Mental Health - Theirs & Ours
MENTAL HEALTH AND IT’S IMPLICATIONS IN CORRECTIONS

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Learning Objectives

- Introduction to Mental Illness and Trauma Informed Care
- Mental Illness in Corrections
- Nutrition and Mental Health
- Best Practice- Strategies for Improvement
Mental Illness

Cancer vs. Mental Illness
Defining Mental Illness

A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning.
“Mental Health is a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”
One in four adults experiences mental illness in a given year. One in 17 live with a serious mental illness such as schizophrenia, major depression or bipolar disorder.

- Serious mental illness costs America $193.2 billion in lost earnings per year.
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions. Adults living with serious mental illness die on average 25 years earlier than other Americans, largely due to treatable medical conditions.
The Impact of Mental Illness in America

- Mood disorders the third most common cause of hospitalization in the U.S. for both youth and adults ages 18 to
- Over 50 percent of students with a mental health condition age 14 and older who are served by special education drop out
- Suicide is the tenth leading cause of death in the U.S.
- Although military members comprise less than 1 percent of the U.S. population, veterans represent 20 percent of suicides nationally.
Approximately 60 percent of adults, and almost one-half of youth ages 8 to 15 with a mental illness received no mental health services in the previous year. African American and Hispanic Americans used mental health services at about one-half the rate of whites in the past year and Asian Americans at about one-third the rate. One-half of all chronic mental illness begins by the age of 14; three-quarters by age 24. Despite effective treatment, there are long delays—sometimes decades—between the first appearance of symptoms and when people get help.
Diagnostic and Statistical Manual of Mental Health Disorders

- DSM- 5
- What makes a Mental Health Diagnosis?
  - We all have...
  - What makes something diagnosable?
  - What info is in the DSM?
  - How do Clinics, Dr’s, therapists use the DSM?
Terms

- Mental health disorders
  - Disorders from the DSM
  - What makes something a mental illness?
- Malingering
- Psychosis- what we see and what the client feels
- SPMI- severe, persistently mental ill
  - Schizophrenia, schizoaffective disorder, borderline personality disorder, bipolar personality disorder, and major depressive disorder
    (as defined by State of Minnesota)
A Look at Mental Illness

- Schizophrenia
- Bipolar disorder
- Major depression
- Anxiety and related disorders
- Borderline personality disorder
Schizophrenia

A medical illness that interferes with a person’s ability to:

- Think clearly
- Manage emotions
- Make decisions
- Relate to others
- NOT “split personality”
Schizophrenia, cont’d.

**Prevalence:** 1% of the population

**Symptoms:**
- Delusions (fixed false beliefs)
- Hallucinations (sensory perceptions)
- Emotional withdrawal
- Lack of expression
- Disorganized/confused thoughts, speech
Symptoms You May Notice

- Slow movement, trouble communicating
- Statements or actions that indicate a distorted reality
- Trouble with memory or the ability to plan
Bipolar
Bipolar Disorder

- **Prevalence:** 4% of the population
- Manic episode = needed for diagnosis
- Extreme shifts in mood, energy and functioning
Mania Symptoms

- Euphoria, irritability, shifting moods
- Decreased need for sleep
- Accelerated thoughts, speech, activity
- Difficulty concentrating
- Agitation, risky or bizarre behaviors
- Decreased inhibitions, increased sense of importance, grandiose or paranoid delusions
Major Depression
Major Depression

- **Prevalence:** 7% of adults each year
- Persistent and can significantly interfere with thoughts, behavior, mood, activity, physical health.
- Leading cause of disability in the U.S.
Persistent sad or irritable mood
Pronounced changes in sleep, appetite, energy
Difficulty thinking, concentrating, remembering
Physical slowing or agitation
Lack of interest in things once enjoyed
Feelings of guilt, worthlessness
Recurrent thoughts of death or suicide
Anxiety
Anxiety Disorders

- **Prevalence**: 18% of adults in the U.S.
- Many kinds of anxiety disorders
- “Fight or flight” response misfires
- We all have some of these symptoms
Anxiety Disorder Symptoms you may notice

- Asking questions
- Constant movement
- Talking about their mind never stopping
- Stream of consciousness talking
- Always wanting to be on the move
- Desire to be busy
- Agitation
Generalized Anxiety

- Excessive anxiety or worry about everyday activities
- Interferes with work and social life
- Physical symptoms: fatigue, edginess, sleep disturbances
Panic Disorder

Intense physical symptoms:

- Heart palpitations and irregularities
- Sweating
- Trembling
- Chest pain
- Nausea
Obsessive Compulsive Disorder

- **Obsessions**: intrusive irrational thoughts and impulses
- **Compulsions**: repetitive rituals (hand washing, checking over and over) to relieve thoughts.
Borderline Personality Disorder

- **Prevalence:** 2% of adults in the U.S.
- **Many symptoms:** must have at least some from each of the following slides to be diagnosed
Emotional Symptoms of BPD

- Mood swings and unstable emotions
- Anxiety
- Inappropriately intense anger or difficulty controlling anger
- Chronic feelings of emptiness
Behavioral Symptoms of BPD

- Impulsive, harmful behavior
- Demanding, self-centered
- Recurrent suicidal behavior, gestures, threats, self-mutilation (e.g., cutting)
- Suicide
Cognitive Symptoms of BPD

- Brief episodes of paranoid thinking
- Dissociative symptoms
- Magical thinking/odd thoughts
- Feelings of unreality, hollowness
- Unstable self-image or sense of self
Social Symptoms of BPD

- Pattern of unstable and intense personal relationships
- Black-and-white view of things
- Frantic efforts to avoid real or imagined abandonment
Co-occurring Disorders

- 37% of those addicted to alcohol have a mental illness
- 53% of those addicted to drugs have a mental illness
- Over 50% of those with drug addictions have psychiatric disorders
Substances & Mental Illness

- 47% of those with schizophrenia have substance abuse disorders
- 61% of those with bipolar disorder
- In jails: 72% of those with mental illnesses
Effects of Substances on Mental Illness Symptoms

1. Speed ONSET of mental illness
2. WORSEN the symptoms
3. Drug side effects can MIMIC the symptoms
4. Drugs used to MASK mental illness symptoms
Post-Traumatic Stress Disorder (PTSD)

- Outbursts of anger or irritability
- Impulsivity
- Difficulty falling asleep or staying asleep
- Difficulty concentrating
PTSD Symptoms you may notice

- Increased vigilance
- Exaggerated startle response
- Persistent re-experiencing (e.g., flashbacks, nightmares)
- Avoiding certain situations or topics
What is Psychological Trauma

“Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and constant state of alert. Trauma impacts one’s spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. Healing is possible.”

(The National Center for Trauma Informed Care--SAMHSA)
Healing Neen

- Video
  https://www.youtube.com/watch?v=QQfWEGTD_bA
Ninety-five percent of women and 89 percent of men entering jail diversion programs have experienced physical or sexual abuse (Policy Research Associates, 2011).
Why is a trauma-informed approach so important?

- Many justice involved clients have experienced a history of childhood abuse and adult victimization.
- Emotional, behavioral and physical reactions can place clients and staff at risk if not fully understood.
Trauma Informed Care

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

Instead of: "What's wrong with you?"
Ask: "What has happened to you?"

Source: National Center for Trauma-Informed Care SAMHSA
What is Trauma Informed Care

- When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

- Source: National Center for Trauma-Informed Care SAMHSA
Repetitive Trauma Cycle

Incarceration

Violence and Trauma

Homelessness

Mental Illness

Substance Abuse

(Adapted from Fallot, 2008)
S.E.L.F.: A Nonlinear Organizing Framework

Source: The Sanctuary Model
Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers
**Effects of Trauma**

**Physiological:**
Changes in neurobiology and physical health that can dysregulate emotions and distort thinking, perceptions and behaviors

“The Body Keeps Score”  (Bessel van der Kolk, MD 1999, p 214)

**Cognitive:**
Amnesia, Blocking, Flashbacks, Dissociation, Confusion and Difficulty Concentrating
Effects of Trauma

Feelings:
Fear, Terror, Anger, Revenge, Hate, Frustration, Guilt or self-blame,(legitimate, illegitimate, survivor), Shame, humiliation and Grief or sorrow

Beliefs:
About Self, About Other People and About the World
Effects of Trauma

**Skill Deficits:**
Self-Awareness, Self-Protection, Self-Soothing/Emotional Regulation, Relational Mutuality/Empathy/Authenticity, Accurate labeling of self and others, and Purpose and Meaning

**Relational Disconnection:**
Trauma affects view of self as well as participation in Relationships; Core experience of trauma is disconnection and disempowerment; and Pathways to healing through connection and empowerment
ACE Study
Ten ACE Categories

- Abuse
  - Emotional
  - Physical
  - Sexual
- Neglect
  - Emotional
  - Physical
- Household Dysfunction
  - Mother treated violently
  - Household substance abuse
  - Household Mental Illness,
  - Parental Divorce
  - Incarcerated Household Member
Healing Neen

- Healing Neen Intro to ACE study
- http://www.youtube.com/watch?v=yU7JPMq2X1Q
The ACE Score is used to assess the total amount of stress during childhood and has demonstrated that as the number of ACE increase, the risk for the following health problems increases in a strong and graded fashion:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
Frontline Video

- Video Clip
The Justice System’s Response to Mental illness

- Balancing traditional objectives of public safety, punishment, and incapacitation with innovative responses to meet the special needs of the mentally ill population
How Did We Get Here?

- There are many people with mental illnesses in the criminal justice system.
- Deinstitutionalization in the 1950s: moved from mental hospitals to community treatment.
1950s
- Progressive construction of jails
- Quiet time for mental health
- Corrections mental health new area

1960s
- Duty to treat
- Deinstitutionalize
- MI had a right to live in the community
- Mental Health Act of 1962
- Psychotropic meds

1970s
- Decrease optimism for rehab
- Increase court and law enforcement
- Overcrowding of jails
- Resources started to dwindle

1980s
- Over ½ million incarcerated
- Continued overcrowding
- No fiscal public awareness of costs
- “Tough on crime”
- Reganomics
- Community MH deteriorating

1990s
- War on Drugs
- State prison costs increase by 82%
- Los Angeles Co Jail surpassed state and private psychiatric providers as nations largest provider

(Dlugacz, 2010)
Mental Illness & Corrections 2000 to the present

- 2.3 Million incarcerated
- Incarcerating MI costs nation 9 billion
- 1st wave of prisoners released (from new sentencing laws)
- Communities see increase of severely MI
- Discontinuity of treatment services
- Recovery and Reinvestment Act of 2009
- Grant funding/federal incentives
- Problem solving courts
Numbers

- National statistics from NAMI
  - In the United State prisons alone, approximately 24% of inmates live with serious mental illness
  - 30% of female and 15% of male inmates in local jails live with serious mental illness such as schizophrenia and bipolar disorder
  - 50% of previously incarcerated individuals living with Serious mental illness are rearrested and return NOT because of a new crime but because they can not comply with conditions often related to MH.
Mental illness is Overrepresented in the criminal justice system

National Prevalence Rates of Mental Illness

- Jail Inmates: 64%
- State Prisoners: 56%
- Federal Prisoners: 45%
- General Population: 11%

(James and Glaze, 2006)
Mental illness is overrepresented in the criminal justice system.

(Teplin, Abram, and McClelland, 1996)
Mental Illness and crime

- Stigmatization of persons with mental illness can lead to difficulties accessing housing and employment

- Can lead to low self-esteem, isolation, and hopelessness

- Two thirds of all people with mental illness to not seek treatment

(Center for Mental Health Services, 2005)
Mental Illness and crime

- Non-access to mental health treatment creates behaviors that are symptomatic of untreated mental health disorders:
  - public disturbance and/or nuisance offenses
  - developing substance abuse disorders
  - homelessness
  - trauma

All of which increase visibility to law enforcement and likelihood that they will enter the justice system

(Prins and Draper, 2009)
Mental Illness and crime

- Incarcerated individuals with mental health issues have more extensive criminal histories and higher levels of criminal activity post-release (James & Glaze, 2006; Baillargeon, Binswanger, et al., 2009).

- 50% of previously incarcerated individuals living with serious mental illness are rearrested and return NOT because of a new crime but because they can not comply with conditions often related to MH.
Mental Illness and crime

- Studies have found no significant relationship between symptom reduction and reducing recidivism when symptoms did improve (Skeem, et al., 2009).

- Skeem and colleagues (2009) assert that the majority of mentally ill offenders come into contact with the legal system for the same reason other offenders who are not mentally ill due to criminogenic needs.

- Mentally ill offenders are at higher risk for these criminogenic needs which explains the high rates of mental illness among those incarcerates.
Entrenchment in the criminal Justice System

Once a mentally ill person is on probation...

- No access to MH TX
- Self-medicate with alcohol or drugs
- Rearrested for public behavior
- Functional impairments No $ or job
- Benefits cut off or delayed
- Unaddressed risk factors
- Technical Probation Violations

(Prins and Osher, 2009)
Three Reasons for Providing Mental Health Treatment in Correctional Settings

1) To reduce the disabling effects of serious mental illness and maximize each inmate’s ability to voluntarily participate in correctional programs.

2) To decrease needless human suffering caused by mental illness.

3) To help keep prison staff, inmates, volunteers, and visitors safe.

Cohen and Dvoskin (1992)
Therapy

- Talk therapy
  - Cognitive behavioral
  - Behavioral
- EMDR
- EGALA
- DBT
- Exposure therapy
- Family therapy
- Group therapy
- Therapy and medication
Medication & Therapy

- People with severe mental illness in jails:
  - 41% receive treatment (usually meds)
  - 16% receive counseling
What Meds Can & Can’t Do

- Do not “cure” the problem
- Take time to work
- Effects are unique to each person
- May stop working
- May only impact some symptoms
- Can interact with drugs or alcohol
Types of Medications

- **Antipsychotics**: schizophrenia, mania
- **Mood stabilizers**: bipolar disorder
- **Antidepressants**: depression
- **Anti-anxiety & antidepressants**: Anxiety & panic disorder
- **Anti-obsvessive agents**: OCD
So what can we do?

- Talk about mental health
- Ask questions
- If possible make adjustments
- Ask clients what you can do to help them cope.
- Jobs in the facility
The Do’s and Don’ts

What to say:

• I believe you
• It wasn’t your fault
• You are not alone
• I will support you

What not to say:

• I don’t believe you
• Why did s/he do that?
• Just forget about it and move on
• I feel sorry for you
• Maybe you misunderstood what happened
• Why did you let him/her?
**DO’s**

- Believe healing is possible
- Be willing to witness great pain
- Be willing to believe the unbelievable
- Examine your own attitudes
- Explore your own history and fears regarding sexual abuse

**Do Not**

- Don’t say or imply blame
- Don’t minimize the abuse
- Don’t spend time trying to understand the abuser
- Never say or imply that she should forgive the abuser
Recognizing a Crisis

Watch for verbal & nonverbal cues:

- Apathy: “Nothing can help me.”
- Panic: “I need help NOW.”
- Helplessness: “I can’t take care of myself.”
- Discomfort: I feel miserable/in pain.
Why De-escalation?

- What is a crisis?
- More effective
- Reduce time with difficult inmates
- Increase staff and inmate safety
- Reduce the need for use of force
Crisis De-escalation, cont’d.

- Be cool and don’t argue:
  - Use clear language
  - Talk in a calm, relaxed manner
- Paraphrase concerns
- Use non-threatening body language
Crisis De-escalation, cont’d.

- Reduce stimulation in environment:
  - Reduce number of people in room
  - Reduce background noise
- Keep inmate focused on present
- Try to slow things down
Crisis De-escalation

- Take concerns seriously
- Do not challenge psychotic thinking
- Express support and concern
- “Problem solving”
- Avoid challenging, sarcasm, laughing
Crisis De-escalation, cont’d.

- Reduce the need for self-justification:
  - Affirm the inmate’s positive qualities
  - Offer the inmate a face-saving out
Use These Skills with Care

- Act, but don’t rush to confrontation
- No touching, shouting, sudden/quick movements
- Avoid intense questioning
- Crisis Intervention Team (CIT) training
Is Suicide a Concern?

• Detoxify the situation by asking:
  Are you thinking of killing yourself?
  Do you have a plan?
• You will not give them the idea.
• Always take a “yes” answer seriously.
What Corrections can offer

- Stability
- Positive interactions
- Medication
- Three balanced meals a day
- Support
- A safe place to be
Food and Mood

- What does food do to our mood?
- Adequate nutrition
- Three meals a day while incarcerated vs?
- Variety of food offerings
Video

The brain is sensitive to the foods we eat on a daily biases. To remain healthy, the brain needs different amounts of: complex carbohydrates, EFAs, amino acids, vitamins, minerals and water.
Food for thought

“Mediterranean, whole food diets have been associated with reduced risk for chronic disease, but very little research has investigated their mental health benefits.
“Our results suggest a potential protective role of the Mediterranean Diet Pattern with regard to the prevention of depressive disorders: additional longitudinal studies and trials are need to confirm these findings”

- What we eat plays a role in our health, life style choices, and how we feel.
- No conclusive causation however, suggestions.
Future considerations

“In middle-aged participants, a processed food dietary pattern is a risk factor for CES-D depression 5 years later, where as whole food pattern is protective.”

(Center for Epidemiological Studies-Depression scale)

- What does this mean?
- What do these outcomes suggest?
Ramsey County Corrections

- What happens in some counties?
- What services are available?
Suicide & Crisis Intervention

Target Population
SPMI

Individual and Group Mental Health Interventions

Transitional Programming to Community

Mental Health Groups

- Men’s Depression Group
- Women’s Anxiety Group
- DBT for both Men and Women
- Trauma Group
RCCF’s Response to Mental Illness

- Crisis Intervention Teams (CIT)
- Jail MH Screening Procedures
- Mental Health Housing Units
- Triaging MH Interventions
- Transitional Programming/Discharge Planning
- Collaboration with Community MH Providers
Lessons learned from implementing the ETP (Research and Evaluation Unit of Ramsey County Community Corrections Department October, 2013):

- There is a strong connection between individuals becoming employed and being successful in gaining a more stabilized life.

- There is a correlation for those receiving housing and chemical dependency treatment and being successful in avoiding re-arrest.

- There are many people with undiagnosed and untreated mental illness within correctional settings or facilities.

- There are many individuals incarcerated who have significant unresolved trauma that contributed to their impairments in functioning and criminal activity.
Framework for transitional services

- Transition planning
- Risk assessment
- Housing
- Benefits
- Releases of information
- Supply of medication
- Fixed appointment with health care provider
- Fixed appointment with probation officer
- Individualized release planning

(Dlugacz, 2010)
What Could Be Waiting For Me When I Leave....

Humiliation
Shame
Guilt
Abuse
Chemical Use
Violence
Crime
Poverty
Homelessness
Why Not Treatment?

- Stigma and fear
- Lack of access - it’s expensive!
- Effects aren’t immediate
- Side effects of medications
- Lack of awareness of the illness
What Do I Need To Succeed

- Food
- Clothing
- Shelter
- Safety
- Support

Access to Collaborative Services
- Mental Health Treatment
- Chemical Dependency Treatment
- Medical Health Treatment
- Parenting Education
Mental illnesses are medical illnesses whose symptoms are behaviors.
Public Perceptions of Mental Illness

- 71% due to emotional weakness
- 65% due to bad parenting
- 45% due to personal fault
- 43% incurable
- 21% controllable
- 10% biological basis
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