

# Mental Health Training For Jailers



Course # 4900

December 2017

Mental Health Training for Jailers  
Course #4900

**ABSTRACT**

This guide is designed to assist the instructor in developing an appropriate lesson plan to teach the course learning objectives. The learning objectives are the minimum required content of the Mental Health Training for Jailers. This course is a legislatively mandated course that is to be completed by August 31, 2021, by persons in the position of county jailer on September 1, 2017, per Occupations Code section 1701.310 (SB1849 section 4.08(b).)

**Note to Trainers: It is the responsibility of the coordinator to ensure this curriculum and its materials are kept up to date. Refer to curriculum and legal resources for changes in subject matter or laws relating to this topic as well as the Texas Commission on Law Enforcement website at [www.tcole.texas.gov](http://www.tcole.texas.gov) for edits due to course review.**

**Target Population:** A person in the position of county jailer on September 1, 2017. This course must be completed no later than August 31, 2021.

**Student Pre-Requisites:**

- Texas Commission on Law Enforcement Licensed Jailer

**Instructor Pre-Requisites:**

- Certified TCOLE Instructor **with documented subject matter experience/content knowledge** and prior completion of course #4900, **OR**
- Documented subject matter expert

**Note: ALSO** guest presenters are **strongly recommended** due to the highly specialized content of this course. Guest speakers will need to be contacted and scheduled by the sponsoring academy or training provider. These speakers may include but are not limited to: Mental Health professionals, consumer and consumer's family, subject matter experts, and persons with role-play experience for authenticity in scenarios.

**Length of Course:** Minimum of 8-10 hours

**Equivalent Courses:** Course # **3524:** Mental Health, Suicide, and De-escalation Techniques for Jailers

**Method of Instruction:**

- Lecture
- Discussion
- Scenario and role-play activities
- Videos

**Class Size: Due to course scenario involvement, suggested class size is a maximum of 25**

**Assessment:** Assessment is required for completion of this course to ensure the student has a thorough comprehension of all learning objectives. Classroom interaction with instructor and students, oral and written participation through role-play and discussion as well as a written test or activities should be used as deemed appropriate by instructor. Training providers are responsible for assessing and documenting the assessment tool(s) utilized and individual student mastery of all objectives in this course.

**Reference materials:**

- Senate Bill 1849
- Occupations Code 1701



## Mental Health Training for Jailers

- 1.0 **Unit Goal:** To gain an understanding of mental impairments and their impact within the jail system.

- A. An increasing number of incarcerated persons today have a documented diagnosis associated with a mental impairment. Jails have become homes to thousands of inmates who have mental impairments, resulting in more severe symptoms and more disruptive behavior. Incarcerated persons, even those that do not have a mental illness, experience significant stress in the jail environment to include: Separation from family and friends, lack of privacy, fear of assault, and boredom. These stressors are compounded for a person with a mental illness, often overwhelming the limited coping skills they do have, resulting in functional deterioration.
- B. With the decrease in inpatient psychiatric beds and decline in the availability of community mental health services, people with serious mental illnesses frequently go without the treatment and services they need. When someone experiences a psychiatric crisis or acts out as a result of symptoms of their illness, police are often the first-line responders, and jails and prisons are increasingly used to house and treat these individuals.

- 1.1 **Learning Objective:** Define the term “Mental Health.”

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

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

- 1.2 **Learning Objective:** Define the term “Mental Illness”

An illness, disease, or condition that either substantially impacts a person’s thought, perception of reality, emotional process or judgment, or grossly impairs a person’s behavior, as manifested by recent disturbance behavior.

Source: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.571.htm#571.003>

- 1.3 **Learning Objective:** Discuss the signs and symptoms of prominent categories of mental illness commonly observed in the jail setting.

Prominent Categories:

- A. Mood Disorders (Depression/Bipolar)
  - 1. Depression: a depressed mood or loss of interest of at least two weeks duration accompanied by symptoms such as sad, hopeless, irritable, weight loss/gain, change in sleeping habits, loss of interest or pleasure, depressed mood, and difficulty concentrating.
  - 2. Bipolar: involves mania (an intense enthusiasm) and depression.
    - a. Manic Phase may include:
      - i. Abnormally high, expansive or irritated mood;
      - ii. Inflated self-esteem;

- iii. Decreased need for sleep;
- iv. More talkative than usual;
- v. Flight of ideas or feeling of thoughts racing; or
- vi. Excessive risk-taking.
- b. Depressive Phase may include:
  - i. Prolonged feelings of sadness or hopelessness;
  - ii. Feelings of guilt and worthlessness;
  - iii. Difficulty concentrating or deciding;
  - iv. Lack of interest;
  - v. Low energy;
  - vi. Changes in activity level;
  - vii. Inability to enjoy usual activities; or
  - viii. Fatigue.
- c. An individual may quickly swing from the manic phase to the depressive phase.
- d. An individual cannot maintain the level of activity normally associated with mania for a long period of time.

#### B. Personality Disorders (Paranoid/Antisocial/Borderline)

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

#### C. Schizophrenia Spectrum Disorder and other Psychotic Disorders

- 1. Schizophrenia: Abnormalities in one or more of five domains, including delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms, which include diminished emotional expression and a decrease in the ability to engage in self-initiated activities. These symptoms are chronic and severe, significantly impairing occupational and social functioning.
- 2. Delusions: false and persistent beliefs that are not part of the individual’s culture. For example, people with schizophrenia may believe that their thoughts are being broadcast on the radio or think they have special powers or even that they are God.
- 3. Hallucinations include hearing, seeing, smelling, or feeling things that others cannot. Most commonly, people with the disorder hear voices that talk to them or order them to do things.
- 4. Psychosis:
  - a. Inappropriate or bizarre attire;
  - b. Body movements are lethargic or sluggish;
  - c. Impulsive or repetitious body movements;

- d. Responding to hallucinations;
- e. Causing injury to self; or
- f. Home environment:
  - i. Strange decorations (e.g., aluminum on windows);
  - ii. Pictures turned over;
  - iii. Waste matter/trash on floors and walls (hoarding);
  - iv. Unusual attachment to childish objects or toys;
  - v. Lack of emotional response;
  - vi. Extreme or inappropriate sadness; or
  - vii. Inappropriate emotional reactions.

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

#### D. Cognitive Disorders (Dementias/Deliriums)

##### 1. Dementia:

Dementia and delirium may be particularly difficult to distinguish, and a person may have both. In fact, frequently delirium occurs in people with dementia.

Dementia is the progressive decline of memory and other thinking skills due to the gradual dysfunction and loss of brain cells. The most common cause of dementia is Alzheimer's disease.

Some differences between the symptoms of delirium and dementia include:

- a. Onset: The onset of delirium occurs within a short time, while dementia usually begins with relatively minor symptoms that gradually worsen over time.
- b. Attention: The ability to stay focused or maintain attention is significantly impaired with delirium. A person in the early stages of dementia remains generally alert.
- c. Fluctuation: The appearance of delirium symptoms can fluctuate significantly and frequently throughout the day. While people with dementia have better and worse times of day, their memory and thinking skills stay at a fairly constant level during the course of a day.

##### 2. Delirium:

- a. Reduced awareness of the environment which may result in:
  - i. An inability to stay focused on a topic or to switch topics;
  - ii. Getting stuck on an idea rather than responding to questions or conversation;
  - iii. Being easily distracted by unimportant things; or
  - iv. Being withdrawn, with little or no activity or little response to the environment.
- b. Poor thinking skills (cognitive impairment) which may appear as:
  - i. Poor memory, particularly of recent events;
  - ii. Disorientation, for example, not knowing where you are or who you are;
  - iii. Difficulty speaking or recalling words;
  - iv. Rambling or nonsense speech;
  - v. Trouble understanding speech; or
  - vi. Difficulty reading or writing.
- c. Behavior changes which may include:
  - i. Seeing things that don't exist (hallucinations);
  - ii. Restlessness, agitation or combative behavior;
  - iii. Calling out, moaning or making other sounds;

- iv. Being quiet and withdrawn, especially in older adults;
- v. Slowed movement or lethargy;
- vi. Disturbed sleep habits; or
- vii. Reversal of night-day sleep-wake cycle.
- d. Emotional disturbances which may appear as:
  - i. Anxiety, fear or paranoia;
  - ii. Depression;
  - iii. Irritability or anger;
  - iv. Sense of feeling elated (euphoria);
  - v. Apathy;
  - vi. Rapid and unpredictable mood shifts; or
  - vii. Personality changes.

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

### 3. Excited Delirium:

- a. Psychotic behavior, aggressiveness, hyperactivity, paranoia, violence, superhuman strength, profuse sweating due to hyperthermia, insensitivity to pain, elevated temperature, dilated pupils, rapid breathing, an extreme fight-or-flight response by the nervous system, respiratory arrest, and death.
- b. Appropriate responses to Excited Delirium would include:
  - i. Notify Medical Staff - rapid chemical sedation can be lifesaving;
  - ii. Remove physical restraints when feasible;
  - iii. When using restraints, monitor the subject for positional asphyxiation.

### 4. Traumatic Brain Injury (TBI):

- a. Caused by impact to the head which creates a movement or displacement of the brain within the skull.
- b. A demonstrated decline in life satisfaction is reported following moderate to severe TBI resulting in for example the inability to maintain employment or quality relationships.
- c. Symptoms vary by person and severity and may include: attention, learning and memory, language, eye-hand coordination, and social awareness.

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

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

## E. Anxiety Disorders

### 1. Anxiety Disorders:

- a. Excessive anxiety and worry that is difficult to control, is disproportionate to the actual risk, and negatively and substantially impacts daily functioning.
- b. These disorders can range from specific fears (called phobias), such as the fear of flying or public speaking, to a Generalized Anxiety Disorder that reports feelings of worry and tension for at least six months and is clearly excessive .

### 2. Other examples of Anxiety Disorders include:

- a. Separation Anxiety Disorder

- b. Panic Disorder
- c. Society Anxiety Disorder
- d. Substance-Induced Anxiety Disorder

#### F. Trauma and Stressor-Related Disorders

Post-Traumatic Stress Disorder (PTSD) is becoming more common in the jail setting. Not only for those entering the system but persons leaving the jail environment as well.

- a. Behavioral symptoms
  - i. Intrusive memories (Example: Being reminded of traumatic event by an everyday experience which may change how an individual reacts to the situation.);
  - ii. Avoiding reminders;
  - iii. Trouble concentrating;
  - iv. Emotional outbursts;
  - v. Hypervigilance;
  - vi. Flashbacks;
  - vii. Loss of interest in hobbies;
  - viii. Withdrawal from others;
  - ix. Reckless or self-destructive behavior; or
  - x. Increased self-medication.
- b. Emotional Symptoms:
  - i. Anger;
  - ii. Irritability;
  - iii. Sadness;
  - iv. Anxiety;
  - v. Hopelessness; or
  - vi. Guilt.
- c. Social Symptoms:
  - i. Becoming withdrawn, detached, or disconnected;
  - ii. Loss of desire for intimacy, closeness;
  - iii. Mistrust;
  - iv. Over-controlling/overprotective behavior;
  - v. Argumentative; or
  - vi. Family violence may result.

#### G. Substance Use Disorder

1. Substance Use Disorders - Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.
2. Co-occurring Disorders - The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. Co-occurring disorders were previously referred to as dual diagnoses.
  - a. Emotional Withdrawal Symptoms
    - i. Anxiety;
    - ii. Restlessness;
    - iii. Irritability;
    - iv. Insomnia;
    - v. Headaches;
    - vi. Poor concentration;



- vii. Depression; or
- viii. Social isolation.
- b. Physical Withdrawal Symptoms
  - i. Sweating;
  - ii. Racing heart;
  - iii. Palpitations;
  - iv. Muscle tension;
  - v. Tightness in the chest;
  - vi. Difficulty breathing;
  - vii. Tremor;
  - viii. Nausea, vomiting, diarrhea;
  - ix. Grand mal seizures;
  - x. Heart attacks;
  - xi. Strokes ;
  - xii. Hallucinations; or
  - xiii. Delirium tremens (DTs).

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

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

#### H. Neurodevelopmental Disorders (Intellectual and Developmental Disorders)

- 1. Speech/Language
  - a. Obvious speech defects;
  - b. Limited response or understanding;
  - c. Inattentiveness;
  - d. Vocabulary or grammatical skills lacking; or
  - e. Difficulty describing facts in detail.
- 2. Social Behavior
  - a. Adult associating with children or early adolescents;
  - b. Eager to please;
  - c. Ignorance of personal space;
  - d. Non-age appropriate behavior;
  - e. Easily influenced by others; or
  - f. Easily frustrated or aggressive in response to direct questioning.

2.0 **Unit Goal:** To gain an understanding of constructive techniques utilized when communicating in a time of crisis in a jail setting.

2.1 **Learning Objective:** Define a crisis as related to mental health

Generally speaking, a crisis is the stage in a sequence of events that could define the outcome for future events. It is the turning point that points toward a positive or negative outcome. In mental health terms, a crisis refers primarily to the person's reaction to an event. One person might be deeply affected by the event while another person is not.

2.2 **Learning Objective:** Discuss practices for de-escalation/communication techniques for the management of individuals in crisis in a jail setting

De-escalation refers to a behavior or technique that is intended to reduce the intensity of a conflict or crisis. How you respond to the behavior is often the key to defusing the situation. The top key de-escalation guidelines include: stay calm, manage your response, set limits, handle challenging questions, and prevent physical confrontations.

De-escalation Paradox:

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

## Keys to Communication

Effective communication involves a lot more than just speaking clearly. In order to be a good communicator, you must also be a good listener. By being a good listener, it shows that care about the other person's needs. Effective communication is important in problem-solving, conflict resolution, and for building positive relationships.

### A. Listening

1. Listening is one of the most important skills used during a crisis de-escalation. Listening effectively establishes trust and allows you to understand information more thoroughly.
  - a. To be an effective listener, remember to:
    - i. Recognize verbal and nonverbal cues;
    - ii. Avoid distractions;
    - iii. Note any extra emphasis the person in crisis places on words or phrases; and
    - iv. Notice speech patterns and recurring themes.
2. Practice active listening. Use phrases like:
  - a. Sounds like your feeling (angry, upset, and sad) - Is that right?
  - b. You're pretty (angry, upset, and sad) right now, aren't you?
  - c. I want to make sure that I understand what you are saying - are you telling me that you are...?

**Instructor Note: Instructor will conduct a scenario here using the above Active Listening Skills.**

### B. Basic Communication Guidelines

1. Use short, clear direct sentences.
  - a. Long, involved explanations are difficult for people with mental illness to handle. They will tune you out.
2. Keep the content of communications simple.
  - a. Cover only one topic at a time;
  - b. Give only one direction at a time; and
  - c. Be as concrete as possible.
3. Keep the "stimulation level" as low as possible.
  - d. High stimulation levels are painfully defeating for anyone who is experiencing a crisis.
4. If the person appears withdrawn and uncommunicative, allow time for them to acclimate to the situation and re-approach.
5. Instructions and directions will often have to be repeated. Be patient.
6. Be pleasant and firm. Make sure your boundaries are specific and clear.
7. To increase the desired results, praise all cooperative behavior.

**Instructor Note: Have students discuss and give examples of each guideline.**

C. Clarification: It is important to remember that any statement not understood needs to be clarified. Nothing should ever be assumed. Some techniques to aid in clarifying:

1. Rephrase the person's statement in a way that encourages the person to clarify.
2. Repeat key words. This focuses attention on particular thoughts and feelings.
3. Admit confusion or misunderstanding of a statement and ask for clarification.
4. Ask "open ended" questions to obtain better understanding.

**Instructor Note: Have students discuss and give examples of each guideline.**

- D. Dealing with Silence: if faced with silence during a crisis situation do not let the silence become discomforting, use it as a time to observe the person's behavior.
- E. Respond Effectively
  - 1. Handle the feelings of the person in crisis with care and concern and treat the person's feelings as legitimate.
  - 2. It is essential not to judge, give advice, or belittle the person during a crisis.
- F. Maintain Personal Space
  - 1. This is a crucial element for effective communication, and is different for every individual in crisis.
  - 2. Observe the person's reaction to proximity in order to create a comfortable space for effective communication.
  - 3. Maintain an appropriate distance to ensure individual safety.
- G. Remember a person in crisis may be further agitated by intervention, even when intervention is necessary.
- H. Nonverbal communication speaks volumes. A cooperative and open stance may be most effective.

**Instructor Note: Instructor will conduct multiple communication skills scenarios here.**

3.0 **Unit Goal:** Identify local resources and partnerships to assist with individuals in crisis and in need of supportive services.

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

- <http://www.dshs.texas.gov/mhsa-crisishotline/>
- <http://tvc.texas.gov/Find-Your-Local-Office.aspx>
- [http://milvetpeer.site-ym.com/page/MVPN\\_PSC](http://milvetpeer.site-ym.com/page/MVPN_PSC)

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

4.0 **Unit Goal:** Be able to utilize the screening tool for identification of suicide risk and the questions and actions necessary when an individual is identified as a suicide risk.

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

A. National statistics

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

**Instructor Note: Refer to this site for updated statistics.**

<http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865>

B. Texas statistics in county jails:

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

**Instructor Note: Contact the Texas Commission on Jail Standards for updated information**

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

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

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

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

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

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

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

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

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

- E. **Myth:** Asking about and probing the inmate about suicidal thoughts or actions will cause him to kill himself.  
**Fact:** You cannot make someone suicidal when you show your interest in their welfare by discussing the possibility of suicide.
- F. **Myth:** All suicidal individuals are mentally ill.  
**Fact:** Although the suicidal person is extremely unhappy, they are not necessarily mentally ill.
- G. **Myth:** The rate of suicide is lower in a jail setting.  
**Fact:** Jail suicides occur several times more often than in the general population.
- H. **Myth:** Inmates who are really suicidal can be easily distinguished from those who hurt themselves but are just being manipulative.  
**Fact:** Manipulative goals as a motive for self-injury are not useful in distinguishing more lethal attempts from less lethal attempts.
- I. **Myth:** You can't stop someone who is really intent on committing suicide.  
**Fact:** Most suicides can be prevented.

4.3 **Learning Objective:** Be able to list risk factors as well as signs and symptoms of potential suicides.

A. Some situational and/or personal factors:

1. First-time arrestee;
2. Young inmate (anyone under 18, regardless of whether in adult court);
3. Persons with high status in community;
4. Previously imprisoned/facing new, serious charges and long prison term;
5. No apparent control over future, including fear and uncertainty over legal process;
6. Isolation from family, friends and community;
7. Dehumanizing aspects of incarceration - viewed from inmate's perspective or fears, based on TV and movie stereotypes, social stigma, etc.;
8. Recent, excessive drinking and/or use of drugs, or withdrawals;
9. Recent loss of stabilizing resources, such as spouse, home, or job;
10. Rape or the threat of it; or
11. Current mental illness, poor health, or terminal illness.

B. Segregation increases risk of psychological difficulties, especially in the mentally ill and juveniles.

C. Key times to observe signs and symptoms:

1. At arrest and booking;
2. During transportation:
  - a. Sentencing Court Appearance;
  - b. Transporting to and from State Correctional Facilities;
3. First 24 hours of confinement;
4. Intoxication/withdrawal;
5. Waiting for high profile trial/sentencing;
6. Impending release:
  - a. Inmate may feel institutionalized and unable to function without the structure provide by a facility;

- b. Fear of repercussions stemming from criminal organizations or retaliation from associates;
- 7. Holidays;
- 8. Darkness (or “lights-out”); or
- 9. Decreased staff supervision.

D. Warning signs and symptoms:

- 1. Talks about or threatens suicide;
- 2. Signs and symptoms of depression (the single best suicide indicator);
- 3. Feelings of hopelessness or helplessness;
- 4. Extreme sadness and crying;
- 5. Withdrawal or silence;
- 6. Loss of or increase in appetite and/or weight;
- 7. Pessimistic attitudes about future;
- 8. Sudden changes in an inmate’s regular sleeping patterns;
- 9. Sudden change in an inmate’s mood or behavior:
  - a. Severe agitation or aggressiveness;
  - b. Expresses unusual or great concern over what will happen to them;
  - c. Begins packing and/or gives away belongings;
  - d. Has increasing difficulty relating to others;
  - e. Does not effectively deal with the present, is preoccupied with the past;
- 10. Loss of interest in people, appearance, or activities;
- 11. Excessive self-blaming;
- 12. Expresses strong guilt and/or shame over offenses;
- 13. Previous suicide attempts and/or history of mental illness;
- 14. May act very calm once the decision is made to kill themselves; or
- 15. Speaks unrealistically about getting out of jail.

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

A. Facility policies, procedures and post orders should clearly include suicide prevention guidance.

B. Potential hazards and risk factors include:

- 1. Suicides most frequently occur in private spaces such as bathrooms, showers, mop closets, or cells.
- 2. Important prevention measures include frequent rounds, not allowing inmates to cover windows, and establishing professional and meaningful relationships.
- 3. Cells that are designated for inmates on suicide watch:
  - a. Violent Cell--A single occupancy padded cell for the temporary holding of inmates harmful to themselves and or others (37 Texas Administrative Code §253.1 (34)).
  - b. Administrative Separation--The assignment of an inmate to a special housing unit, usually a separation or single cell, when staff determines that such close custody is needed for the safety of inmates or staff, for the security of the facility, or to promote order in the facility (37 TAC §253.1 (1)).
  - c. Single Cell --A cell designed to accommodate one inmate. The cell minimally contains 1 bunk, toilet, lavatory, table and seat (37 TAC §253.1 (30)).
- 4. Place at-risk inmates in higher visibility cells.
- 5. Monitor the clothing, bedding, property, and meals allowed for inmates on suicide watch.



6. Supervision requirements of inmates on suicide watch:
  - a. Observation shall be performed at least every 30 minutes in areas where inmates known to be assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior are confined (37 TAC §275.1).
  - b. Supervision. Provisions for adequate supervision of inmates who are mentally disabled and/or potentially suicidal and procedures for documenting supervision (37 TAC §273.5 (5)).
  - c. Refer to departmental policy regarding supervision and documentation of suicide watch.
- C. Behaviors to observe and document during a suicide watch:
  1. Is the inmate eating meals?
  2. Is the inmate sleeping normally?
  3. Inmate's behavior when awake
  4. Is the inmate attentive to personal hygiene?
  5. Does the inmate communicate appropriately with jailers and other inmates?
- D. Refer to your departmental policy for discontinuing suicide watch and/or regarding the contacting of a mental health provider during and after business hours.

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

- A. If you believe inmate is in danger of suicide, implement suicide prevention protocols and keep the inmate in a safe place:
  1. Maintain contact;
  2. Address inmate by name;
  3. Don't be reluctant to express your concerns about the inmate;
  4. Eye contact - show concern, not disapproval or disgust;
  5. Try to keep the inmate's sense of future positive;
  6. Focus on programs available to inmate, i.e., school, vocational training, substance abuse, etc.;
  7. Support from family and friends that care;
  8. Provide a feeling of control;
  9. Find something in their past to give them hope in the future;
  10. Help them discover a reason to live; and
  11. Suicide attempt #99 should be treated as seriously as #1!
- B. What not to do:
  1. Treating the inmate as non-person;
  2. Provoking or escalating the situation;
  3. Acting sarcastic, teasing, or making jokes about the situation;
  4. Challenging inmate to follow through with threat- NO REVERSE PSYCHOLOGY;
  5. Suggesting a more lethal method;
  6. Ignoring, discounting, or making unpleasant remarks about inmate's feelings;
  7. Being afraid to ask direct questions about suicidal ideation;
  8. Accepting the inmate's denial of suicidal ideation too quickly;
  9. Offering solutions or giving advice;
  10. Making promises that you cannot keep;
  11. Trying to make a diagnosis;
  12. Becoming angry, judgmental, or threatening; or
  13. Ignoring the risk or threat – inmates can become suicidal at any point during incarceration.

4.6 **Learning Objective:** The student will be able to explain methods for responding to a suicidal inmate.

A. Approaching a responsive suicidal inmate:

1. Remember that the inmate may attempt to have others kill them.
2. Remain calm.
3. Call for assistance.
4. Develop a plan and follow it: rushing to rescue increases the risk to all those who are involved.
5. Be alert.
6. Check out the situation.
7. Ask the inmate to remove the means if time permits. This allows them to take action for their own safety. Ironically, taking the means away from them as a show of force can trigger a suicide.

B. Inmate attempting to hang self:

1. First jailer on scene will conduct visual assessment of inmate from outside cell to determine if inmate has article around neck and is attempting to hang self.
2. If possible, observe inmate's hands for possible weapons.
3. First jailer on scene should stay at cell front to observe and request backup and a medical response.
4. Once a minimum of two (2) jailers have arrived at cell, if possible, staff shall enter the cell.
5. Cut victim down immediately; avoid cutting the knot for investigative purposes, if possible.
6. One person should hold the body up.
7. The other person should cut the noose with a readily available tool.
8. Lay the inmate on the floor and remove the article around the neck.
9. Begin basic life-saving techniques, health care staff will assume the lead role in life-saving techniques assisted by jailer if necessary.
10. Refer to department policy for first aid methods.

C. Unresponsive Inmate:

1. Conduct a visual assessment from outside cell to determine if inmate is either unconscious or experiencing a medical emergency.
2. First jailer on scene should stay at cell front to observe and request backup and a medical response.
3. First staff on scene will observe inmate's hands for any objects that may be weapons.
4. Once a minimum of two (2) jailers have arrived at cell, if possible, staff shall enter the cell.
5. Jailers will enter the cell with caution and be prepared to use force if necessary, but move quickly to secure the inmate.
6. Begin basic life-saving techniques as applicable, health care staff will assume the lead role in life-saving techniques assisted by jailers if necessary.

4.7 **Learning Objective:** Review via class discussion the Screening Form for Suicide and Medical/Mental/ Developmental Impairments and the Continuity of Care Query (CCQ).

**Instructor Note: Provide the Students with a copy of the required TCJS**

**Screening form** [http://www.tcjs.state.tx.us/docs/ScreeningForm-SMMDI\\_Oct2015.pdf](http://www.tcjs.state.tx.us/docs/ScreeningForm-SMMDI_Oct2015.pdf)

A. Basic Information

1. The Screening Form for Suicide and Medical and Mental Impairments has three goals:
  - a. To create an objective suicide risk assessment with clear guidance for front-line personnel of when to notify superiors, mental health providers, and magistrates;
  - b. To assist sheriffs to meet all statute requirements such as Code of Criminal Procedure §16.22; and
  - c. To be user friendly for the typical range of experience of a Texas county jailer.
2. Intake screening is the first step and is crucial to determine which inmates require more specialized mental health assessment. Unless inmates are identified as potentially needing mental health treatment, they will not receive it.
3. The purpose of intake screening is for correctional staff to triage those who may be at significant risk for suicide; identify inmates who may be in distress from a mental health disorder/psychosis or complications from recent substance abuse; and assist with the continuity of care of special needs inmates.
4. Per 37 TAC §273.5, an intake screening form must be completed on all inmates immediately upon admission into the facility.
5. Additional screenings should be completed when staff has information that an inmate has developed a mental illness or the inmate is suicidal at any point during an inmate's incarceration. Any additional screening forms must be maintained in the inmate's medical file.
6. For counties that will create an electronic copy or import the form into their software package, all questions from this form must be present along with required notifications.
7. For counties that will use a paper format, counties may insert blank space into the comments sections of the Word version of the form to create more writing space.
8. The form should be completed by a trained booking jailer or medical/mental health personnel.
9. Fill out the form completely and in its entirety.
10. If the inmate is unable to or refuses to answer questions, notify supervisor and place the inmate on suicide watch until a form can be completed. Notate the reason why the form cannot be completed. Complete a new form when the inmate is able to answer the questions.

**Instructor Note: Have each student complete the most current suicide screening form with partner in role-play format. Practice completion utilizing learned communication skills from previous sections. If students need additional familiarization with the screening form, complete below section prior to scenario involvement.**

- B. The following section is a review of the screening form and the appropriate way to complete it. Time allotted for this process should depend on the familiarity and proficiency of the students with this completion process. Review as needed.

1st Section: Basic Information and Medical Information

1. The first section consists of basic identifier information and medical information.
2. All applicable boxes should be checked. Provide additional information where required.
3. The below two medical questions require that a supervisor or medical personnel be notified if jailers receive a "yes" answer:

- a. Do you think you will have withdrawal symptoms from stopping use of medications or other substances (including alcohol or drugs) while you are in jail?
- b. Have you ever had a traumatic brain injury, or loss of consciousness?
4. Medical personnel or supervisors should assess and take appropriate action.

C. 2nd Section: Self-report Questions

1. If the inmate is unable to answer questions, note the reason why, notify supervisor and place inmate on suicide watch until a form can be completed.
2. Questions 1a-d are strong indicators of inmates at high risk of suicide. Any “yes” answer requires notification to supervisor, magistrate and mental health immediately, and placement of inmate on suicide watch.
3. However, if for any reason a jailer believes an inmate to be at risk of suicide regardless of the answer to 1a-d, an jailer should place the inmate on suicide watch and notify a supervisor.
4. Inmates should only be removed from suicide watch after assessed by qualified mental health personnel.
5. Questions 2-12 include questions about mental health symptoms and risk factors that warrant supervisor/magistrate notification. Self-report symptoms relate to possible psychosis, schizophrenia, bipolar disorder, depression and PTSD. Question 11 also attempts to detect possible developmental disability.
6. If a screener receives a “yes” answer, please ask follow-up questions to gain a better understanding of the symptoms.

D. 3rd Section: Observation

1. Make careful observations of the inmate’s demeanor and appearance.
2. Look for cuts to the wrist, impressions around the neck, or any other evidence of self- harm.
3. Notate when applicable.
4. A comment box is provided for any additional information that the screener believes is relevant including an exact or CCQ match. This completed form will likely be viewed by magistrates and mental health professionals, so additional information will be beneficial.

E. 4th Section: Notification

1. A “yes” answer to most questions on the form will require notification to a supervisor, magistrate, and/or mental health or medical personnel.
2. Space is provided for each notification. Jailers shall notate when they make required notifications.
3. In addition, the space for magistrate notification shall indicate whether electronic or written notification was made. A completed copy of this form should be sent to the magistrate.

F. CCP §16.22 - EARLY IDENTIFICATION OF DEFENDANT SUSPECTED OF HAVING MENTAL ILLNESS OR INTELLECTUALLY DISABILITY. (a) (1) Not later than 12 hours after receiving credible information that may establish reasonable cause to believe that a defendant committed to the sheriff’s custody has a mental illness or is a person with an intellectual disability, including observation of the defendant’s behavior immediately before, during, and after the defendant’s arrest and the results of any previous assessment of the defendant, the sheriff shall provide written or electronic notice of the information to the magistrate.