

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES TRAINING ACADEMY

**TITLE:** Recognizing and Managing the Special Needs Inmate

**OBJECTIVES:** at the end of this class, each participant will be able to:

- 1) List the 7 types of disorders likely to be encountered in correctional facilities
- 2) List the 3 tips for effective communication with inmates in crisis
- 3) List, in proper, sequence, the 4 steps for making a mental health referral

(As discussed in class)

**TOTAL TIME:** Up to 3 Hours

**SUPPLIES AND EQUIPMENT:** Whiteboard, markers, PowerPoint slides, handouts. Materials needed for role plays: cot, broom, mop & bucket, set of bars to look like a cell, table: phone, hand scanner.

**PRIOR READING:**

**TARGET GROUP DATE:** Correction Officer Recruits

**PREPARED BY:** NYSDOCS Bureau of Mental Health/ NYS Office of Mental Health/ NYSDOCS Albany Training Academy

**APPROVED FOR INSTRUCTION BY:** \_\_\_\_\_

**AUTHORIZED BY:** \_\_\_\_\_  
\_\_\_\_\_

**CONTENT**

**INSTRUCTOR NOTES**

NAME: \_\_\_\_\_

PRE/POST TEST

DATE: \_\_\_\_\_

1. **List the 7 types of disorders likely to be encountered in correctional facilities.**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_

2. **List the 3 tips for effective communication with inmates in crisis.**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

3. **List, in proper sequence, the 4 steps for making a mental health referral.**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**CONTENT**

**INSTRUCTOR NOTES**

NAME: \_\_\_\_\_

**PRE/POST TEST w/ANSWERS**

DATE: \_\_\_\_\_

**1. List the 7 types of disorders likely to be encountered in correctional facilities.**

1. Schizophrenia
2. Depression
3. Bipolar Disorder
4. Posttraumatic Stress Disorder
5. Antisocial Personality Disorder
6. Borderline Personality Disorder
7. Adjustment Disorder

**2. List the 3 tips for effective communication with inmates in crisis.**

1. Keep it simple
2. Do not argue
3. Keep the inmate calm and focused

**3. List, in proper sequence, the 4 steps for making a mental health referral.**

1. Contact Medical or/and Mental Health Department
2. Contact the area supervisor
3. Enter incident in the area log book
4. Complete a Mental Health Referral Form

## CONTENT

## INSTRUCTOR NOTES

### **INTRODUCTION**

As a Correction Officer, your job involves care, custody and control of Inmates. Part of the care aspect of your responsibilities includes aiding in the treatment of special needs inmates. You will need to be able to recognize potential mental health issues and other special needs and take the necessary steps to get the inmate appropriate services. You are not being asked to become clinicians, but this lesson plan will make sure you are aware of the different skills needed and know how to manage a situation, given the variety of inmate issues. This lesson plan will focus on Mental Health disorders and issues, specialized programs in DOCS that you will most likely work in at some point in your careers, and figuring out what to do when confronted with an inmate displaying mental health problems.

INTRODUCTION  
GROUND RULES  
GRABBER  
PRE-TEST  
SLIDE# 1

TELL CLASS

### **VALUE**

It is important to understand mental health symptoms in a correctional context because often these can result in an inmate becoming disruptive to the facility routine, victim prone, or suicidal. At times, you may need to transfer these inmates to specific treatment areas, such as an observation cell in the Mental Health Unit. If you follow the steps outlined in this lesson plan, you will be prepared to do your job responsibly if an inmate is in crisis. Understanding their behavior and knowing how to manage each situation will ensure the safety and security of the facility, your co-workers, yourself and the inmate.

### **OBJECTIVES**

At the end of this class, each participant will be able to:

1. List the 7 types of disorders likely to be encountered in correctional facilities.
2. List the 3 tips for effective communication with inmates in crisis.
3. List, in proper sequence, the 4 steps for making a mental health referral.

SLIDE# 2

## CONTENT

## INSTRUCTOR NOTES

### CONTENT

The first area we are going to review today is the mental health disorders most commonly seen in a correctional setting. Next, we want you to recognize some of the potential mental health and/or special needs that these inmates may have and how to get them to the appropriate services. At the end of this morning we will review specialized programs that exist in different facilities. Finally, we will review how to make a mental health referral either if it is an emergency or someone needs to speak to an OMH clinician.

TELL CLASS  
SLIDE# 3

There is a great deal of attention focused on mental health services in Corrections. As a Correction Officer you spend the greatest amount of time with the inmate population and are often the first responder to mental health issues within the correctional facility. You are going to become familiar with inmates' patterns of behavior and what is normal. In the course of your day, you may observe inmates who are not acting within their usual pattern of behavior. Some may even appear to be depressed, anxious or agitated. By being able to observe and record inmate behavior, provide accurate information and make the proper referrals needed for each situation, you will be able to adequately meet the challenges that routinely confront you in the course of your duties.

Special needs inmates for our purpose include those who exhibit signs and symptoms of mental illness, are mentally retarded or developmentally disabled, or are sensorially disabled.

SLIDE# 4

### OVERVIEW

SLIDE# 5

Mental health services in DOCS

In 1976, NYS Legislature passed Correction Law 401 and 402 which gave NYS Office of Mental Health the responsibility for treating the mentally ill within DOCS. There are about 62,000 inmates currently in the state system. The current OMH caseload is about 9,000 inmates. We have roughly 1,000 beds for inmates with mental health issues. Any inmate can require OMH intervention.

## CONTENT

## INSTRUCTOR NOTES

### OBJECTIVE # 1

**List the 7 types of disorders likely to be encountered in correctional facilities.** TELL CLASS

There are several common types of mental health disorders you will see in Corrections. Again, you are not expected to become a clinician; however, you should be aware of the disorders and the behaviors associated with them. This knowledge will give you a better understanding of Mental Health Disorders so that you will be able to take the appropriate action when necessary.

### SCHIZOPHRENIA

SLIDE# 6

Schizophrenia involves problems in the formation of thought, the organization of ideas, and speaking. Examples of associated behaviors and symptoms are:

- ◆ Delusions
- ◆ Hallucinations
- ◆ Disorganized speech
- ◆ Disorganized or bizarre behavior
- ◆ Negative symptoms

Negative symptoms may be a general blunting of functioning such as:

SLIDE# 7

- ◆ a dulled emotional expression or response
- ◆ lack of, or little speech (and presumably thought)
- ◆ lack of initiative or motivation

Schizophrenia is not controlled by the inmate. The symptoms can be perceived by the inmate as frightening and disorganizing. In response to this, some schizophrenics can become impulsive and violent. The two major components of schizophrenia are:

SLIDE# 8

- ◆ Delusions
- ◆ Hallucinations

SLIDE# 9

Delusions – fixed false beliefs, such as:

SLIDE# 10

- ◆ someone is talking about you
- ◆ Someone is controlling your thoughts

## CONTENT

## INSTRUCTOR NOTES

- ◆ Something is physically wrong with you
- ◆ Someone is monitoring you (chip in the brain)
- ◆ Grandiose thoughts

TELL CLASS

Hallucinations – sensory experiences that do not have a basis in external reality.

SLIDE# 11

- ◆ Can be any of the five senses. Most common are auditory and visual. Can be very scary.
- ◆ Auditory – hearing imaginary voices. It is common to observe the inmate responding to the voices and not paying attention to his/her surroundings. Internal voice is not often pleasant and can be a command hallucination.
- ◆ Visual – seeing things that are not there
- ◆ Taste – often involving food
- ◆ Tactile – feeling things that are not there. This hallucination is common in alcohol withdrawal.
- ◆ Olfactory – smelling things no one else can. This is usually explained by a medical issue.

People with schizophrenia have difficulty recognizing or admitting they are ill or need help. Some behaviors associated with schizophrenia are:

SLIDE# 12

- ◆ disorganized thoughts
- ◆ withdrawal
- ◆ talking to self
- ◆ ignoring personal hygiene
- ◆ shifting from one thought to another without any real connection
- ◆ avoiding eye contact
- ◆ behavior problems / bizarre behaviors

The Department Programs which address the needs of schizophrenics are:

SLIDE# 13

- ◆ Intermediate Care Program (ICP)
- ◆ Specialized Treatment Program (STP)

## CONTENT

## INSTRUCTOR NOTES

### 2. DEPRESSION

TELL CLASS  
SLIDE# 14

A major depressive episode is a period of depressed mood and/or loss of interest or pleasure in all or almost all activities, accompanied by some of these symptoms:

STRESS TO  
CLASS THE  
INDICATOR IS A  
CHANGE IN  
BEHAVIOR

- ◆ Insomnia or excessive sleeping
- ◆ Weight loss or overeating
- ◆ Irritability
- ◆ Fatigue or lack of energy
- ◆ Feelings of hopelessness, helplessness and/or worthlessness
- ◆ Reduced ability to think, concentrate or make decisions

STRESS  
IMPORTANCE OF  
“HOPELESSNESS  
AND  
HELPLESSNESS”  
SLIDE# 15

### 3. BIPOLAR DISORDER

Bipolar disorder is a mental disorder characterized by alternating episodes of depression and mania.

**Manic Episode** – A period of notably elevated or irritable mood lasting at least a week and accompanied by some of these symptoms:

SLIDE# 16

- ◆ Very decreased need for sleep
- ◆ Talking incessantly
- ◆ Hyperactivity
- ◆ Lack of judgment
- ◆ Heightened distractibility
- ◆ Overconfidence, grandiosity

Symptoms of Bipolar Disorder vary from person to person and people may deny the symptoms for fear of appearing weak. If treated, medication can help greatly. If untreated, this disorder can lead to larger mental health problems. Programs addressing the needs of inmates with Bipolar Disorder are:

- ◆ Intermediate Care Program (ICP)
- ◆ Special Treatment Program (STP)
- ◆ Intensive Intermediate Care Program (IICP)

SLIDE# 17



## CONTENT

## INSTRUCTOR NOTES

**APPLICATION QUESTION:**

**Which mental health disorder may involve hallucinations or delusions?**

ASK SPECIFIC PARTICIPANT

**ANSWER:**

**Schizophrenia.**

REPEAT ANSWER  
TELL CLASS  
SLIDE# 18

### **4. POSTTRAUMATIC STRESS DISORDER**

PTSD follows exposure to a traumatic event involving actual or threatened death, serious injury or threat to the physical integrity of one's self or others. Effects can include:

- ◆ re-experiencing traumatic events – unwanted, distressing memories or thoughts of the event(s) and/or dissociations/flashbacks/re-living the event or an aspect of it.
- ◆ sleep disturbances – difficulty falling or staying asleep, nightmares
- ◆ irritability / outbursts of anger
- ◆ exaggerated startle response
- ◆ hyper-vigilance
- ◆ reactivity – easily distressed by cues that symbolize or resemble an aspect of the event(s)

### **5. ANTISOCIAL PERSONALITY DISORDER**

SLIDE# 19

Antisocial Personality Disorder is a pervasive pattern of disregard for the rights of others and property rights, including some or all of the following:

- ◆ repeated lying
- ◆ impulsiveness (or failure to plan ahead)
- ◆ aggressiveness and irritability reckless disregard for the safety of self or others
- ◆ lack of remorse
- ◆ cleverness
- ◆ deceit and manipulation, which can include repeated lying and conning others

## CONTENT

## INSTRUCTOR NOTES

Programs addressing the needs of inmates with Antisocial Personality Disorder are: TELL CLASS

- ◆ Behavioral Health Unit (BHU)
- ◆ Therapeutic Behavior Unit (TBU)
- ◆ Group Therapy Program (GTP)

SLIDE# 20

### **6. BORDERLINE PERSONALITY DISORDER**

SLIDE# 21

Borderline Personality Disorder is marked by some or all of the following:

- ◆ unstable and intense relationships
- ◆ impulsive behaviors that are potentially self-damaging
- ◆ self-injurious and/or suicidal behaviors
- ◆ unstable emotions
- ◆ intense anger or difficulty controlling anger
- ◆ feelings of emptiness

STRESS  
ANTISOCIAL AND  
BORDERLINE PD  
ARE BOTH  
ADEPT STAFF  
SPLITTERS

Department programs addressing the needs of these inmates are:

SLIDE# 22

- ◆ Behavioral Health Unit (BHU)
- ◆ Therapeutic Behavior Unit (TBU)
- ◆ Group Therapy Program (GTP)

### **7. ADJUSTMENT DISORDER**

SLIDE# 23

Development of emotional and/or behavioral symptoms in response to a stressor, which can include:

- ◆ anxiety
- ◆ depression
- ◆ acting out
- ◆ impairment in functioning (work, program and/or social)
- ◆ marked distress

**CONTENT**

**INSTRUCTOR NOTES**

**MINI-SUMMARY 1**

The 7 types of disorders likely to be encountered in correctional facilities are:

SLIDE# 24  
TELL CLASS

1. Schizophrenia
2. Depression
3. Bipolar Disorder
4. Posttraumatic Stress Disorder
5. Antisocial Personality Disorder
6. Borderline Personality Disorder
7. Adjustment Disorders

**OBJECTIVE # 2**

**List the 3 tips for effective communication with inmates in crisis.**

There are several tips for effective communication with inmates in crisis. When working such an inmate, follow the following guidelines:

1. Keep it simple – give clear, concise directions. An inmate in crisis will have difficulty in responding to and obeying complicated directions. Simple, familiar language may reduce the possibility of increasing the confusion of an inmate who is possibly seeing or hearing things that are not there.
2. Do not argue – Listen to what the inmate is saying to you. Do not make fun of the inmate or be judgmental. DO NOT agree a hallucination or delusion is real, but remember the hallucination or delusion is real to the inmate. You can ask them what they are hearing or seeing, but if you do not hear or see it, tell the inmate that. Again, do not argue.

SLIDE# 25

Never promise to do things you cannot do.

**APPLICATION QUESTION**

**Which tip for effective communication with inmates in crisis involves giving clear, concise directions?**

ASK SPECIFIC PARTICIPANT REPEAT ANSWER

**Keep it simple.**

## CONTENT

## INSTRUCTOR NOTES

3. Keep the inmate calm and focused – Keep his or her concentration on what you need him or her to do. Use your communication skills and remain professional. Give directions in a calm, non-threatening voice. Communicating effectively with the inmate may prevent an escalation to frustration and violence.

TELL CLASS

Manage the situation using the following techniques:

SLIDE# 26

- ◆ Engage (communicate)
- ◆ Recognize (observable behavior)
- ◆ Assess (danger to self or others)
- ◆ Refer (to Mental Health)

### **MINI-SUMMARY 2**

The three steps for effective communication with an inmate in crisis are:

1. Keep it simple.
2. Do not argue
3. Keep the inmate calm and focused.

### **OBJECTIVE # 3**

**List, in proper sequence, the 4 steps for making a mental health referral.**

Remember, Correction Officers are not expected to be clinicians, but it is important to identify inmates who exhibit signs and symptoms of mental illness, are mentally retarded or developmentally disabled or sensorially disabled. Correction Officers need to be able to recognize potential problems and take appropriate steps to get the inmate appropriate services. Regardless of whether or not he or she is on the OMH caseload, any inmate can require OMH intervention. Officers should communicate and work cooperatively with medical and mental health staff receiving referrals. If you encounter an inmate who appears to need OMH attention, you must be sure to make a mental health referral.

SLIDE# 27

## CONTENT

## INSTRUCTOR NOTES

### GROUP EXERCISE

You are now going to break into groups. Each group will review a situation and report back to the class. Your report will include:

1. A summary of the situation.
2. Any signs or symptoms indicating the inmate has Special Needs, and
3. Your decision whether or not to refer the inmate to Mental Health.

Note to Instructor: Separate class into groups of six to eight participants each. Some groups will have the same case study.

### Case Study #1

Inmate G is a 50 year old Caucasian male. He is serving a 25 to Life bid for Murder 2<sup>nd</sup>. He has served 23 years. He runs out of line and hides in the Sergeant's Office, which, results in an inaccurate count. Officers discover the inmate who states he is "out of place" and that he wants his CIA file brought to him. He is unable to state his name and appears disoriented and disorganized. He adamantly denies that he has a mental illness.

Summary. Symptoms. Mental Health Referral.

1. Contact the Medical or/and Mental Health Department
  - a. Medical – if there is a medical emergency or if there is no mental health presence.
  - b. Mental Health – if inmate needs mental health services.

2. Contact the area supervisor

3. Complete a Mental Health Referral Form.

Employees who observe behavior of inmates that they believe is peculiar or out of the ordinary should complete the Mental Health Services Referral Form as follows:  
Inmate's complete name, DIN, housing area date and time of referral, staff making referral

TELL CLASS  
SLIDE# 28

DISTRIBUTE  
HANDOUTS 1-4  
BY GROUPS

DISTRIBUTE  
HANDOUT #5 TO  
ALL.

SLIDE# 29  
UNDERLINED  
INFORMATION  
SHOULD BE  
REFLECTED IN  
RECRUITS'  
ANSWERS.

SLIDE# 30

SLIDE# 31

SLIDE# 32

**CONTENT**

**INSTRUCTOR NOTES**

Section (i): Check all specific areas that apply to the inmate being referred.  
“Observable behaviors”.

TELL CLASS

Section (2): Note the dates and times of behaviors necessitating this referral.

Section (3): Where did the behavior(s) that you circled occur most frequently?

Comments – Note any other pertinent information regarding this inmate; i.e.

Negative parole board decision

Death of a loved one

Disciplinary confinement

Conflict on the housing unit

Fear of gangs, etc.

**APPLICATION  
QUESTION**

**Which step in making a mental health referral involves alerting a higher ranking security officer of the situation and possible movement of the inmate?**

ASK SPECIFIC PARTICIPANT

**ANSWER**

**Contact area supervisor**

REPEAT ANSWER

- 4. Enter incident in the area log book – Note all activities and any recommendation from Mental Health staff in the logbook. Include times and names of staff contacted.

SLIDE# 33

Case Study #1 History

SLIDE# 34

He denies any past in-patient/outpatient treatment however it is documented that he has been psychiatrically hospitalized on two prior occasions. OMH staff attempt to stabilize patient. They offer medication but the inmate refuses and becomes agitated. . He writes bizarre letters to the FBI, CIA and public officials such as the Governor. For example, he wrote to Gov. Paterson making references to terrorism and requesting that satellites cease their monitoring of him. He threatens mental health staff with litigation when they attempt to engage him in treatment. He continues to refuse treatment. Case remains open with OMH however to the consternation of the inmate.

Additionally, Inmate G denies any drug use history, however he has received Misbehavior Reports for drugs. During his long bid, he has received tickets for Assault on Staff (1997); Interference, and Harassment (both 2000). Most notably,

## CONTENT

## INSTRUCTOR NOTES

this inmate attempted to escape while in Great Meadow CF. In the recent past, Inmate G has not presented with dangerous behaviors toward himself or others.

TELL CLASS

### Diagnosis: Schizophrenia

Inmate G was escorted to RCTP. OMH staff attempted to stabilize him. They offered medication, but the inmate refused and became agitated. The inmate required immediate medication over objection for agitation. Inmate-patient's mental status did not improve. He was admitted to CNYPC. Inmate-patient required COPM (Court Ordered Psychiatric Medications). After a two month hospitalization, patient was less agitated and less bizarre. He returned to his home facility and entered ICP.

### Case Study #2

SLIDE# 35

Inmate M is a Hispanic male of 35 years. He is doing his second NYS bid. He is doing 25 years for Robbery 1<sup>st</sup> degree with 5 years down. This inmate has served state and federal time. Recently, he has been quiet and withdrawn, lacking interest and motivation. He is fearful of spending the rest of his life in prison. The Officer on rounds notes a small puddle of blood on the cell floor and the Inmate lying in bed. In response to direct orders, the Inmate sits up. The Officer sees that Inmate M is bleeding profusely from his right and left forearms. He cut himself with his state razor.

Summary, Symptoms, Mental Health Referral

SLIDE# 36

### Case Study #2 History

SLIDE# 37

Following the robbing of a bank wherein Inmate G had a gun and told the teller, "Open your drawers or I'll fucking kill you", he sent threatening letters to the victims of this robbery. Inmate M's criminal behavior dates back to his age 14 and includes over 25 arrests. He has required out of home placements due to his behavior i.e. defiant behavior towards authority figures; truancy; destruction of property; and grand theft auto.

He has a significant history of violence i.e. he was abusive to his girlfriend and when her father attempted to intervene, he broke the father's arm. He also has an

## CONTENT

## INSTRUCTOR NOTES

extensive history of suicide attempts including hanging and requiring being cut down by family members, overdosing and “playing Russian roulette” in the presence of an ex-girlfriend. TELL CLASS

### Diagnosis: Depression and Antisocial Personality Disorder

Officers intervened and brought him to Medical then RCTP. He was depressed, withdrawn, lacking interest and motivation. He began antidepressant medication but continued to think of killing himself. He was sent to CNYPC. His symptoms seemed adequately managed by his medication regime. He returned to his facility and had Tier 3 Misbehavior Reports pending including Violent Conduct; Weapon; Direct Order; Threats and Damage to State Property. He was given 3 months of Long Term Keeplock. He was placed in IICP. When his sanction is completed, he will go to TrICP.

### Case Study #3

SLIDE# 38

Inmate J is a 31 year old male who is serving a Life Sentence without parole for Murder 1<sup>st</sup> degree. Inmate J has been attending GTP in his facility. He is superficially cooperative with OMH staff; however, he is disrespectful with select DOCS staff. Inmate J has been refusing to comply with Unit rules and regulations. He threatens to throw feces and urine on specific DOCS staff. He is refusing to discuss issues with the DOCS Corrections Counselor. He threatens “bury” DOCS staff in paperwork

Summary, Symptoms, Mental Health Referral.

SLIDE# 39

### Case Study #3 History

SLIDE# 40

At age 12, he attempted to jump from a 4 story apartment building. His criminal activities began by age 13. He has been placed in DFY and then prison. He has made a very poor adjustment to prison. This inmate has a noted long-standing history of impulsive, violent behaviors



## CONTENT

## INSTRUCTOR NOTES

### Diagnosis: Antisocial Personality Disorder –

TELL CLASS

He has received over 80 Misbehavior Reports since his incarceration began eleven years ago. Tickets have included Drug Use and Possession; Direct Order; Movement Violation; Interference; Creating Disturbance; Threats Harassment; Demonstration; Lewd Conduct; Violent Conduct and Unhygienic Acts. As of today's report, Inmate J is doing SHU time until Late 2014.

The goal is to transfer this inmate to Phase 1 of the BHU at Great Meadow CF in order to treat his behavioral issues, then, if he does well, Phase 2 & 3 of the BHU at Sullivan CF and GP eventually.

### Case Study #4:

SLIDE# 41

Inmate P is a 25 year old Hispanic female who is serving a 5 year bid for Robbery. Midnight rounds officers find Inmate P thrashing about in her cell. She is screaming, "Get away from me! Leave me alone!" The officers attempt to awaken the inmate. Upon waking, she appears afraid and begins to chew on her arm. She has a history of cutting herself.

Summary, Symptoms, Mental Health Referral

SLIDE# 42

### Case Study #4 History

SLIDE# 43

Her offense is related to her drug use. She grabbed a woman's purse in order to access cash for drugs. She has a history of physical, emotional and sexual abuse. Inmate P has been irritable, has been "out of it", and cuts herself. She is doing SHU time for Assault on Staff. She has had an extremely poor adjustment to prison. The mental health staff attempts to engage this inmate in a therapeutic alliance, however she is highly resistant.

### Diagnosis: Borderline Personality Disorder and PTSD

Inmate P was brought to RCTP. She was evaluated by the team and referred to TBU. Inmate P does well in the TBU. The eventual goal is GP.

## CONTENT

## INSTRUCTOR NOTES

### MINI-SUMMARY 3

The four steps, in proper sequence, for making a mental health referral form are:

1. Contact the Medical or/and Mental Health Department
2. Contact the area supervisor
3. Enter incident in the area log book
4. Complete a Mental Health Referral Form

TELL CLASS  
SLIDE# 44

### Mental Retardation:

Based on the standard set by the American Association for Mental Deficiency, mental retardation is characterized by significantly sub-average intellectual functioning with the onset before age 18 and concurrent deficits or impairments in adaptive functioning in at least two of the following skill areas:

- ◆ communication
- ◆ self-care
- ◆ home living
- ◆ social/interpersonal skills,
- ◆ work
- ◆ leisure,
- ◆ health
- ◆ safety

SLIDE# 45

There are four degrees of severity of mental retardation. Generally, inmates in our system who evidence Mental retardation are in the first category – Mild Mental Retardation. Clear, simple directions are best when dealing with lower functioning inmates. Use simple language and speak slowly and clearly.

For individuals who are developmentally delayed, social skills are often lacking. Awareness of common social conventions is often limited. For example, these individuals are often overly friendly. This can lead to these inmates being easily led to do things against the rules by other, higher functioning inmates. They are also subject to ridicule from others and may be victim prone. These inmates may experience more emotion in social situations than they are able to express, leading to considerable underlying tension and frustration.

SLIDE# 46

## CONTENT

## INSTRUCTOR NOTES

Individuals with mild retardation usually acquire basic living and vocational skills to function more or less autonomously in the community. Often these inmates do very well with repetitive type job assignments such as mopping floors or working in the mess hall. The department offers training in daily living and vocations skills in the Special Needs Units located in Wende, Arthurkill and Sullivan for inmates who evidence this need.

TELL CLASS  
SLIDE# 47

### Sensorially Disabled

This section specifically deals with the hearing and/or visually impaired population. The Department has established Directive 2612 which outlines the necessary Reasonable Accommodations that must be provided to this population. Reasonable accommodations are any change in the environment in which a task is completed that enables a qualified individual with a disability to participate in a program or service such that the accommodation should not impose any undue hardship on the Department.

SLIDE# 48

Reasonable accommodations might include the following:

SLIDE# 49

For the Hearing Impaired:

- ◆ sign language interpreters for communication with hearing individuals
- ◆ TTY telephone devices
- ◆ closed captioning for a television set, etc.

For the Visually Impaired

- ◆ sighted guide – a person to escort and orient the disabled inmate to an area
- ◆ books on tape
- ◆ magnifiers, etc

The primary goal of reasonable accommodations is to ensure equal access in all areas of the facility and programs. Blind and deaf inmates are all housed in designated facilities. Most inmates who are either hearing or visually impaired are located at Eastern, Wende, Sullivan, Woodbourne, Wyoming, and Bedford Hills.

SLIDE# 50

There are several treatment units and programs for special needs inmates. The

## CONTENT

## INSTRUCTOR NOTES

most commonly used ones are:

- |         |   |           |
|---------|---|-----------|
| BHU–    | Behavioral Health Unit – a three phase treatment program for inmates currently diagnosed with a mental disorder, who have demonstrated a history of treatment resistance and poor custodial adjustment/behavior. Phase 1 (38 cells) is at Great Meadow. Phases 2 & 3 (60 cells) are at Sullivan.  | SLIDE# 51 |
| STP–    | Special Treatment Program – provides assessment and treatment for seriously mentally inmates in SHU status – locations include Attica, Five Points and Green Haven.   | SLIDE# 52 |
| ICP–    | Intermediate Care Program – a mental health program for seriously mentally ill inmates. The goal of the program is to improve ability to function so the inmate may return to general population. The following facilities have ICP programs: Albion, Attica, Auburn Bedford Hills Clinton, Elmira, Five Points, Great Meadow, Mid-State, Sing Sing, Sullivan, and Wende. | SLIDE# 53 |
| GTP –   | Special Housing Unit Group Therapy Program – is for inmates currently diagnosed with a serious mental illness who are serving time in SHU but are not considered appropriate for, or may not have been able to adjust to, other programs. These units are located at Clinton, Elmira, Southport and Wende.  | SLIDE# 54 |
| TBU–    | Therapeutic Behavioral Unit – a program at Bedford Hills for females who are serving SHU time and have a history of mental illness and/or poor custodial adjustment.  | SLIDE# 55 |
| TrICP – | Transitional Intermediate Care Program – provides OMH case management services and treatment to seriously mentally ill inmates in a general population location, helping their adjustment to the regular prison environment. Many of these inmates are graduates of other mental health programs, such as ICPs.   | SLIDE# 56 |

## CONTENT

## INSTRUCTOR NOTES

RCTP – Residential Crisis Treatment Program (also called Satellite Unit) is for evaluation and treatment of inmates in need of short-term psychiatric care. There are observation cells and a dorm area for inmates in crisis and in need of intensive treatment and monitoring.

SLIDE# 57

Several of our facilities house Mental Health Programs:

### Wende

- 961 beds
- 764 GP beds
- 27 Reception beds
- 52 SNU beds
- 38 IICP beds
- 80 RMU beds
- 12 GTP beds
- SDU inmates in GP
- 18 TrICP

SLIDE# 58

### Attica

- 2,253 beds
- 2141 GP beds
- 78 ICP beds
- 34 STP beds
- 78 SHU beds
- 36 TrICP beds

SLIDE# 59

### Auburn

- 1,819 beds
- 1,679 GP beds
- 50 ICP beds
- 18 TrICP beds

SLIDE# 60

## CONTENT

## INSTRUCTOR NOTES

### Five Points

- 1,500 beds
- 1,428 GP beds
- 22 ICP
- 50 STP

SLIDE# 61

### Elmira

- 1,856 beds
- 1,371 GP beds
- 429 Reception beds
- 56 ICP beds
- 12 GTP beds
- 18 TrICP beds

SLIDE# 62

### Clinton

- 2,958 beds
- 1,775 GP beds
- 5 Reception beds
- 604 Annex beds
- 216 Merle Cooper beds
- 258 APPU beds
- 60 ICP beds
- 12 GTP beds
- 18 TrICP

SLIDE# 63

### Great Meadow

- 1,693 beds
- 1,587 GP beds
- 68 ICP beds
- 38 BHU beds
- 18 TrICP beds

SLIDE# 64

### Green Haven

- 2,232 beds
- 2,172 GP beds
- 24 STP beds

SLIDE# 65

## CONTENT

- 36 AVP beds

### Sullivan

- 829 beds
- 400 GP beds
- 240 Annex
- 64 BHU
- 64 ICP
- 64 SNU
- SDU inmates in GP

### Downstate

- 1,234 beds
- 288 GP
- 946 Reception beds

### Bedford Hills

- 942 beds
- 758 GP beds
- 16 ICP beds
- 122 Reception beds
- 30 RMU beds
- 16 TBU beds
- 18 TrICP beds

### Sing Sing

- 1,803 beds
- 1,409 GP beds
- 64 ICP
- 31 CORP
- 18 TrICP beds

## INSTRUCTOR NOTES

SLIDE# 66

SLIDE# 67

SLIDE# 68

SLIDE# 69

**CONTENT**

**INSTRUCTOR NOTES**

**FINAL SUMMARY**

The 6 types of disorders likely to be encountered in correctional facilities are:

SLIDE# 70

1. Schizophrenia
2. Bipolar Disorder /Depression
3. Posttraumatic Stress Disorder
4. Antisocial Personality Disorder
5. Borderline Personality Disorder
6. Adjustment Disorders

The three steps for effective communication with an inmate in crisis are:

SLIDE# 71

1. Keep it simple; give clear, concise directions.
2. Do not argue
3. Keep the inmate calm and focused on what you need him or her to do.

The four steps, in proper sequence, for making a mental health referral form are:

SLIDE# 72

1. Contact the Medical or/and Mental Health Department
2. Contact the area supervisor
3. Enter incident in the area log book
4. Complete a Mental Health Referral Form

SLIDE# 73

ADMINISTER  
POST-TEST

PREPARE FOR  
ROLE PLAYS



## CONTENT

## INSTRUCTOR NOTES

### ROLE PLAYS

Special needs inmates can present you with circumstances that, if not recognized and adequately managed, can escalate into potentially dangerous situations for you and/or the inmate. The role playing exercises you are about to witness and participate in, with the help of the Role Players, will give you an exposure to some of the events and conditions you need to prepare for to fulfill your responsibilities as an officer.

TELL CLASS

These are very realistic scenarios. You are expected to act as if you are the correction officer in a facility in this situation. I will read the scenarios twice. Four recruits will be selected for each scenario. You will be able to use the material on the table and it is assumed that you are carrying a radio.

**Materials needed:** cot, broom, mop & bucket, table, set of bars to look like a cell. Materials needed for Role Players: ID cards, state-issue inmate clothing.

SET UP ROOM

**Materials on the table:** phone, Mental Health Referral Form, hand scanner. Recruits will form their chairs in a semi-circle around the role-play area.

### **Rules of the Role Play Exercise:**

1. **NO** physical contact with Role Players. This is extremely important! Under no circumstances should you have any physical contact!
2. Respect your colleagues. No laughing or judging your classmates; this is a training exercise to help you prepare for the duties you are about to assume. This is also a respect issue. It is difficult enough to have to stand in front of your colleagues. Treat them as you would want to be treated yourself.
3. If you are chosen, you will continue the scenario from where the prior recruit left off. Pay attention! Listen to the questions asked and the answers given.
4. Your area supervisor will be the Uniformed Staff Instructor (Supervisor if available) present if needed during the role play. The DOCS Mental Health staff instructor will play the role of the clinician and “answer the phone” for medical or mental health if needed during the role play.
5. Remember: safety and security are of utmost importance. Remember to use the interpersonal communication skills we have talked about.

EXPLAIN AND  
EMPHASIZE  
RULES

This exercise is to incorporate the skills you have learned over the last two days.

TELL CLASS

## CONTENT

## INSTRUCTOR NOTES

Remember to use the interpersonal communication skills we have talked about.

**REMEMBER:** Engage (communicate)  
Recognize (observable behavior)  
Assess danger (self or others)  
Referral to Mental Health

### SCENARIO #1 – SUICIDAL

Inmate Robinson appears upset and is refusing to attend program. This is unusual because he/ she is a reliable, hard worker who never refuses program. Inmates at this facility have just received parole board decisions and several inmates have been very emotional this evening.

**Participant:** You are the Correction Officer assigned to her housing unit. You are attempting to find out what is the reason Robinson is not attending evening program and assess the situation.

**Player:** You will be holding a lanyard, slowly pacing, acting despondent and initially giving up little information. You will be angry and confrontational about needing to be left alone and will allude to suicide but not say it directly, unless directly asked. You will also attempt to hang up if the recruit leaves.

You are the parent of 2 teenagers, 13 & 15, whom you promised you would be home for (you do not volunteer this information readily). They live with your mother and you are worried about them getting upset or in trouble and are upset that you were hit for 24 months. You will come out willingly after the officer gets you to talk about your children and doesn't promise you a phone call but promises to look into it.

**Uniformed Instructor / Supervisor:** Don't bail them out. Say you will be up in a couple minutes or are handling another situation and will be there as soon as you are available. Make sure the recruit knows not to say too much on the radio (i.e. say only that it is a medical emergency and immediate assistance is requested.)

**DOCS Mental Health Instructor:** Do not give your name when you answer the

READ ONLY THE  
SCENARIO AND  
PARTICIPANT  
ROLE TO  
RECRUITS

INFORMATION  
FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

INFORMATION

## CONTENT

## INSTRUCTOR NOTES

phone. Just say, "Mental Health." Ask for the DIN. If they ask that the inmate be seen, say they can bring the inmate down if they request something, but you cannot go there immediately.

FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

**Action Response Sought:** The key for this situation is getting the inmate to talk about her kids. If the recruit gets the inmate to start talking, she will ask for a phone call and talk about her children.

### Debriefing:

1. Ask:
  - a. Is the person suicidal?
  - b. Does the inmate have mental health issues?
  - c. What did you notice about the inmate (inabilities, abilities, unusual behavior)?
2. Tell the recruits they cannot be afraid to talk to inmates.
3. Tell them: If something is not normal, they must find out what the problem is. Do not just try to make it be normal.
  - a. Ask the proper questions to get as much information as you can so you can make rational decisions.
4. Ask: What are the appropriate steps to take with this inmate?
  - a. Are you making a mental health referral? Review the 4 steps:
    - i. Contact Medical or OMH (if it is not a medical emergency).
    - ii. Contact the area supervisor.
    - iii. Fill out a Mental Health referral form.
    - iv. Log it in the log book – include names and times.
  - b. How do you deal with this inmate's inabilities?
  - c. Use everything at your disposal to manage the situation.
5. What is the next step after you get the inmate to comply?
6. Make sure they are aware:
  - a. It is an emergency and the inmate is suicidal
  - b. Never leave the inmate alone.
  - c. Focus on what is hopeful in her life.
  - d. Use of IPC skills.

### Key Points:

INFORMATION

## CONTENT

1. Though it may be uncomfortable, ask directly if the inmate is suicidal (you may not have much time).
2. Keep in mind security aspects and inmate safety.
3. Know your facility policy.
4. Be aware of other inmates in the area; if they know what is going on, they may try to escalate the situation.
5. If the inmate gives indication he/she is suicidal, you will have to get help; go to PAS – tell the arsenal you have an emergency and need assistance.
6. It may be necessary to lock the other inmates in.

## INSTRUCTOR NOTES

FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

### SCENARIO #2 – MENTAL RETARDATION

Inmate Jones has just received a new program as your porter. His first job is to mop the day room and empty the garbage cans. He appears to have difficulty following directions but is not a disciplinary problem. The Area Supervisor is making rounds and is questioning why the area is not clean.

READ ONLY THE  
SCENARIO AND  
PARTICIPANT  
ROLE TO THE  
RECRUITS

**Participant:** You are the assigned Correction Officer in this housing unit and you are in the process of trying to get inmate Jones to comply with your direction to mop the floor.

**Inmate:** You are a recent SNU transfer. You are a concrete thinker, and are telling the participant that you don't know how to do this job and that you were a dishwasher at McDonalds. Keep going back to that point, over and over.

At some point you will give up information and will mention that Big Bertha is going to get the Area Supervisor (refer to him/her by name. You will then comply, but will need step-by-step directions.

**Uniformed Instructor / Supervisor:** Don't bail the recruit out. Make sure to admonish the recruit for being called up for an emergency when the inmate is just not doing his/her work.

INFORMATION  
FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

**DOCS Mental Health Instructor:** Only answer the phone, "Mental Health." Ask for

INFORMATION

## CONTENT

## INSTRUCTOR NOTES

the DIN to see if the inmate is active on the OMH caseload. Ask if the inmate is suicidal. State that you are currently handling an emergency. The inmate may be brought down later, but indicate the inmate is not on the OMH caseload.

FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

**Action Response Sought:** The scenario will resolve when the participant demonstrates how to do the job and gives clear, step-by-step directions.

### **Debriefing:**

1. Ask:
  - a. Is the person suicidal?
  - b. Does the inmate have mental health issues?
  - c. What did you notice about the inmate (inabilities, abilities, unusually behavior)?
2. Tell the recruits they cannot be afraid to talk to inmates.
3. Tell them: If something is not normal, they must find out what the problem is. Do not just try to make it be normal.
  - a. Ask the proper questions to get as much information as you can so you can make rational decisions.
4. Ask: What are the appropriate steps to take with this inmate?
  - a. Are you making a mental health referral? Review the 4 steps:
    - i. Contact Medical or OMH (if it is not a medical emergency).
    - ii. Contact the area supervisor.
    - iii. Fill out a Mental Health referral form.
    - iv. Log it in the log book – include names and times.
  - b. How do you deal with this inmate's inabilities?
  - c. Use everything at your disposal to manage the situation.
5. What is the next step after you get the inmate to comply?

### **Key points:**

1. This is not a mental health issue.
  - a. If you are not sure, fill out a Mental Health Referral.
2. Your job is to supervise and instruct.
3. Use IPC skills. Make directions clear and simple.
4. Address the confidential information about the threat to the Area Supervisor:
  - ◆ Notify the area supervisor there is a potential problem and what it is.

INFORMATION

## CONTENT

- ◆ Do not question the inmate where other inmates can hear. Let the area supervisor question the inmate.
- ◆ Be aware: the inmate could now be in danger.

## INSTRUCTOR NOTES

FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

### SCENARIO #3 – SCHIZOPHRENIA

Inmate Brown is the area porter and he has not been performing his job responsibilities satisfactorily. He appears distracted and preoccupied and insists that he is communicating with someone.

READ ONLY THE  
SCENARIO AND  
PARTICIPANT  
ROLE TO  
RECRUIT

**Participant:** You are the Correction Officer assigned to the housing unit, attempting to communicate with Inmate Brown and assessing the situation.

**Inmate:** You are frantic, repeating that there is an invasion and that you both have to get out right away. Use the broom as a microphone to announce an evacuation. You are clearly delusional and believe that you have been given the task of leading everyone to safety. If the officer challenges the delusion, act as if the officer is delusional.

INFORMATION  
FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

**Uniformed Instructor / Supervisor:** Do not bail the recruit out. Say either that you are busy or that help is on the way.

**DOCS Mental Health Instructor:** Only answer the phone, “Mental Health.” Ask for the DIN to see if the inmate is active on the OMH caseload. Ask if the inmate is suicidal. State that you are currently handling an emergency. The inmate may be brought down later.

**Response Action Sought:** The participant should continue to keep the inmate calm, using the four steps for communicating with an inmate in crisis (ERAR). Participant should get as much information as possible from the inmate, especially whether the inmate is on medication, and determine an action to maintain the security of the area until response arrives, i.e. lock in, sit by desk, etc.

**Debriefing:**

INFORMATION

## **CONTENT**

1. Ask:
  - a. Is the person suicidal?
  - b. Does the inmate have mental health issues?
  - c. What did you notice about the inmate (inabilities, abilities, unusually behavior)?
2. Tell the recruits they cannot be afraid to talk to inmates.
3. Tell them: If something is not normal, they must find out what the problem is. Do not just try to make it be normal.
  - a. Ask the proper questions to get as much information as you can so you can make rational decisions.
4. Ask: What are the appropriate steps to take with this inmate?
  - a. Are you making a mental health referral?
    - i. Contact Medical or OMH (if it is not a medical emergency).
    - ii. Contact the area supervisor.
    - iii. Fill out a Mental Health referral form.
    - iv. Log it in the log book – include names and times.
  - b. How do you deal with this inmate's inabilities?
  - c. Use everything at your disposal to manage the situation.
5. What is the next step after you get the inmate to comply?

### **Key points:**

1. Ask questions; why is the person acting this way?
  - a. For instance, are they taking their medications?
  - b. Why did they stop?
2. Do not agree with hallucinations or delusions. Do not make promises you cannot keep.
3. Do not escalate the situation.
  - a. If the inmate is not a threat, do not pressure him/her.
4. What you do depends on the actions of the inmate.
  - a. Security concerns are primary.
  - b. Or, can you get information for Mental Health?
5. Should the inmate stay on the unit or be removed?
  - a. Is it a medical emergency?
  - b. Know your facility. When and how are Mental Health services available?

## **INSTRUCTOR NOTES**

FOR ROLE  
PLAYER AND  
TRAINING STAFF  
ONLY

## CONTENT

## INSTRUCTOR NOTES

- i. You may have to call Medical or your supervisor.

### **SCENARIO #4 – POSTTRAUMATIC STRESS DISORDER/CROSS GENDER PAT FRISK**

Inmate Evans is the assigned Teacher's Aid in the school building. She has been her in the area for the past six months. Inmate Evans has just failed the metal detector search.

**Participant:** You are the Correction Officer assigned to the school building. You are in the process of trying to persuade Inmate Evans to comply with the pat frisk procedures, and you assess the situation.

**Inmate:** Refuse to be pat frisked. Refuse to face the wall. You become very agitated and eventually start calling all the male officers "daddy" and all the female officers "mommy". Include, "You will never touch me again!"

**Uniformed Instructor / Supervisor:** You are busy with another emergency and cannot respond at this time. If the participant requests a female officer, send one.

**DOCS Mental Health Instructor:** Only answer the phone, "Mental Health." Ask for the DIN to see if the inmate is active on the OMH caseload. Ask if the inmate is suicidal. State that you are currently handling an emergency. The inmate may be brought down later.

**Response Action Sought:** Male participants must try to keep the inmate calm and request a female to pat frisk the inmate. When the female participant responds, the male must remain alert and not leave the area. The female participant must use the hand scanner and explain very clearly what she is doing, step by step, and does not go behind the inmate out of her field of vision.

**Debriefing:**

MALE RECRUIT SHOULD BE CHOSEN FOR THIS SCENARIO READ ONLY THE SCENARIO AND PARTICIPANT ROLE TO RECRUITS

INFORMATION FOR ROLE PLAYER AND TRAINING STAFF ONLY

INFORMATION



## **CONTENT**

1. Ask:
  - a. Is the person suicidal?
  - b. Does the inmate have mental health issues?
  - c. What did you notice about the inmate (inabilities, abilities, unusual behavior)?
2. Tell the recruits they cannot be afraid to talk to inmates.
3. Tell them: If something is not normal, they must find out what the problem is. Do not just try to make it be normal.
  - a. Ask the proper questions to get as much information as you can so you can make rational decisions.
4. Ask: What are the appropriate steps to take with this inmate?
  - a. Are you making a mental health referral?
    - i. Contact Medical or OMH (if it is not a medical emergency).
    - ii. Contact the area supervisor.
    - iii. Fill out a Mental Health referral form.
    - iv. Log it in the log book – include names and times.
  - b. How do you deal with this inmate's inabilities?
  - c. Use everything at your disposal to manage the situation.
5. What is the next step after you get the inmate to comply?

### **Key points:**

1. Check IDs.
2. Know proper frisk procedures.
3. Do not provoke the inmate.
4. You know the inmate set off the metal detector and has metal on her person. You do not need to pat frisk the inmate: use a hand scanner.
  - a. Explain how you will use it so the inmate is fully aware of what you are going to do.
  - b. Be aware of positioning so you do not provoke the inmate.

## **INSTRUCTOR NOTES**

FOR ROLE  
PLAYER AND  
TRAINERS ONLY

Concluding remarks:

TELL CLASS

## **CONTENT**

## **INSTRUCTOR NOTES**

In these scenarios we did not have someone respond right away for a reason. Many times, even in the best of circumstances, when someone can respond right away, you will have a period of time when it is just you and the inmate. Developing your communication skills, developing the skills to de-escalate an inmate is extremely important.

DISMISS CLASS