

You receive a phone call from a distressed member of staff at an approved premises; one of the clients on your caseload called Debbie has caused considerable disruption overnight. The home manager is at her wits' end. She says she is considering calling the police.

She says Debbie has been displaying extremely agitated behaviour including barricading her room door and threatening to self-harm. There has also been conflict with some of the other residents, one of them has accused Debbie of theft. Debbie is demanding to be moved to alternative accommodation, saying she fears for her safety.

Your notes tell you that Debbie has a long history of contact with mental health services. She has served

several short sentences relating to fraud. Clinically she has been treated for a variety of disorders but the notes indicate she has been diagnosed with borderline personality disorder.

Debbie also has a lengthy history of drug and alcohol abuse. While in prison she did engage in deliberate self-injury by self-laceration. She has a history of unstable relationships and has a child that was taken into care when Debbie was 16. You know that Debbie has a nice, fun side to her personality and can be endearing at times. Debbie is quite lucky to be in her present accommodation as there is a shortage of female-only accommodation in the area.

Q.1

You agree to visit the premises. What short-term problems need to be resolved? How might you do this?

ANTI-SOCIAL PERSONALITY DISORDER (ASPD)

DEFINITION: *Anti-social Personality Disorder is a condition that begins in childhood and continues into adulthood. It is characterized by persistent disregard for, and violation of, the rights of others. Deceit and manipulation are central features of this disorder. This disorder is diagnosed when these behaviours become persistent and very disabling or distressing over the longer term. It is often associated with similar terms such as sociopath, or the legal category of psychopathic disorder. People with this diagnosis are likely to have a forensic history. Like other personality disorders it is not easy to treat, often professionals dislike working with this group as typically they face difficult encounters, out of control-ness, and a sense of power imbalance.*

SOME COMMON CHARACTER TRAITS

- A lack of conscience
- Lack of remorse
- Feeling victimized
- Violating others (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

POSSIBLE TREATMENTS

- Short-term courses of medications
- One to one talk therapies
- Group therapy

HOW COMMON IS IT?

Using research by Singleton and colleagues on the prevalence of neurotic disorder amongst prisoners: Male remand 63%; male sentenced 49% of men. 31% of female prisoners - Singleton, ONS 1997 General Population: 3% of men and approx 1% of women

ASSOCIATED RISKS AND CONDITIONS

- Alcohol and substance misuse
- Anxiety
- Depression
- Eating disorders
- Homicide
- Self-injury and suicide
- Frequent imprisonment for unlawful behaviour

WHAT STEPS CAN YOU TAKE TO HELP

- Try not to pre-judge the offender on the basis of their diagnosis.
- Think about your physical safety, avoid being alone with clients who are in an agitated emotional state
- Show them that you are trustworthy and dependable.
- Treat them equitably, don't promise things you can't deliver
- Work closely with your Offender Manager and raise any concerns you have with them. A referral to specialist help may be indicated.
- Avoid colluding with any strong ideas, particularly about other staff members
- Maintain clear, firm boundaries.
- Observe for signs of vulnerability and exploitation
- Please be patient and mindful
- Take account of your own psychological safety; be prepared to deal with your own feelings of professional powerlessness.
- Seek supervision from experienced colleagues
- Communicate with other staff working with specific clients, to help avoid splitting

It is estimated that 35-55% of people with substance misuse problems also have symptoms of a personality disorder. A common misconception is that Anti-social Personality Disorder refers to people who have poor social skills. People with this disorder can appear charming on the surface, but they are likely to be aggressive and irritable.

YOUNG OFFENDERS & MENTAL HEALTH

DEFINITION: *A young offender is young person involved with the criminal justice services who is under the age of 21. Some institutions and specialist youth offending teams deal with children as young as 13. Not all young offenders have mental health problems. It's important to remember that a mental illness and personality problems may not be fully formed at this age and therefore will change in nature.*

SOME FACTORS YOU MAY NOTICE

- High rates of neurotic symptoms, such as anxiety, depression, fatigue and concentration problems, are common.
- High rates of self-injury, up to 40% of new offenders attempted suicide in the previous 12 months.
- 70 per cent of male sentenced young offenders had hazardous drinking histories, compared with 51 per cent of female sentenced young offenders.
- Dependence on opiates such as heroin and methadone was reported by 23 per cent of the women in the sentenced group, 21 per cent of the male remand, and 15 per cent of the male sentenced group.

POSSIBLE RISKS

- Alcohol and substance abuse
- Self-injury, suicide
- Vulnerability to exploitation
- Self-neglect
- Eating distress
- Aggressive outbursts and inappropriate anger
- Drug-induced illness

Almost 80% of young people in trouble with the law are male. There are currently 11,500 young people under 21 in the prison system in England and Wales. (April, 2008)

WHAT STEPS CAN YOU TAKE TO SUPPORT YOUNG OFFENDERS WITH BEHAVIOURAL PROBLEMS?

- Treat each young person with respect and as an individual
- Refer the young offender on to specialist services as soon as possible if you suspect underlying mental health problems as soon as possible.
- Many 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 that expected of an 11-year-old, although their average age is 17.
- 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)

DEFINITION: *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?

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.



THE MENTAL HEALTH OF OLDER OFFENDERS

A Department of Health study (2000), revealed that 85% of older prisoners had one or more chronic illnesses. The most common illnesses were psychiatric, cardiovascular, musculo-skeletal and respiratory. More than half of all elderly prisoners suffer from a mental disorder. The most common disorder is depression, which often emerges as a result of imprisonment. Resettlement is often a period of increased risk, as many older prisoners have become estranged from family members. Equally, many approved premises just aren't geared up for the needs of older offenders.

ALZHEIMER'S AND RELATED DEMENTIAS

Dementia can take many forms. It is an umbrella term that applies to a number of diseases that affect the normal functioning of the human brain. Dementia is taken seriously by the Department of Health owing to demographic changes and the high prevalence of the condition. There is presently a strategy to raise public consciousness on the subject; for more information see 'Living well with dementia: a national strategy'.

Although Dementia is associated with the elderly, the Alzheimer's Society estimates that of the 700,000 people in the UK estimated to have dementia, 13,500 of them are under 65, (Mind, 2009). It can shorten people's lives and is an important cause of disability.

TYPES OF ORGANIC ILLNESS

ALZHEIMER'S DISEASE

Alzheimer's disease is the most common form of dementia. The causes are unknown, however, over the long term, changes in the brain, leading to memory loss and confusion, mood state and can affect a person's personality and behaviour. Over time people with Alzheimer's disease begin to lose the ability to carry out normal, everyday activities for themselves.

VASCULAR DEMENTIA (multi-infarct dementia)

This is the second most common form of dementia and is triggered by a series of small strokes that destroy brain cells. It usually has less effect on the personality than Alzheimer's, and those who have this problem are generally more aware of their limitations. Vascular dementia may come on gradually or quite suddenly. There's usually a settled period, or even an improvement, after each episode of decline. People may experience acute confusion, depression and, sometimes, epileptic fits.

PARKINSON'S DISEASE

Parkinson's is one of the most common neurological diseases in the UK, and people usually experience dementia in its final stages. The drugs frequently prescribed to relieve the awkward movements that characterise Parkinson's can also cause acute confusional states. It's therefore important to distinguish this from the onset of dementia caused by the illness itself, (Mind website).

Recent changes in sentencing policy have led to a steep increase in older prisoners with consequent increases to the general offender population. The majority of men in prison aged 60 and over (56%) have committed sex offences. The next highest offence is violence against the person (20%) followed by drug offences (11%) (Prison Reform Trust)



WHAT CAN YOU DO TO HELP?

- Dementia usually gets worse slowly over the longer term; eventually the person affected will no longer be able to live independently. This may trigger a referral to primary care services, who can arrange for the provision of social care facilities.
- There are currently no treatments that can cure or stop the progression of most forms of dementia. However, drugs and other treatments can improve symptoms in some people.
- You may need to be sensitive to the needs of carers and family as caring for people can be extremely taxing. Often they need respite from those affected with dementia.
- A person with dementia continues to be a person of worth and dignity and deserving of the same respect as any other human being.
- You may need to adopt a slightly different set of interpersonal skills in working with older people. Speak clearly, checking they have understood what you have said.
- Help them to stay orientated to the present with calendars, newspapers and pictures of friends and family.
- Monitor the risks of suicide.
- Monitor basic self-care, like diet and cleanliness.
- Explain basic information to the older offender and any carers, where possible giving information on sources of help and support.

RISK FACTORS FOR OLDER PEOPLE COMING INTO CONTACT WITH CRIMINAL JUSTICE SERVICES

- Depression
- Suicide
- Self-neglect
- Physical health problems, for example, incontinence
- Vulnerability – for example, people with dementia can often get lost
- Exploitation

SELF-INJURY AND SUICIDAL BEHAVIOUR

SELF-INJURY (OR SELF HARM) is an emotive issue that causes a great deal of concern to probation workers. Offenders injure themselves for a number of complex reasons, often to cope with emotional pain or to break feelings of numbness by arousing sensation.

With this kind of behaviour there is not always an intention to die, however, accidental fatalities have occurred by infected wounds or by self-strangulation. Ways of harming includes 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 said to feel emotionally and mentally wounded and cannot envision healing or surviving for as long as healing is anticipated to take.

SOME SIGNS YOU MAY NOTICE

Self-harm:

- Covering scar tissue, even when warm
- Self-isolating, withdrawn behaviour
- Secretive behaviour
- Hoarding unusual items
- Avoiding sporting activities that involve changing clothes.

Suicide:

- Tidying up affairs - making a will, giving away possessions.
- Change in behaviour - withdrawn, low spirited, severely agitated.
- Physical appearance, taking less care of themselves and their immediate environment.
- Comments such as, 'You'd be better off without me' or 'Maybe I won't be around too much longer...'

RISK FACTORS FOR SUICIDE

- **AGE:** The incidence of suicide increases with age. However, recently the incidence in young men up to 45 years of age has been increasing.
- **GENDER:** Suicide is approximately three times higher in men across all ages. Self-harm has a higher incidence among females, especially those aged 25 and under.
- **RACE:** Suicide and self-harm has a higher incidence among traditional white populations.
- Marital status. Suicide has a higher incidence among divorced, single or widowed individuals.
- Living circumstances. Suicide and self-harm have a higher incidence among those living alone or homeless.
- **EMPLOYMENT:** Suicide and self-harm have a higher incidence among the status unemployed.
- Occupation. Suicide has a higher incidence among certain professions, for example, farmers, dentists and doctors, (possibly associated with accessibility of methods).
- **EPISODE OF LOSS:** Suicide has a higher incidence among those experiencing bereavement or recent losses, for example, loss of job, partner, health status especially chronic illness.
- **SEASONAL:** Suicide has a higher incidence during the spring (except for prison populations where the incidence increases in the autumn).

- **REGIONAL:** Suicide has a higher incidence in rural regions.
- Deliberate self-injury. Suicide and self-injury is at greater risk if there is previous or current history of such behaviour.
- **MENTAL ILLNESS:** The suicide rate is higher for people receiving treatment or who have been an in-patient in the last twelve months.
- Social support. Suicide and self-harm have a higher incidence among those who have poor social support networks.
- **SUBSTANCE MISUSE:** Suicide and self-harm have a higher incidence among those with a history of substance misuse.
- **FORENSIC HISTORY:** Suicide and self-harm has an increased incidence for those who commit violent crime.
- **BIOLOGICAL:** Suicide risk is greater where there is a family history of suicide factors.

Harrison A, (2006)

POSSIBLE TREATMENTS

- For most people, recovery from self-injury is a slow process, concerning personal growth and support to build coping skills.
- Generally the 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 urge to hurt themselves arises.
- Emergency help-lines, self-help groups and sourcing other support networks.

POSSIBLE 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

GENDER ISSUES

There is a higher-than-average incidence of self-injury amongst young Asian women. 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

SOME THINGS YOU CAN DO TO HELP

- Try and approach each case with an open mind; individuals harm themselves for different reasons.
- Raise any concerns with the Offender Manager immediately.
- Show understanding, care and concern for their situation.
- Demonstrate active listening and be respectful
- Give time and 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.
- Don't try to 'jolly' them out of it.
- Remain cognisant that people who self-injure often experience feelings of guilt after the event.

THE OFFENDER WITH DUAL DIAGNOSIS

DEFINITION: *The term ‘dual diagnosis’ can be defined in a number of ways but for the purpose of this publication it will be taken to mean the co-existence of severe mental health and substance misuse problems. Clearly the relationship between mental illness and substance use is complex. Some theorists have speculated that the reasons why people misuse substances are similar to the reasons why mental health problems develop.*

Historically, people with dual diagnosis have been said to slip between mental health and substance misuse services, or passed between the two with neither service taking full responsibility. It is generally accepted that individuals with dual diagnosis suffer poorer health outcomes and present significant challenges to both health and criminal justice services.

OFFENDERS WITH DUAL DIAGNOSIS ISSUES:

- Often experience worse psychiatric symptoms than those with mental illness only.
- Generally have an increased use of services.
- Are more likely to have severe social problems and are more likely to be homeless.
- More likely to have experienced difficulties with education and employment.
- Are more inclined to be involved with the criminal justice system.
- Have an increased risk of violent incidents (as victim and as perpetrator).
- Suffer increased incidence of drug-related overdoses.
- Are at 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.

WITHDRAWAL FROM SUBSTANCES:

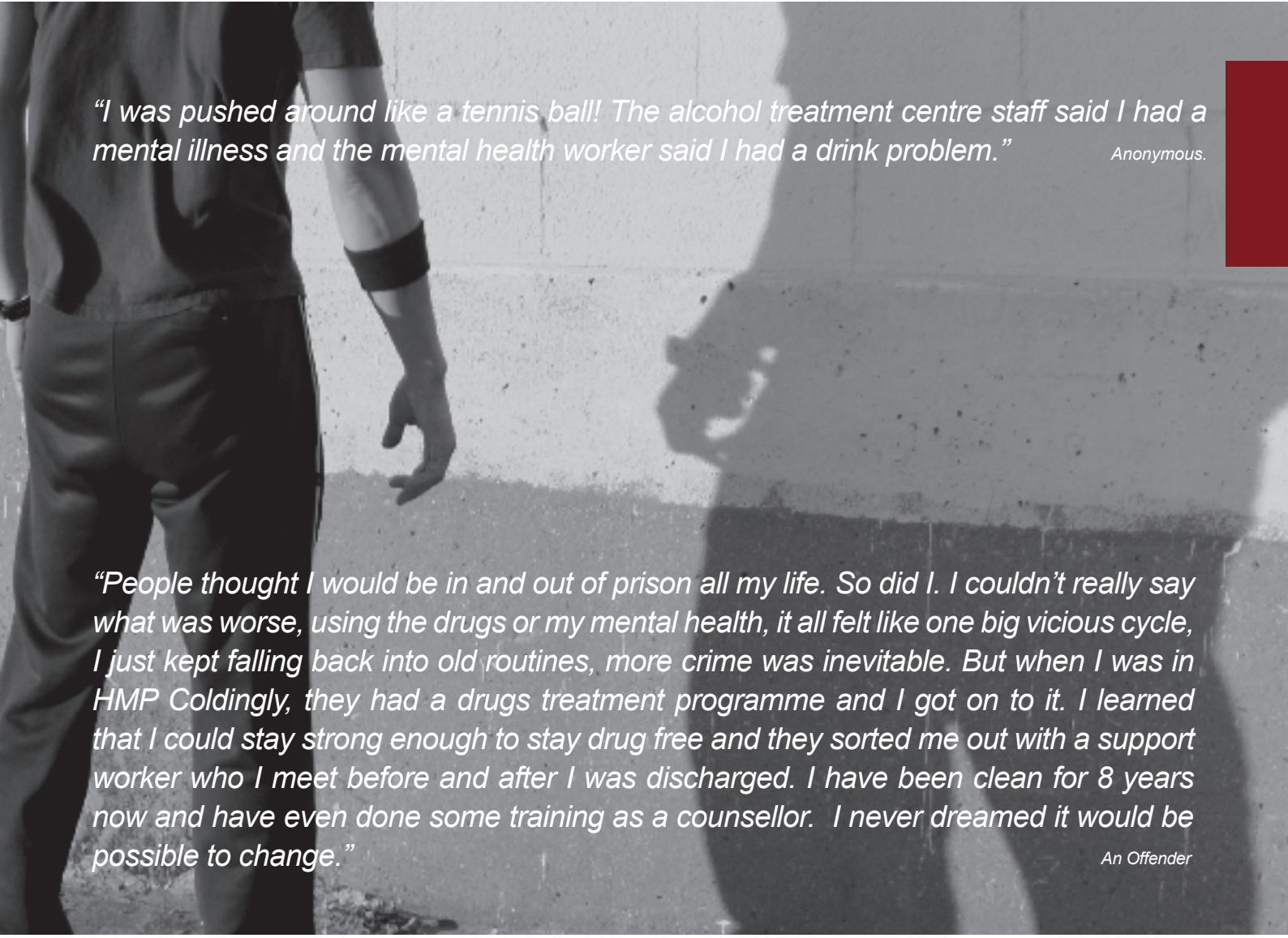
The effects of withdrawal from illicit drugs can produce or mimic symptoms of mental ill health:

- Withdrawal from alcohol can pose life-threatening risks and should be taken seriously. Some side-effects are: anxiety, insomnia, cardiac problems, hallucinations (commonly visual) and clouded thinking.
- Withdrawal from stimulants such as, amphetamine and cocaine often result in confusion, irritability and low mood. It can make people feel suicidal, provoking an attempt.
- Withdrawal from opiates can cause a number of unpleasant physical side-effects. Also, low mood, irritability.

TREATMENT FOR DUAL DIAGNOSIS:

Many offenders with dual diagnosis problems are regarded as harder to reach than some other client groups. They are more likely to come into contact with services when reaching crisis point, with problems relating to social, legal, housing, welfare and lifestyle issues.

Treatment for individuals varies depending on the severity of the problems at play. The mental disorder, substance misuse problem and complex social problems all need to be managed with professional input.



“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.”

Anonymous.

“People thought I would be in and out of prison all my life. So did I. I couldn’t really say what was worse, using the drugs or my mental health, it all felt like one big vicious cycle, I just kept falling back into old routines, more crime was inevitable. But when I was in HMP Coldingly, they had a drugs treatment programme and I got on to it. I learned that I could stay strong enough to stay drug free and they sorted me out with a support worker who I meet before and after I was discharged. I have been clean for 8 years now and have even done some training as a counsellor. I never dreamed it would be possible to change.”

An Offender

WHAT CAN WE DO TO SUPPORT PEOPLE WITH DUAL DIAGNOSIS?

- Express any concerns you have with the Offender Manager. Try and work within the existing networks of care.
- Get as much information you can by reading any previous reports or information on the offender before any scheduled meeting.
- Assess your own health and safety risks.
- Observe for signs of a deterioration in mood or mental state.
- Discuss and observe for possible triggers for relapse or aggression.
- Approach each offender with an open mind - try not to prejudge them based on previous encounters with other offenders.
- If you suspect an individual’s mental state is slipping liaise with their mental health worker or refer them on to specialist help at an early stage.
- Try to encourage the offender to comply with the medication they are prescribed.
- Remember that offenders with schizophrenia may find it difficult to follow or abide by instructions due to aspects of their illness.
- Adopt a patient approach to relationship building and communication; anticipate frustrating moments when progress isn’t as forthcoming as you might expect.
- Handle delusions or strong beliefs with sensitivity even if they seem unrealistic. Try not to dismiss or collude with their beliefs.
- Seek supervision from experienced team members where possible.
- Try and retain a sense of optimism; most people with dual diagnosis go on to gain control of their symptoms.

EFFECTIVE COMMUNICATION

DEFINITION: *Effective communication in criminal justice settings may pose particular difficulties, for example, cultural 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 to anticipate and eliminate potential sources of confusion.*

IT HELPS TO CONSIDER:

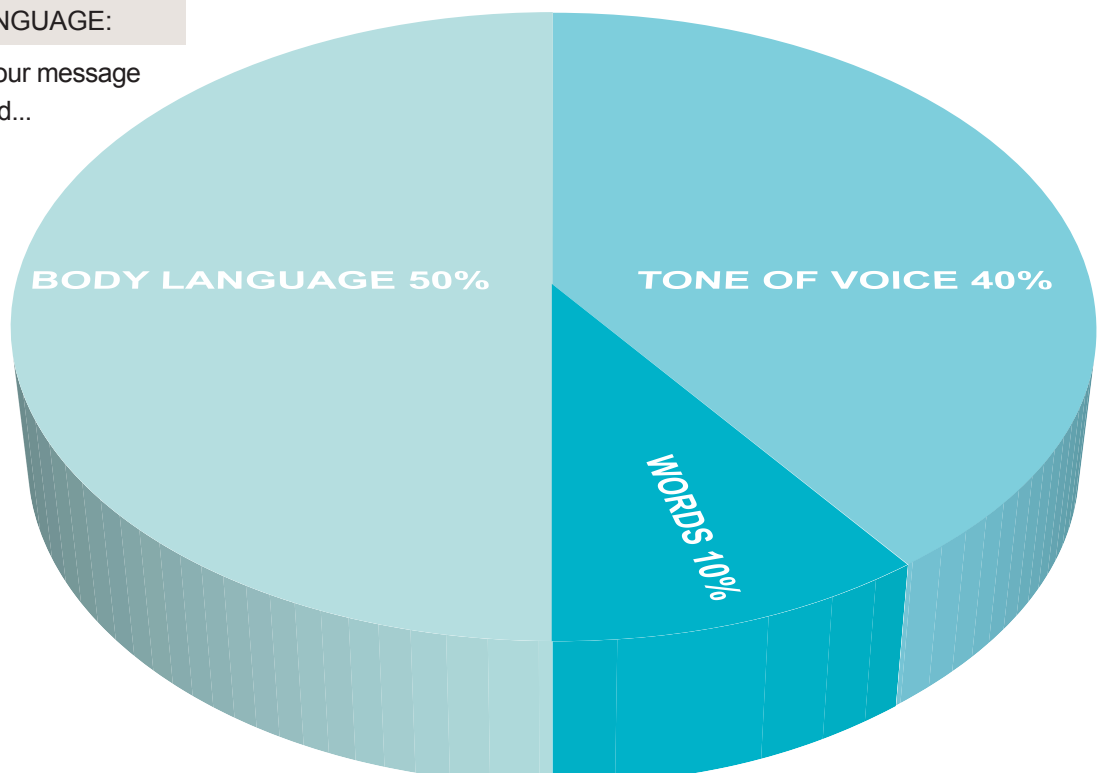
- **WHY** - they need your information
- **WHAT** - information you wish to convey
- **WHO** - is your audience (think about situational or cultural influences)
- **WHAT** - you wish to communicate
- **HOW** - can you best communicate your message
- **WHEN** - your communication relevant
- **WHERE** - does the location affect the communication?

ATTITUDE:

Your attitude is the first thing people notice in face-to-face communication. Just as laughing, yawning, and crying are infectious, attitude can be infectious. Your body language often reflects your attitude towards a particular person or situation.

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. If someone has severe mental health problems or are feeling agitated, it's probably best to demonstrate interest in their situation but vary the amount of eye contact.

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 from 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: *Questioning is a very important method of establishing a basis for effective communication. Effective questions open the door to knowledge and understanding. The art of questioning lies in knowing which type of questions to ask and when.*

GETTING RESPONSE YOU NEED – TYPES OF QUESTIONS

- **OPEN:** questions do not invite any particular answer, but opens up discussion or elicit a wide range of answers. Typically, open questions start with 'Why', 'How', 'What', 'Tell me about ...' This type of questioning followed by a pause is often the best way of helping the offender to explain their situation as they see it.
- **CLOSED:** questions are specific and usually answered with short, yes or no answers, or with a short account of specific details.
- **FACT-FINDING:** questions are aimed at getting information on a particular subject.
- **FOLLOW-UP:** questions are intended to get more information or to elicit an opinion.

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.

- Look at the speaker directly.
- Put aside distracting thoughts.
- Avoid being distracted by environmental factors.
- Observe the speaker's body language.
- Read between the lines for information not stated verbally.
- 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 at appropriate intervals.
- Smile and use other facial expressions.
- Note your posture and make sure it is open and inviting.
- Encourage the speaker to continue with paraphrasing, or 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 the overall message. You may wish to clarify some issues by:

- Reflecting what has been said: "What I'm hearing is..." or "Sounds like you are saying..."
- Summarize the speaker's comments periodically
- Directly question certain points: "What do you mean when you say...?" "Is this what you mean?"

4. DEFERRING JUDGMENT

Interrupting frustrates the speaker and limits full understanding of the message.

- Don't interrupt the speaker but be aware of time boundaries
- Try to avoid arguments as this blocks communication.

5. RESPONDING APPROPRIATELY

Active listening is a model for respect and understanding. The aim is to gain information and perspective.

- Be candid, open, and honest in your response.
- Assert your opinions respectfully.
- Don't collude with strong feelings about other staff or aspects of the service.
- Treat the other person as he or she would want to be treated.

LISTENING MICRO SKILLS

(Attention to client)

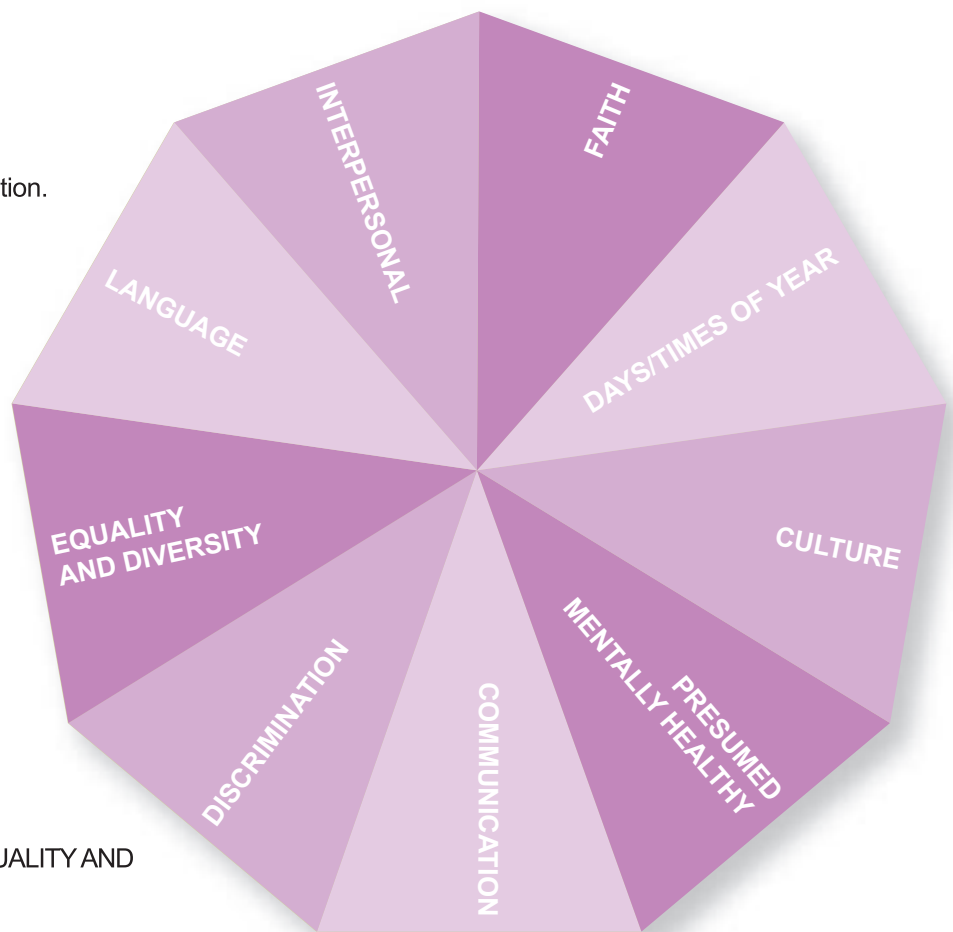
S.O.L.E.R. (Egan, 1977)

- S** Sit squarely (not necessarily face on) and upright.
- O** Open posture
- L** Lean slightly forward
- E** Eye contact
- R** Relaxed

EQUALITY AND DIVERSITY

In common with other public authorities, probation workers should strive to extend the concept of equality to all of the following areas:

- Culture – certain 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 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 and cheaper to build disability equality into a project's designs from the start
- It improves the chances of success and the achievement of strategic aims.

THE MENTALLY DISORDERED OFFENDER CARE PATHWAY AND ACCESS TO OTHER HEALTH AND SOCIAL CARE SERVICES

Many offenders will need support for their health and mental health problems in the community. The vast majority of these will be dealt with by Primary Care (or community-based) services. The general practitioner is the gateway for these services, therefore it is vital that the offender is registered with a local general practice surgery. This can be done by going into the local surgery and asking for the relevant forms, which enable the transfer of personal medical records from one surgery to another. Alternatively, try contacting the local Primary Care Trust, as they can advise on which local surgeries have the facilities to deal with specialist issues, such as, alcohol and substance misuse or surgeries more able to deal with hard to reach groups.

The offender may have a history of involvement with drug and alcohol services. In this scenario it is worth checking to see if they have been referred to local services. If not, consideration should be given to a referral.

Offenders with more severe and enduring forms of mental illness will be subject to the Care Programme Approach (CPA). This is a process whereby all significant stakeholders are involved with assessing the problem, planning and helping the client to make appropriate decisions and choices about their future. It addresses a wide range of provision including housing, advice on benefits, education and employment. Usually a care coordinator (often a community mental health nurse), takes the lead for this sequence of actions.

On-going care for people with severe mental illness involves active links with the offender's community mental health team. There needs to be a high degree of information sharing between agencies to ensure that care is delivered and risks are managed adequately. Plans should reflect actions to take should a crisis occur or the offender's mental state deteriorates.

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 detailed information
- Reviewing historical information to anticipate future change
- Analysis of potential outcomes
- Identifying specific risks

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 something about it.
- Multi-disciplinary team 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 consideration should be given to overriding this right when there are risks to the individual, other members of the public or of serious crime.
- Risk-related information should be shared between staff and teams directly concerned with the management of specific individuals.
This often benefits the offender as well as the staff and public.



GOOD PRACTICE TIPS:

- Talk with people, not at them; where possible, involve them with information sharing.
- Promote equality, especially with black, Asian and minority ethnic groups.
- Identify and work with the individual's strengths.
- Offer appropriate support, reflection and guidance.
- Respectfully remind the offender of the consequences of potentially risky behaviour.
- Signposting to other service providers who can assist with issues such as anger management or self-injury.
- 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, listen actively.
- 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 as well as perpetrators
- 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.
- Use team meetings and individual supervision for support.

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 make them come across as 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 is 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 with desire for attention and admiration. They have an intolerance of criticism, and disturbed self-centred interpersonal relations. They are often described as being conceited, and generally have low self-esteem as well. They act selfishly interpersonally, with a sense of entitlement over others.

Dependent personality:

Dependent personality is evidenced 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 in 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 & Severe Personality Disorder:

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 which 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.

Manic Depression:

Also called bipolar affective disorder until lately, 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 and 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.

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 is 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 counsellor

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, youths or people with drug or alcohol problems.

COUNSELLOR

Counsellors provide a 'talking therapy' where the client will be invited to talk about their thoughts and feelings; the counsellor 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 aspects 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 to, 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 be given a care plan and a care coordinator to assess and arrange services for them.

RECOMMENDED READING

THE OFFENDER MANAGEMENT GUIDE TO WORKING WITH WOMEN OFFENDERS, National Offender Management Service (NOMS), 2008.

POSITIVE PRACTICE POSITIVE OUTCOMES, A handbook for professionals working in the criminal justice system working with offenders with learning disabilities. CSIP, 2007.

A PATHWAY TO CARE FOR OLDER OFFENDERS: A toolkit for good practice' DH (2007)

CHILDREN OF OFFENDERS REVIEW Ministry of Justice and Department for Children, Schools and Families, 2007.

WHEN TO SHARE INFORMATION: Best practice guidance for everyone working in the Youth Justice System' (DH, 2008)

WORKING WITH MENTALLY DISORDERED OFFENDERS (A training pack for staff in criminal justice agencies, health and social care, and the voluntary sector'), NACRO CD-ROM, 2005.

PROMOTING MENTAL HEALTH AND WELL-BEING IN LATER LIFE: A first report from the UK Inquiry into mental health and wellbeing in later life, Age Concern and the Mental Health Foundation, 2006.

MAKING IT POSSIBLE: Improving mental health and well-being in England. National Institute for Mental Health in England, 2005.

THE TEN ESSENTIAL SHARED CAPABILITIES: A framework for the whole of the mental health workforce, (2004). DH Publication ref: 40339.

OFFENDER MENTAL HEALTH CARE PATHWAY, Department of Health, January 2005.

LIVING WELL WITH DEMENTIA: A national dementia strategy' Department of Health, (2009).

MARTEAU, D. 'A GUIDE FOR THE MANAGEMENT OF DUAL DIAGNOSIS FOR PRISONS' Ministry of Justice, NOMS, Department of Health. (2009).

USEFUL EXTERNAL ORGANISATIONS

ORGANISATION	WEB SITE ADDRESS
Department of Health	www.dh.gov.uk
Care Services Improvement Partnership	www.csip.org.uk
Offender Health	www.dh.gov.uk/en/Healthcare/Offenderhealth/
MIND (Mental Health Charity)	www.mind.org.uk/
Sainsbury Centre for Mental Health	www.scmh.org.uk
National Institute for Mental Health in England	www.nimhe.org.uk
Turning Point, social care organisation	www.turning-point.co.uk/
Personality Disorder	www.frontline-training.org

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