

# **MENTAL HEALTH AWARENESS TRAINING**

***FOR PROBATION WORKERS'***



## COURSE AIMS

- *To increase understanding of the issues relating to mental well-being, illness and some common psychiatric conditions.*
- *To enable you to feel more confident when dealing with offenders displaying signs of mental ill health.*
- *To enhance your ability to observe, recognise and refer people you feel require support for their mental health.*
- *To sign post 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 re-offending upon release or in the community.*
- *To contribute to your professional development in this field.*

# INTRODUCTION

## HOW THE TRAINING PACK CAN BE USED

*The Government feels it is very important that everyone working in the criminal justice sector have a basic understanding of mental health awareness. This introductory training package is intended for use with probation service workers of all grades. It is comprised of three elements:*

- **DELEGATES WORKBOOK** for issue to all participants of the course
- **TRAINER'S GUIDE** suggestions for planning and delivering taught sessions
- **POWER POINT PRESENTATION** for use within training sessions

Trainers are advised to carefully read through all the course information to familiarise themselves with the content and format. The Trainer's Guide has been developed recognising that the facilitator will face groups of staff with differing levels of ability and motivation to learn. Additionally, the groups will contain staff with varying degrees of contact and experience of dealing with mentally disordered offenders. Timeframes for delivery will vary from organisation to organisation. The course material is therefore designed for flexible use in terms of both time and content.

The guide is divided into a number of sections and modules. Within each section and module we have included trainer's notes and further information to complement the relevant power point slides. This means the facilitator can select the appropriate units from a repertoire of material depending on the needs of the group he or she is working with and how much time they have with the group.

A standard day's training might consist of an introduction, four hour-long units and an evaluation, for example:

- Introduction to the day
- Understanding mental health
- Neurotic conditions
- Mood disorders
- Psychotic conditions
- Evaluation, round off.

Trainers will find that each unit has learning outcomes and a suggested lesson plan. These are designed to help the facilitator to structure their session. Often issues evolve spontaneously and at times it seems right to let the group have a say

in the material to be covered. As the facilitator gains experience, it is hoped that they will use their discretion to judge which elements to include at which stage.

The modules have been designed to provide a 'pick and mix' approach to the training. This is to give the trainers the flexibility and versatility to ensure delegates receive appropriate training in the timescale available to deliver it. For example, if the training is being delivered to a youth-offending team, the trainer may wish to work with the information on young people's mental health and self-harm. The choice rests with the facilitator.

Additional modules contain:

- Self-injury and Suicide
- The Offender with Eating Distress
- The Mental Health of Young Offenders
- The Mental Health of Older Adults
- The Offender with Dual Diagnosis
- Working with Risk
- Equality and Diversity

Additional information:

- Additional activities, case studies and exercises.

Each section begins with the learning objectives and a suggested lesson plan, outlining estimated timing for each activity and a selection of activities. The units will be colour coded in both the trainer's guide and delegate's workbook, offering ease of referencing specific resources.

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

## PROFILE OF THE TRAINER

*It is desirable that the facilitator has completed some form of teaching experience and that they are familiar with the subject. It could be detrimental to the training if the trainer does not understand the issues around working with people experiencing mental distress.*

### IDEALLY THE TRAINER SHOULD HAVE:

- Knowledge of reflective learning
- Experience of managing group dynamics
- An aptitude for managing others emotions, in a safe and empathetic manner
- Good interpersonal skills
- High level of self awareness

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

- Managerial support with the administration for the training
- Access a personal supervisor
- Ring fenced time to run the sessions

### NOTES TO THE TRAINER

It is advisable that you familiarise yourself with the role of the organisation you are preparing to work with before embarking on the training as it is possible they may have specific training needs. Some organisations will have their own suicide awareness and diversity packages in place - the mental health awareness training should dovetail with these.

Before commencing any training, you need to dedicate some time and thought as to how you will structure the session, in terms of the length of time available to deliver the training and how you will close the training session.

If role-play exercises are used, ensure the participants spend some time debriefing from their respective roles. It may also be worthwhile ensuring there are support mechanisms in place for the group members to use outside of the sessions, and that the group members know these are available. These mechanisms should be the usual staff support or supervision systems within the organisation.

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

### AFTER THE TRAINING

It is considered good practice to meet with the managers that were involved in organising the training, to feedback the key points from the session. Recommendations can be made for structuring future training and support.

Use the trainer's evaluation (**Appendix 1**) for suggested headings for this feedback to the organisation managers.

## PRACTICALITIES

### TIMINGS:

Variable, remember to allow for regular breaks.

### VENUE:

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

### NUMBER OF PARTICIPANTS:

Groups of 15-20 delegates are recommended.

### EQUIPMENT REQUIRED:

Laptop and Multimedia data projector  
Visual audio DVD  
Flip chart paper and pens, sticky labels

### HANDOUTS:

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

### PREPARATION:

Trainers Working Programme  
Enough copies of group handouts

## OUTCOMES OF THE OPENING SESSION

- To set the scene for the training – aims and content
- To encourage positive participation in the session and effective learning
- To agree the structure and timing of the training
- To agree group rules for the session

## LESSON PLAN

15 mins	Slide 1	<p><b>INTRODUCTION AND WARM UP</b></p> <ul style="list-style-type: none"> <li>• Invite each participant to state their name, job title and one word they associate with mental ill health.</li> <li>• Link the training to personal learning objectives and PDP aims</li> <li>• Do they have any expectations, concerns and/or worries from training session.</li> </ul> <p><i>Further ice breaker exercises can be found at the end of the trainers guide</i></p>
10 mins	Slide 2	<p><b>BOUNDARIES/SAFETY CONTRACT</b></p> <ul style="list-style-type: none"> <li>• Agree a safety contract with the group. Some of the course content can lead on to personal and emotive discussions, therefore the group should agree to maintaining one another's confidentiality outside of the session.</li> <li>• Some examples of the safety contract relate to: <ul style="list-style-type: none"> <li>• Timings of the training session; punctuality.</li> <li>• Use of bleeps/mobiles during the training</li> <li>• Respect each others comments and use appropriate behaviour at all times within the group</li> <li>• Only have one person speaking at one time</li> </ul> </li> </ul>
10 mins	Slide 3	<p><b>EXPLANATION ON THE COURSE MATERIAL</b></p> <ul style="list-style-type: none"> <li>• Reference to the PowerPoint</li> <li>• Explanation of delegate's workbook. The workbook is designed to complement the information delivered in the session and is kept by the participant to use as a reference source. It contains: an information guide, further information and some statistics.</li> </ul>

# WHAT IS MENTAL HEALTH?

## LEARNING OUTCOMES

- Course participants to be able to define mental health, mental well being and mental illness.
- Students to understand the connection between mental health and coping.
- Students to gain an insight into what factors may contribute towards mental health problems.

## AN EXAMPLE OF A LESSON PLAN

10 mins	slide 4	<p>INTRODUCTION AND OVERVIEW</p> <ul style="list-style-type: none"> <li>• What are we talking about when we use the term 'Mental health'?</li> <li>• What is mental illness?</li> <li>• Mental disorders</li> </ul>
15 mins	slide 5	<p>FACILITATED DISCUSSION</p> <p>Introductory questions, can be in pairs or groups:</p> <ul style="list-style-type: none"> <li>• How would you define good mental health?</li> <li>• How would you describe poor mental health?</li> </ul> <p>Feedback</p>
15 mins	slide 6	<p>GROUP EXERCISE</p> <p>This small group exercise is designed to encourage delegates to think about their own mental health and then apply the same principles to probationers they currently are working with.</p> <ul style="list-style-type: none"> <li>• What coping mechanisms do you use to maintain or improve your mental health?</li> <li>• Do people coming into contact with the criminal justice system have access to the same coping resources as we do? What might they do to help themselves cope? <i>examples – Physical exercise, relaxation, 'time out' etc</i></li> </ul> <p>Feedback</p>
10 mins	slide 8/9	<p>QUESTION</p> <p>What are the likely causes of mental illness? <i>examples – Stress, financial problems, unsympathetic colleagues, inadequate housing.</i></p> <p>Feedback</p>
10 mins	slide 11	OVERVIEW OF THE MAIN CATEGORIES OF MENTAL DISORDER
10 mins		MENTAL HEALTH AND STIGMA
10 mins		QUESTIONS AND SUMMARY

# WHAT ARE WE TALKING ABOUT WHEN WE USE THE TERM MENTAL HEALTH?

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 its 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 one in four 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 users 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. Our understanding of mental health is likely to be influenced by a number of factors; for example, this may vary from country to country and culture to culture.

As a probation service employee you can use your inter-personal and observational skills to play a vital role in recognising mental distress.

## WHAT AFFECTS OUR MENTAL HEALTH?

*Mental health is determined by socio-economic, cultural and environmental factors - All of these can interact together to determine mental health and mental health disorders.*

*There are:*

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

**MENTAL HEALTH IS LINKED TO BEHAVIOUR:** *Physical, mental and social factors may interact to intensify their effects on a person's well-being and in turn their behaviour.*

### 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
- Asking for help

### COPING MECHANISMS: Questions & Answers

EXAMPLES OF POSITIVE COPING MECHANISMS:

- Eliminating the source of stress
- Sharing concerns
- Using support
- Time management
- Assertiveness
- Leisure pursuits
- Relaxation
- Exercise
- Meditation
- Spiritual beliefs
- Positive self talk
- Accepting praise
- Acknowledging and dealing with internal criticism
- Reducing expectations on self
- Counselling or talking therapies
- Medication

ALTERNATIVE EXAMPLES:

- Alcohol
- Tobacco
- Other drugs
- Self-blame
- Blaming others
- Avoidance
- Isolation and withdrawal
- Aggression
- 'Fire-fighting'

**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.

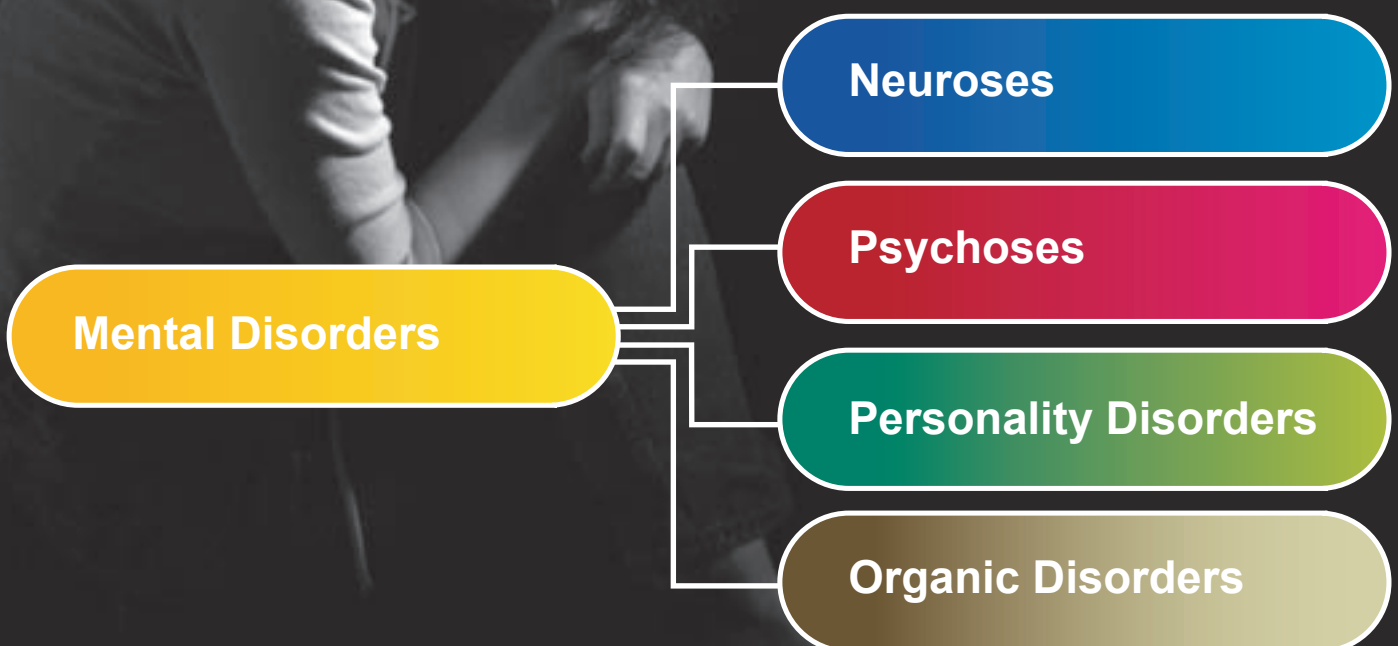
*Most people who suffer mental distress fully recover and go on to lead fulfilling lives.*

## WHAT IS MENTAL ILLNESS?

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

*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.*

## THE FOUR MAJOR GROUPS OF MENTAL DISORDERS



## 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 term mental illness' actually encompasses numerous psychiatric disorders.*

*Common conditions include: -*

- *Generalised Anxiety*
- *Depression*
- *Bipolar Disorder*
- *Schizophrenia*
- *Personality Disorders*

A person can experience a mental illness over the short, medium or long term. The type, intensity and duration of symptoms vary from person to person. They often have no clear start or end point and do not always follow a regular pattern. This differs from our understanding of physical health problems, which are often easy to identify with observable prognosis. It is often more difficult to predict when symptoms will improve or worsen, even if treatment recommendations are followed.

Although the symptoms of mental illness often can be controlled effectively through medication and/or psychotherapy, in some people the illness continues to cause periodic episodes that require treatment.

Consequently, some people need little or no support, others may need only occasional support, and others may require more substantial, ongoing support for long periods of their lives.

# THE OFFENDER WITH ANXIETY

## LEARNING OUTCOMES

- *Course participants to gain an understanding of the term anxiety.*
- *Students to gain insight into the physiological, psychological and social effects it might have on an individual.*
- *Course participants to be able to discuss some methods of helping offenders with anxiety.*

## SUGGESTED LESSON PLAN

10 mins	slide 12	OVERVIEW What is anxiety?
15 mins	slide 13/14	EXCERCISE What are the physical and psychological effects of anxiety? How can we recognise it? Sub groups to discuss the following and then nominate one person from each group to feedback.
15 mins		EXCERCISE Discuss in small groups and make a list of some of the possible causes of anxiety. Feedback
20 mins	slide 15	ROLE PLAY Optional
5 mins		SUMMARY

## EXERCISE 1: *What are the effects of anxiety? How can we recognise it?*

Split into group into two sub groups. Think about a time that you felt anxious about something – how did you feel, what sort of events triggered it, did you have any physical symptoms, how long did it last?

- Group one: physical effects
- Group two: psychological affects

Sub groups to discuss the following and then nominate one person from each group to feedback.

The symptoms vary in their duration and intensity from individual to individual but some common signs are:

### **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.

## EXERCISE 2: *Recognising an offender with anxiety*

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

## EXERCISE 3: *How can we help an individual with anxiety?*

The subgroups to discuss and feedback on how a probation worker might help someone with an anxiety disorder in their respective settings.

- 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 possible
- 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 reacting, 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.

**PANIC ATTACKS:** *are sudden feelings of terror that strike without warning. These episodes can occur at any time, even during sleep. A person experiencing a panic attack may believe that he or she is having a heart attack or that death is imminent. The terror that a person experiences during a panic attack is not in proportion to the true situation and may be unrelated to what is happening around them.*

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

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

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

**ROLE PLAY EXERCISE:** *SCENARIO – Pete has become friends with Kevin who has recently been released from prison to an approved premises. During the course of a conversation between Pete and his key worker, he mentions to you (the member of staff), that Kevin had a really bad ‘turn’ in his room recently.*

Split into groups of four. In each group, nominate one person to be the hostel staff, one person to play Pete, and one person to play Kevin (who has a number of personal problems) and one person should observe the actions.

- In role-play, the member of staff must try to find out from Pete what has been happening to Kevin
- In role-play, the member of staff must then talk to Kevin to try and find out more about what has been happening to him, both physically and psychologically
- The observer should feedback on the performance of the member of staff in the role-play. For example, what steps could be taken to help Kevin, what could have made the member of staff more effective?
- Each group to feedback to the whole group.

# THE OFFENDER WITH DEPRESSION

## LEARNING OUTCOMES

- *Course participants to gain an appreciation of the terms depression and mood disorder.*
- *Students to be able to recognize the main physical, psychological and social effects of depression on the individual.*
- *Students to be able to discuss some methods of helping offenders with depression.*

## SUGGESTED LESSON PLAN

10 mins	slide 16	OVERVIEW What is depression?
20 mins	slide 17/18	LARGE GROUP EXERCISE How might someone with depression present? List the physical, psychological and social effects of depression Feedback
5 mins		DISCUSSION The different types of depression
20 mins		GROUP EXERCISE What distinguishes depression from a bad day? How would you know if an offender was just having a 'bad day' compared to suffering from a depressive episode? Discussion
20 mins		OPTIONAL EXERCISES OR ROLE PLAY
25 mins		CASE STUDY AND FEEDBACK FROM QUESTIONS
5 mins		QUESTIONS AND SUMMARY

**OVERVIEW:**

- *Depression has been described as the ‘common cold’ of mental disorder, but its consequences can be serious.*
- *The condition involves disturbances in mood, concentration, sleep, activity, appetite and social behaviour.*
- *The individual’s thinking is dominated by themes of pessimism and hopelessness.*
- *Quite often, depression is accompanied by very negative thoughts, decreased self-esteem, self-worth and self-confidence.*

**STATISTICS**

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

**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 re occur 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, not loving the baby enough or even being hostile towards the 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.

## TREATMENTS FOR DEPRESSION - MEDICATION

### SSRI's (SELECTIVE SEROTONIN REUPTAKE INHIBITORS)

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

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

### MAOIs (MONOAMINE OXIDASE INHIBITORS)

These are a powerful form of anti-depressant. Particularly effective for atypical depression. Because of their strength, they should be used as a last line of defence.

*Examples are: - Phenelzine (Nardil)*

Other types of medication include;

### SNRIs (SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITOR)

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

*Examples are: - Venlafaxine (most commonly used)*

*\*see guidance sheet containing the different forms of depression*

### TALKING TREATMENTS

There are many different forms of talking therapies, but the most effective are CBT (Cognitive Behavioural Therapy), Psychoanalysis and Counselling

### ECT (ELECTROCONVULSIVE THERAPY)

### WHICH ARE MOST EFFECTIVE?

They are both as effective as each other – but SSRI's have fewer side effects

Also a major advantage for SSRI's is that they are so dangerous if someone takes an overdose

**GROUP EXERCISE:** *Split into groups to discuss the following statements and then nominate one person from each group to feedback to the whole group.*

**Q.1** What distinguishes depression from a 'bad day'?

**Q.2** How would you know if an offender was just having a 'bad day' compared to suffering from a depressive episode?

**Facilitator notes:**

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



**OPTIONAL EXERCISE:** *Split main group into three sub groups*

**G.1** Discuss and feedback to the group what phrases an offender might use if he/she was depressed

**Facilitator notes:**

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

**G.2** Discuss and feedback to the group what body language the offender might display if he/she were depressed

**Facilitator notes:**

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

**G.3** Discuss and feedback to the group the type of behavioural changes the probationer might show if he/she were depressed

**Facilitator notes:**

- Withdrawal from people they would normally socialise with
- Unwilling or unable to participate in activities
- Lack of energy and enthusiasm for anything
- Unable to concentrate on even the simplest tasks
- Lack of personal care and hygiene
- Wakefulness at night or sleeping excessively
- Refusing meals or eating more
- Anger, irritability, tearfulness
- Agitation, for example, unable to sit for any length of time.

**OPTIONAL ROLE PLAY EXERCISE:** *Identifying depression*  
*(ideally this role-play would follow on from Exercise 2 above)*

- Q.1**
- Split into groups of 3-4 and each group develop a role-play scenario (maybe based on experience). Consider what questions the probation worker should ask to identify if the prisoner may be depressed
  - Each group will then nominate one person to adopt the role of the probation worker, and nominate another to adopt the offender role (with body language associated with depression).
  - Perform the role-play with the other group members observing

**Q.2** In each individual group, discuss what action could be taken by the worker to help the person

**Q.3** Each individual group nominates someone to feedback to the entire group what action could be taken to help the person

## 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 re-possessed 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 everyday. 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.1** How would you begin to engage with Darren?

**Q.2** What are the main concerns about Darren?

### **OPTIONAL EXERCISE:** SCENARIO: Reception, Probation Service Offices

*A gentleman enters the office for an appointment with his allocated probation officer. He appears tired and unkempt, his facial expression is blank. He is slow to respond to your questions, when he talks, he sounds under confident and quite apologetic. He expresses negative comments about himself.*

**Q.3** You suspect the man is low in mood and wish to alert his allocated worker to your observations. List three things that concern you about the clients presentation, what are the possible risks?

# THE OFFENDER WITH EATING DISTRESS

## LEARNING OUTCOMES

- *Course participants to gain an understanding of the term eating distress.*
- *Students to gain an insight into the range of conditions this can include*
- *Students to increase their knowledge on the physical, psychological and social effects of living with eating distress*
- *Course participants to understand how to signpost offenders with eating distress on to the appropriate services.*

## SUGGESTED LESSON PLAN

10 mins	slide 19	OVERVIEW Facilitator overview, eating distress, anorexia, bulimia
15 mins	slide 20	EXERCISE How would you define eating normally, is this the same for everyone? Feedback
15 mins		EXERCISE What are the signs and symptoms of a) Anorexia, b) Bulimia? Feedback
10 mins		GENERAL DISCUSSION What things can we do to help?
20 mins		SCENARIO Small group discussion and feedback
10 mins		QUESTIONS AND SUMMARY

**OVERVIEW:** *'Eating Distress' is a relatively new, coverall term that embraces the various forms of eating disorders. It is often used interchangeably with the term 'eating disorder'. Eating disorders treatable conditions, which frequently co-exist alongside other psychiatric disorders, such as depression or anxiety. The main eating disorders are: Anorexia, Bulimia, Binge eating disorder, Compulsive Eating. People also suffer other physical health problems including heart conditions and kidney failure.*

#### NORMAL EATING

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

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

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

#### DISORDERED EATING

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

#### EATING DISTRESS AFFECTS:

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

## STATISTICS

- **At least 1.1 million people in the UK have an eating disorder.**
- **Ten times higher in females than males**
- **1% of female suffer anorexia, 4% suffer bulimia**
- **10% of suffer's are male**
- **10% of people with an eating disorder will DIE**
- **Affecting children as young as six.**

**ANOREXIA NERVOSA - ' means 'loss of appetite for nervous reasons'**

- It is more likely that the individual has lost the ability to allow themselves to satisfy their hunger.
- 10 to 20% of sufferer's will die from complications related to anorexia. Anorexia kills more people than any other psychiatric disorder.
- Only about 60% will recover – with about a third making a full recovery
- Usually begins in teenage years, although it can start in childhood or later life
- 1 15-year-old girl in every 150
- 1 15-year-old boy in every 1000.

**SYMPTOMS:**

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

**TREATMENT OF ANOREXIA - involves 3 components:-**

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

**BULIMIA - means "the nervous hunger of an ox".**

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

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

**SYMPTOMS**

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

## BINGE EATING DISORDER

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

### SYMPTOMS

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

### COMPULSIVE OVEREATING - Binge eating compulsively

- Feeling out of control when eating. Fear not being able to stop eating
- Depression, low self-esteem, constant need for love and acceptance
- Secretive eating patterns, hiding food
- Self-punishment following compulsive eating
- Avoiding situations and activities – fear of eating in front of others
- Trying many diets but failing
- Believe they will be a better person if thin
- Feelings are based on weight and eating habits
- Believe food is only friend
- Poor sleeping habits.

### COMMON TO ALL EATING DISORDERS

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

### CAUSES OF EATING DISORDERS - GENETICS

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

### EATING DISORDERS AND MEN

- 10% of people with eating disorders are men
- Lack of recognition of eating disorders in men
- Its more difficult for men to access specialist eating disorder services, or be diagnosed, so often their illness is well-established before treatment is offered.
- Culturally there is less pressure on men to be slim; however there is pressure to have well defined muscles including the 'six-pack' shape.
- Usually the onset of an eating disorder in men is triggered by situations such as: childhood bullying/teasing, being overweight as a child, bodybuilding or specific occupations.

## RECOVERY

- Acknowledge and recognise you have a problem. Admitting this to yourself can take a long time.
- Tell someone - this is scary and full of uncertainty.
- Visit a doctor – referral to therapist and dietician.

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

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

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

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

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

## WHAT CAN YOU DO TO HELP?

- Treat each offender as an individual, don't be judgemental about their circumstances
- Inform the Offender Manager of your concerns. Find out if the offender has a GP and encourage them to make an appointment.
- Give the offender an opportunity to talk about their feelings
- Help the person to recognise that there is a problem. Explain that asking for help does not mean they lack character. Help the offender to understand that they have taken a big step and encourage them.
- Be patient, remember that progress will take time
- Don't try to talk the offender out of his or her feelings. The feelings may be irrational, but you might try saying, 'I'm sorry that you are feeling bad. What can I do to help?'
- Use your listening skills - don't dominate conversations.

**SCENARIO – SMALL GROUP EXERCISE:** *Sarah comes to the staff office of the approved premises where she is lodged. She tells you that one of the girls, Fariah, is in 'a bit of a state'. She says she's crying and she thinks she could hear her vomiting earlier.*

*You decide to approach Fariah to see what the issues are. She is sitting on her bed looking tearful. She clutches her hands to her chest; it appears she is in some pain. You sit beside her and try to engage her in conversation although she is rejecting and will not speak to you.*

**Q.1** How does this make you feel as a professional?

**Q.2** What simple steps do you feel you can take in the short term?

# THE OFFENDER WITH BIPOLAR DISORDER

## (Manic Depression)

### LEARNING OUTCOMES

- Participants to gain an understanding of the term bi polar disorder.
- Course participants to gain an insight into the individual's physical, psychological and social experience of living with bi polar disorder.
- Participants to increase their knowledge of how to signpost probationers with bi polar disorder to the appropriate services

### SUGGESTED LESSON PLAN

10 mins	slide 21	OVERVIEW
15 mins	slide 22-25	SUGGESTED EXERCISE - LARGER GROUP <ul style="list-style-type: none"> <li>• Group 1 to discuss how someone would suffering from mania might behave</li> <li>• Group 2 to discuss how someone suffering from hypomania might behave</li> </ul> Each group to nominate a spokesperson to feedback to the whole group for discussion
20 mins		DISCUSSION Case Study Feedback
10 mins		QUESTIONS AND SUMMARY

*Bipolar Disorder is a serious but treatable medical illness. It is characterised by extreme shifts in mood, energy, thinking and behavior. Bipolar Disorder is marked by periods of mania (highs), greatly elated moods, or excited states interspersed with periods of depression (lows).*

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

- euphoria or being 'high'
- extreme hyperactivity
- irritability
- paranoia
- depression.

There can also be long periods of stability in between episodes.

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

## 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. If possible 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 of 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.

## BEHAVIOUR INDICATIVE OF MANIA:

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

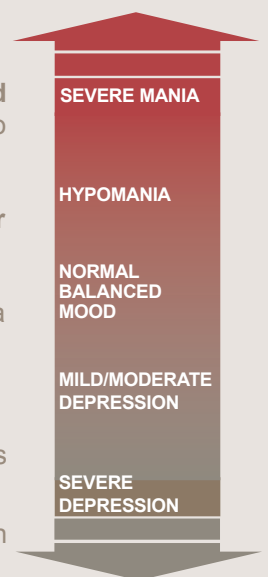
## THERE ARE DIFFERENT TYPES OF BI POLAR

**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.



**COURT SCENARIO:** *The court welfare officer approaches you expressing concern about a prisoner that has arrived this morning. You go to the cells area and are introduced to a man called Michael. He is not threatening, in fact he is quite cheerful and pleased to see you. He is very keen to talk to you but refuses to speak to uniformed staff. He tells you he is okay, that he is amongst his people. He tells you he has only slept for 20 minutes in the past four days. You observe he is stripped to the waist and he holds out his arms, you suspect to emulate a crucifix.*

**Q.1** What kind of information do you share with the other court staff?

# THE OFFENDER WITH SCHIZOPHRENIA

## LEARNING OUTCOMES

- Participants to gain an understanding of the condition schizophrenia.
- Course participants to gain and insight into the physical, psychological and social impact of living with schizophrenia.
- Students to be able to discuss the impact of schizophrenia on the probationer's lifestyle and say how it might affect their working relationship.

## SUGGESTED LESSON PLAN

10 mins	slide 26	INTRODUCTION AND OVERVIEW
20 mins	slide 27/28	LARGE GROUP DISCUSSION What are your experiences of working with schizophrenic offenders? How did they present? How did it make you feel? Feedback
10 mins	slide 29-31	FACILITATOR LED DISCUSSION Symptoms of schizophrenia, positive and negative
20 mins		CASE STUDY Engaging with people with schizophrenia Feedback
10 mins		FACILITATOR LED DISCUSSION: What's helpful to people with schizophrenia?
10 mins		SUMMARY AND QUESTIONS

*“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.

#### ADDITIONAL INFORMATION: POSITIVE AND NEGATIVE SYMPTOMS

Clinicians often divide the symptoms of schizophrenia into two broad groups:

##### POSITIVE SYMPTOMS

- Hallucinations
- Delusions
- Thought disorder
- Catatonia

##### NEGATIVE SYMPTOMS

- Lack of Volition
- Lack of excitement
- Poverty of thought
- Poverty of speech *(Norman I and Rylie I, 2004)*

The terms positive and negative could be misleading if taken in our normal understandings of the terms. In this case positive is taken to mean an exaggeration of normal experience, for example, an over-interpretation of normal forms of stimulation. The term negative is taken to mean a reduction of normal experience, for example, a loss of motivation

#### 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 difficulty concentrating, being withdrawn and feeling apathetic. Negative symptoms can result in people neglecting their diet and themselves. They may not get involved with typical activities and they can appear preoccupied with their own thoughts. Negative symptoms can also lead to troubles with education, which can contribute to difficulties 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.

## THERE ARE DIFFERENT TYPES OF SCHIZOPHRENIA

### PARANOID TYPE:

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

## POSSIBLE RISKS IN OFFENDERS WITH SCHIZOPHRENIA

- 40% of people that have Schizophrenia will attempt suicide at least once. The result of these attempts is that between 10% and 15% of people with Schizophrenia have historically committed suicide.
- Males with Schizophrenia attempt suicide at a much higher rate than females; approximately 60% will make at least one attempt.

## TREATMENTS FOR OFFENDERS WITH SCHIZOPHRENIA

Medication is the main treatment for Schizophrenia:

- Antidepressants - to relieve symptoms of depression
- Mood stabilisers - to moderate extreme mood changes
- Antipsychotics - to relieve symptoms of psychosis
- Talking therapies.

## WHAT CAN YOU DO TO HELP AN OFFENDER WHO IS DISPLAYING SIGNS OF PSYCHOSIS?

- 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 and receives a depot injection every two weeks.

Dwaine presents as a quiet, often-distant man. He is often 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's 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 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?

### **POSSIBLE SOLUTIONS:**

- Attempt to win Dwaine's trust
- Liase with CMHT
- Assess mental state, capacity
- Possible informal / formal admission
- Create case conference / CPA
- Explain to Dwaine he will need to move to alternative accommodation
- Assess this accommodation for his needs
- Structure day with activities

# THE OFFENDER WITH A PERSONALITY DISORDER

## LEARNING OUTCOMES

- *Course participants to gain an insight into the meaning of the term 'personality disorder'.*
- *Students to increase their understanding of some of the potential risk factors involved in working with offenders with personality disorder.*
- *Participants to increase their understanding of an individual's experience of living with a personality disorder.*

## SUGGESTED LESSON PLAN

15 mins	slide 32	LARGE GROUP DISCUSSION What does the term personality disorder mean to you? Feedback, make notes on flip chart paper
10 mins		FACILITATOR LED DISCUSSION Overview of personality disorder, anti-social and borderline types.
20 mins		CASE STUDY Small group discussion Feedback
10 mins		QUESTIONS AND SUMMARY

**OVERVIEW:** *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 probationers 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 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.

Nationally the profile of people with Personality Disorder has increased in the public eye, as has its presence within professional services; health and social care

settings; the Police and Prison services. This is partly as a result of increased media attention, but it is also due to a professional recognition that there is a need to reduce associated risks, client distress and the inefficient use of resources.

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

## THE VARIOUS TYPES OF PERSONALITY DISORDER

<b>CLUSTER A</b>	PARANOID	Distrustful, suspicious
	SCHIZOID	Indifferent to social relationships, Emotionally detached
	SCHIZOTYPAL	Interpersonal and social deficits, odd beliefs
<b>CLUSTER B</b>	ANTI SOCIAL	Disregard for violation of rights of others.
	BORDERLINE	Instability of relationships, self-image and mood; impulsivity
	HISTRIONIC	Excessive emotionality; attention-seeking; suggestibility, superficiality
	NARCISSISTIC	Grandiose, lack empathy, arrogance, need for admiration
<b>CLUSTER C</b>	AVOIDANT	Fear of negative evaluation; socially inhibited; feelings of inadequacy, hypersensitivity.
	DEPENDENT	Persistent dependence, submissive
	OBSESSIVE-COMPULSIVE	Perfectionist, inflexible

(DSM IV, 2003)

## THE ORIGINS AND CAUSES OF PERSONALITY DISORDERS

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

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

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

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

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

## 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 CHARACTERISTICS 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.

### WHAT CAN YOU DO TO HELP AN OFFENDER WITH BPD?

- Try not to pre-judge the individual 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.
- Discuss your concerns with the Offender Manager, where necessary 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 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.

A good way of remembering the main issues for someone with BPD is;

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

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

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

## 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.*

### ANTISOCIAL PERSONALITY DISORDER INVOLVES BEHAVIOUR THAT:

- Manipulates
- Exploits
- Violates the rights of others

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

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

### TREATMENT

- Medications have not proved helpful. Often they are not taken regularly or are abused so they are not effective
- Group therapy has been shown to be helpful if the patient feels comfortable in the group setting. Individual therapy may be helpful if the patient develops a sense of trust with the therapist
- It is important to stress that at times, officers and staff can feel abandoned by psychiatric/health services in how to approach/care for a person who has a personality disorder.

**SUGGESTED EXERCISE:** *It may be useful at this point to ask delegates to recount scenarios of particularly challenging individuals and how they were managed, either positively or negatively.*

## CASE STUDY: *Personality Disorder, Deliberate Self Injury*

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?

### POSSIBLE SOLUTIONS:

- Assess the situation for police intervention
- Assess for the safety of all concerned
- Allow hostel staff to manage the other residents
- Engage you client
- Engage in problem solving activities
- Arrange for medical assessment with local GP
- Asses to see if she will continue to be able to live at the accommodation
- Prepare a plan to repair damaged relationships within the home

# YOUNG OFFENDERS AND MENTAL HEALTH

## LEARNING OUTCOMES

- *Participants to increase their awareness of the risk factors that young people face within the criminal justice system.*
- *Course participants to enhance their awareness of the ways in which young people with emerging mental health problems present.*
- *Participants to increase their understanding of ADHD*

## SUGGESTED LESSON PLAN

10 mins		INTRODUCTION AND OVERVIEW
		What does the term personality disorder mean to you? Feedback, make notes on flip chart paper
15 mins		GUIDED DISCUSSION:
		Why might young people in the criminal justice system be more vulnerable than adults?
15 mins		QUESTION:
		What particular problems do young people with ADHD face within criminal justice services?
10 mins		QUESTIONS AND SUMMARY

**DEFINITION:** A young offender is young person involved with the criminal justice services who is under the age of aged between 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
- Suicide rates are high, and it has been found that up to 40% of new offenders had tried to commit suicide in the previous 12 months.
- 70 per cent of male sentenced young offenders had a hazardous drinking pattern compared with 51 per cent of female sentenced young offenders.
- Dependence on opiates such as heroin and methadone was reported by 23 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.
- Severe mental illnesses such as Schizophrenia are very rare but their prevalence rises in adolescence.

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

- Treat each young person with respect and as an individual
- Express any concerns with the Offender Manager. Refer the young offender on to specialist services as soon as possible, if you suspect underlying mental health problems.
- 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.

*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)*

## 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 PROBATION SERVICE USERS

## LEARNING OUTCOMES

- *Participants to increase their understanding of the factors which increase vulnerability in older adults*
- *Course participants to gain an insight into the conditions which can affect offenders in later life*
- *Participants to discuss some examples of actions to take and where to signpost older offenders in need of support*

## SUGGESTED LESSON PLAN

10 mins		INTRODUCTION AND OVERVIEW
10 mins		FACILITATOR LED DISCUSSION :
		Specific conditions affecting older adults
15 mins	slide 33	GUIDED DISCUSSION:
		Why might older adults in the criminal justice system be more vulnerable than adults?
		What particular problems do older adults face within criminal justice services?
10 mins		SUMMARY AND QUESTIONS

*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.*

### 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.

*Recent changes in sentencing policy have lead 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)*

## 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,

## 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 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

## LEARNING OUTCOMES

- *Course participants to become familiar with the definitions of self injury and suicide*
- *Students to gain an understanding between the difference between self-injury and suicidal behaviour.*
- *Participants to gain an insight into the methods of self-injury and the reasons why people self-harm.*

## SUGGESTED LESSON PLAN

10 mins		INTRODUCTION AND OVERVIEW
15 mins		SUGGESTED EXERCISE Split the group into pairs, allow 10 minutes to discuss the different ways in which people can self harm? Feedback to main group
15 mins	slide 34	SUGGESTED LARGE GROUP EXERCISE Why Do People Self Harm? Feedback, write up on flip chart
10 mins		SUMMARY AND QUESTIONS

**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)

## ADDITIONAL INFORMATION

- Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way.
- The vast majority of people who self-harm keep their behaviour a secret, and this can often go on for a long time undetected. Self-harm has a huge impact on everyday life.
- This often leads to extreme feelings of guilt and the burden of the secret is often hard to carry.
- People often start self-harming to deal with their problems and feelings, but it soon often leads to other very serious problems. It can set up a pattern of very addictive behaviour, which can be extremely hard to break free from.
- Because people often find release or even positives from self-harm, it can be difficult to envisage life without it.

Self Harm can involve.....

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

Self Harm Is Regarded As a Symptom, NOT the Core Problem. It usually occurs as a result of multi dimensional causes including:

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

**SOME THINGS YOU CAN DO TO HELP**

- Try and approach each case with an open mind; individuals harm themselves for different reasons.
- Discuss your concerns with the offender manager and refer on to specialist help at an early stage.
- Show understanding, care and concern for their situation.
- Demonstrate active listening and be respectful.
- Give time, support, and 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.

**SUBSTITUTIONS TO SELF HARM - Taken from the 'truth about self harm' National enquiry 2006**

Self-harmers have shared their most successful distraction techniques and substitutes:

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

**SUGGESTED EXERCISE:** *Why Do People Self Harm?  
How Can It Possibly Make Them Feel Better?*

By deliberately hurting their bodies, young people say:	<i>It can change their state of mind, a way of dealing with pain</i>	<i>Help them cope better with 'other' pain they feel</i>
<i>Physical pain helps to distract from emotional pain</i>	<i>A conscious sense of release, especially from emotional scarring</i>	<i>A 'wake up' to situations of numbness, when they can't feel anything</i>

# THE OFFENDER WITH DUAL DIAGNOSIS

## LEARNING OUTCOMES

- *Participants to increase their understanding of the term ‘dual diagnosis’.*
- *Course participants to increase their understanding of the individuals experience of living with a dual diagnosis.*
- *Participants to increase their understanding of the particular risks that people with dual diagnosis face in their everyday lives.*

## SUGGESTED LESSON PLAN

10 mins		INTRODUCTION AND FACILITATOR OVERVIEW: What is dual diagnosis?
20 mins		CASE STUDY EXERCISE Read in small groups, then feedback
10 mins		FACILITATED DISCUSSION What particular risks do people experiencing dual diagnosis issues face? Feedback
10 mins		QUESTION: How can support be arranged for people with dual diagnosis?
10 mins		SUMMARY AND QUESTIONS

**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.*

*“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*

*“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*

**FOUR PRIMARY DEFINITIONS:** *(Department of Health, 2009)*

1	A PRIMARY MENTAL HEALTH PROBLEM THAT PROVOKES THE USE OF SUBSTANCES	As may be the case with someone suffering from schizophrenia who finds that heroin reduces some of his symptoms.
2	SUBSTANCE MISUSE AND/OR WITHDRAWAL LEADING TO PSYCHIATRIC SYMPTOMS OR ILLNESS	Emergence of depression post-detoxification – insomnia and low mood; also the emergence of a psychiatric disorder to which the individual was vulnerable pre-substance misuse.
3	A PSYCHIATRIC PROBLEM THAT IS WORSENERD BY SUBSTANCE MISUSE	For example, a person with heightened anxiety of danger from others who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation.
4	SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS THAT DO NOT APPEAR TO BE RELATED TO ONE ANOTHER	For example, someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug and alcohol use.

### 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 incidences 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 results in confusion, irritability and low mood, can make people feel suicidal, provoking an attempt.
- Withdrawal from opiates can cause a number of unpleasant physical side effects. Also, low mood, and 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 reached crisis point, with problems relating to social, legal, housing, welfare & 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.

### WHAT CAN WE DO TO SUPPORT PEOPLE WITH DUAL DIAGNOSIS?

- Discuss your concerns with the Offender Manager.
- Get as much information as 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 comply with 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

## LEARNING OUTCOMES

- Participants to become gain knowledge on effective questioning
- Participants to become familiar with basic listening skills

## SUGGESTED LESSON PLAN

10 mins		INTRODUCTION AND OVERVIEW
		The importance of communication skills
5 mins		FACILITATOR-LED DISCUSSION
		Effective questioning
5 mins		FACILITATOR-LED DISCUSSION
		Active listening
30 mins		ROLE PLAY EXERCISE
		Putting it together
10 mins		SUMMARY AND QUESTIONS

**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.*

### THE COMMUNICATION PROCESS?



*“Communication skills are an essential element of professionalism.”*

Ustan (2006)

### 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.

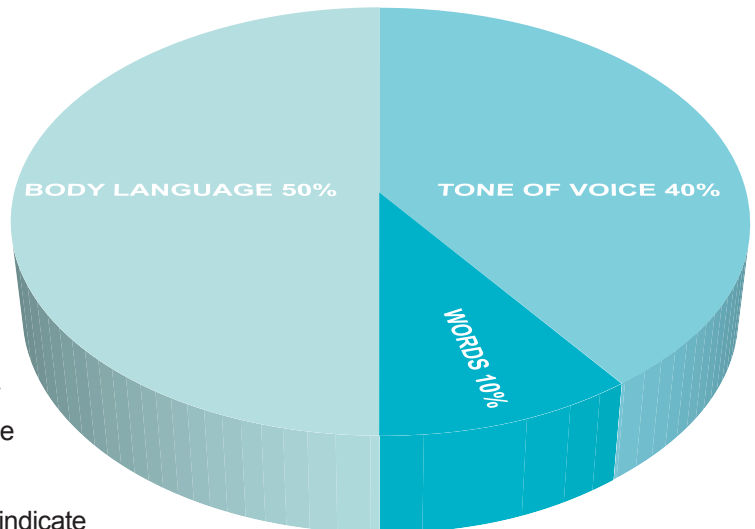
**BODY LANGUAGE:**

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 five 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)*

<b>S</b>	Sit squarely (not necessarily face on) and upright.
<b>O</b>	Open Posture
<b>L</b>	Lean slightly forward
<b>E</b>	Eye contact
<b>R</b>	Relaxed

### SUGGESTED ACTIVITY: *Small groups of three*

*SCENARIO: The first person role plays an older person who is being admitted to an approved premises, after being released from prison. The second person plays a member of staff who ‘listens’ and ‘questions’ using the skills outlined above, while they disclose feelings of loss and distress about not being able to return to his family.*

*The third person acts in the role of observer. They should take notes and feedback to the person playing the member of staff based on their opinion of their listening skills. After ten minutes rotate roles until all three participants have played each role.*

## WORKING WITH RISK

### LEARNING OUTCOMES

- *Participants to become familiar with definitions of risk and risk assessment*
- *Participants to gain knowledge of the basic principles of risk assessment*

### SUGGESTED LESSON PLAN

15 mins		<b>GUIDED LARGE GROUP DISCUSSION</b> What is your experience of risk assessment? Is it always accurate? Feedback, capture on flipchart
10 mins		<b>FACILITATOR-LED DISCUSSION</b> 1. Definitions of risk and risk assessment 2. Principles of risk assessment
5 mins		<b>SUMMARY AND QUESTIONS</b>



**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 over riding 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-stigmatize mental health issues; explain things carefully.
- Remember language is powerful and just by asking about risk you can create barriers.

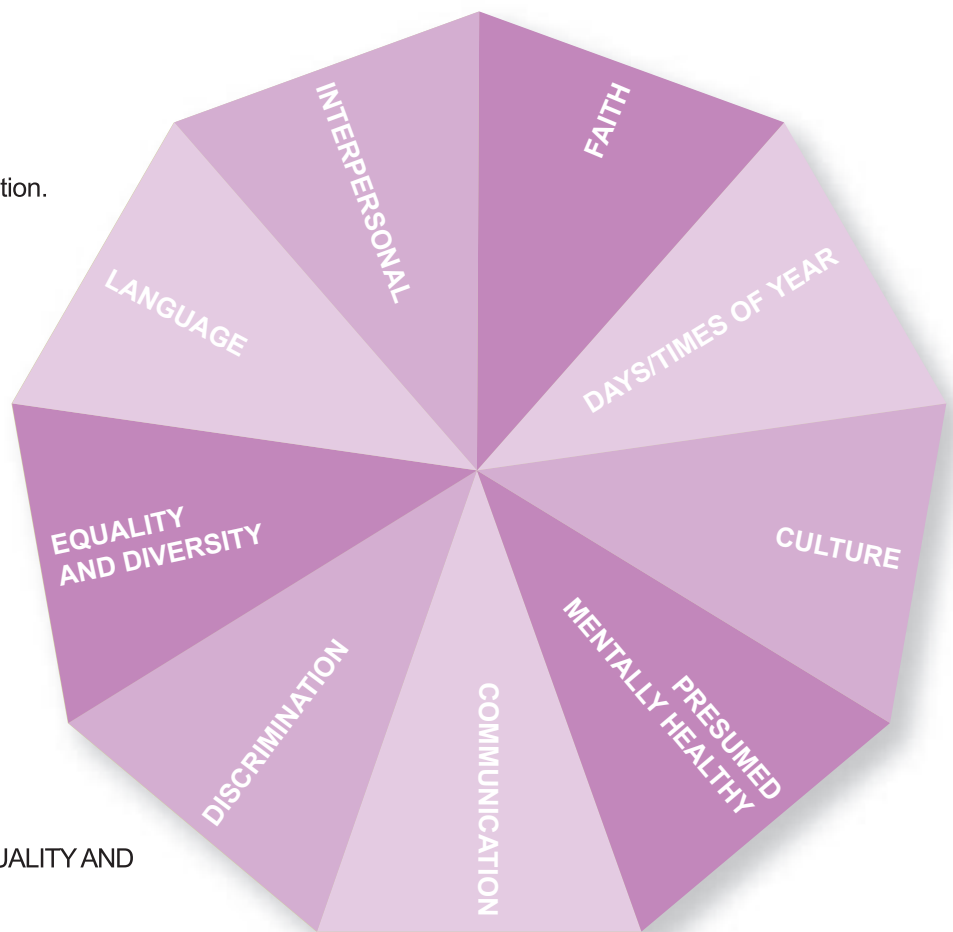
#### FOCUS ON ENGAGEMENT:

- 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.

## 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.

### RELEVANT ACTS OF PARLIAMENT AND LEGISLATION

- Mental Health Act 2007
- Mental Capacity Act 2005
- Health And Safety At Work Act 1974
- Police And Criminal Evidence Act 1984
- Human Rights Act 1998
- Disability Discrimination Act
- Youth And Criminal Evidence Act 1999
- Criminal Justice Act 2003
- Hoc 66/90 Provisions For Mentally Disordered Offenders
- Mental Health Act Codes Of Practice

# GROUP EXERCISES

*Appropriate For Any Module*

**DELEGATES HANDOUT:** *Please pick a famous, successful person from the attached list who you admire:*

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

**AIMS AND OBJECTIVES:** *This introductory exercise is designed to reinforce the Mental Health Continuum – Anyone can get a mental illness!!!*

**TRAINERS INSTRUCTIONS**

5 mins Ask delegates to choose a famous person from the list provided on the delegate's handout

10 mins Once everyone has chosen their famous person, you can inform them that for the duration of the course they now have a mental illness!!  
You can either handout the list of famous people with diagnoses below or go through them verbally informing everyone which diagnosis they now have

CELEBRITIES:	DIAGNOSIS:	LEADERS:	DIAGNOSIS:	SCIENTISTS:	DIAGNOSIS:
Jim Carrey	Depression	Winston Churchill	Depression	John Nash	Schizophrenia
Frank Bruno	Schizophrenia	Alexandra the Great	Depression	Stephen Hawking	Depression
Stephen Fry	Bipolar	Richard Nixon	Depression	Sir Isaac Newton	Depression
Sting	Bipolar	Menachem Begin	Depression	Sir Charles Darwin	Depression
Ellen DeGeneres	Depression	Napoleon Bonaparte	Depression	Primo Levi	Depression
Buzz Aldrin	Bipolar	Oliver Cromwell	Depression	Karl Paul Link	Depression
Linda Hamilton	Bipolar	Calvin Coolidge	Depression		

AUTHORS:	DIAGNOSIS:	ARTISTS:	DIAGNOSIS:
Graham Greene	Depression	Vincent Van Gogh	Bipolar
Samuel Beckett	Depression	Jackson Pollack	Depression
John Bunyan	Depression	Edward Lear	Depression
Ernest Hemingway	Depression	Paul Gauguin	Depression
Victor Hugo	Depression		
Henry James	Depression		

## INTRODUCTORY EXERCISE: LET'S GET LYRICAL

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

### TRAINERS INSTRUCTIONS

- 5 mins Ask delegates to brainstorm in the larger group and think of a song title or the name of a singer or band that you associate with a mental illness or symptom or mood.  
e.g. You Drive Me Crazy, Radiohead; The Only Way is Up, Borderline, Moody Blues, and Paranoia  
\* This exercise could be expanded on and lead on to the following;
- 10 mins Ask delegates to brainstorm in the larger group and think of images/myths and stereotypes, that words from the first brainstorm may portray?  
Where do these images come from? Do they truly depict what is reality and what is not?

## INTRODUCTORY EXERCISE: 'DIAGNOSIS LABELS'

*AIMS AND OBJECTIVES: This exercise could possibly be used at beginning of the training session and at the end to measure differences in general mental health awareness.*

### TRAINERS INSTRUCTIONS

- 15 mins Trainer to write a series of diagnoses on sticky labels and stick them on the backs of delegates while the delegates are standing.  
Each delegate to then look at each others labels and say a word they associate with that diagnosis without using the word itself.  
Each delegate then has to deduce what their label says.

## REFERRAL EXERCISE:

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

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

### TRAINERS INSTRUCTIONS

- As the trainer, you should facilitate questions:  
Who did their referrals go to?  
Was there a single point of entry to mental health services?  
Are they aware of the care pathway?

## EXAMPLE OF SERVICES AVAILABLE FOR OFFENDERS

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

HOUSING SUPPORT:	<ul style="list-style-type: none"> <li>• Nacro</li> <li>• Housing Advice Service</li> </ul>
EMPLOYMENT:	<ul style="list-style-type: none"> <li>• Carter &amp; Carter</li> <li>• Outwork department</li> <li>• Jobs Bus</li> <li>• “Take Control” self-employment project.</li> </ul>
LEARNING OPPORTUNITIES:	<ul style="list-style-type: none"> <li>• The Adult Learning Centre</li> <li>• Outside College via Carter &amp; Carter</li> <li>• Open &amp; Distance Learning via The Signpost</li> <li>• Workshop NVQs</li> </ul>
PHYSICAL ACTIVITY:	<ul style="list-style-type: none"> <li>• Healthy Living</li> <li>• Health Trainers</li> <li>• Gym classes</li> <li>• Fitness suite</li> </ul>
INFORMATION ON MENTAL HEALTH:	<ul style="list-style-type: none"> <li>• Health Trainers</li> <li>• Healthcare leaflets</li> </ul>
TIME OUT AND CREATIVITY:	<ul style="list-style-type: none"> <li>• Beauty appointments</li> <li>• Relaxation sessions</li> <li>• Acupuncture</li> <li>• Library</li> <li>• Poetry Group</li> <li>• Art classes</li> <li>• Massage</li> <li>• Association Room</li> <li>• Recreational Gym</li> </ul>
DIET AND WEIGHT MANAGEMENT:	<ul style="list-style-type: none"> <li>• Health Trainers</li> <li>• Healthy Living</li> <li>• Gymnasium</li> </ul>
SUBSTANCE MISUSE:	<ul style="list-style-type: none"> <li>• Rehab Unit</li> <li>• Narcotics anonymous</li> <li>• Smoking Cessation advice</li> <li>• Alcoholics Anonymous</li> <li>• Acupuncture</li> <li>• Legal Services</li> </ul>
DEBT:	<ul style="list-style-type: none"> <li>• Legal Services</li> <li>• National helpline (Tel: 0808 808 4000)</li> </ul>
SUPPORT WITH CHILDCARE:	<ul style="list-style-type: none"> <li>• Mothers Union</li> </ul>
TALKING THINGS OVER:	<ul style="list-style-type: none"> <li>• Samaritans</li> <li>• Counsellor</li> </ul>
CONFIDENCE AND SELF-ESTEEM:	<ul style="list-style-type: none"> <li>• Counselling services</li> <li>• Healthy Living</li> </ul>
DOMESTIC ABUSE:	<ul style="list-style-type: none"> <li>• Counsellor</li> <li>• Samaritans</li> <li>• Faith groups</li> <li>• National helpline (Tel: 0808 2000 247)</li> </ul>
DIVERSITY:	<ul style="list-style-type: none"> <li>• Hibiscus</li> <li>• Diversity Peer Support Workers</li> <li>• Faith groups</li> </ul>

# APPENDICES

## APPENDIX (1): TRAINERS EVALUATION FORM

COURSE TITLE:	MENTAL HEALTH AWARENESS
NAME:	
ORGANISATION:	
JOB TITLE:	

### A WAS THE COURSE PITCHED AT ABOUT THE RIGHT LEVEL FOR YOUR DELEGATES?

Too low  About right  Too high  (please tick)

### B DID YOU FEEL THE COURSE PROVIDED SUFFICIENT OPPORTUNITIES FOR LEARNING IN THE FOLLOWING AREAS? 1 = lowest score 4 = highest score (please tick)

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

**NOW PLEASE GIVE YOUR RATINGS ON THE FOLLOWING ASPECTS OF THE COURSE**

1 = lowest score 4 = highest score (please tick)

C

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

**ANY OTHER COMMENTS YOU WISH TO MAKE ABOUT THE CONTENT OF THE COURSE?**

D

**USING WHAT YOU'VE LEARNED WHAT WILL YOU DO DIFFERENTLY AS A RESULT OF RUNNING THIS COURSE/EVENT?**

E

**CAN YOU THINK OF ANY OTHER SPECIFIC MODULE THAT YOU WOULD LIKE TO INCORPORATE WITHIN THE MENTAL HEALTH AWARENESS TRAINING?**

F



# REFERENCE LIST

MIND website 2009

PRISON REFORM TRUST, website 2009

GOVERNMENT SCOTLAND, website 2008

WORLD HEALTH ORGANISATION, website 2009

DIAGNOSTIC STATISTICAL MANUAL OF MENTAL DISORDERS, fourth Ed, (2004).

TEN ELEMENTS OF MENTAL HEALTH PROMOTION AND DEMOTION  
Identified by McDonald and O'Hara (1998)  
as cited in Norman I and Ryrie I, (2004)

THE ART AND SCIENCE OF MENTAL HEALTH NURSING: A text book of principles and practice.  
Open University Press, Norman I and Ryrie I, (2004)

NSF STANDARD FOR OLDER PEOPLE (DH, 2001)

PSYCHIATRIC MORBIDITY AMONGST OFFENDERS,  
Singleton et al, (1997).

OFFENDER MENTAL HEALTH CARE PATHWAY,  
Department of Health, Jan 2005

LIVING WELL WITH DEMENTIA: A National Dementia Strategy  
Department of Health, (2009).

THE SKILLED HELPER: A problem-management and opportunity. A developmental approach to helping  
Egan G

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

SELF-HARM AND SUICIDE PREVENTION  
In Harrison A and Hart C (eds) Mental Health Care for Nurses: Applying mental health skills in the general hospital.  
Harrison, A (2006). Oxford: Blackwell.

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*West Midlands  
Regional Development Centre*