



TDCJ

**Rehabilitation Programs Division
On-Line Distance Training**

Course 1020

Non-Violent Crises Intervention

Three (3) General Education Credit Hour

TDCJ/RPD

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Course 1020 Non-Violent Crisis Intervention

Psychological crisis is a brief, non-illness response to severe stress. When maladaptive responses to crisis are detected, crisis intervention is employed to achieve a more adaptive resolution and a more effective learning experience. ²⁴

Working with offenders in the criminal justice system exposes employees and counselors to people in crisis all the time. Imagine being incarcerated in prison for a lengthy period – wouldn't that alone add an enormous amount of stress on an individual? Many times we see offenders "break", "crack", or "snap" under that strain. There are also many variables that exist with our prison population that may potentiate a crisis. Co-occurring disorders, substance abuse issues, withdrawal, prison violence, inability to act on sexual desires, living in close quarters with other "criminals" are a few.

Look at your own situation. What causes you stress? It may be money problems, divorce, family illness, death, or work-related stress. Do you have a healthy way to relieve that stress? Can you even identify when you feel stress? More over, are you aware when you may be in crisis? Many of us cannot when we are in that situation – and most times, neither can the offenders we counsel or supervise.

The extreme results of crisis may be acting out or suicide but there are other, less obvious symptoms such as minor acting out and depression. These are often harder to notice with offenders and we spend little time focusing on these symptoms because we are busy with our daily duties. Also, we are use to seeing antisocial behavior so we may not associate that with being in crisis.

When offenders come to you in crises, how do you know what to do? What are you looking for? Is there a systematic approach to follow or do you simply 'go with the flow', letting offenders tell you their story? Are there different levels of crisis? When do you refer to a licensed psychologist? Can your safety be at risk? This training is designed to give you an understanding of what crisis is, the different stages of crisis, and how crisis intervention works. This process is important in the prison system due to the antisocial and often violent responses offenders may have to crisis. Even though the majority of us are not clinical psychologists we are first responders and see offenders in crisis on a daily basis. Indeed, our response may prevent a violent act or a suicide. If possible we want to intervene before the offender reacts in an antisocial manner.

The following KSA(s) apply to this training:

Competency 24

Establish rapport, including management of a crisis situation and determination of need for additional professional assistance.

Competency 26

Screen for psychoactive substance toxicity, intoxication and withdrawal symptom; aggression or danger to other; potential for self-inflicted harm or suicide; and co-occurring mental disorders.

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Competency 86

Apply crisis prevention and management skills.

CCJP - Domain 6 Section 10

Stabilize offenders in crisis through immediate intervention to ensure the safety of the offender and others.

To Get Us Thinking

Scenario #1

You are a counselor on a prison unit. You arrive at work one morning and are met by the Program Director and the Major. They inform you that an offender on your caseload created a serious disturbance in the dorm last night. The offender had awakened during the night around 2:00 A.M., screaming, throwing things, and then physically attacked another offender.

When you meet with the offender, he informs you that offender Doe, with the assistance of two other offenders, sexually assaulted him and threatened his life if he told anyone about it. The offender states he is having difficulty sleeping and is having suicidal thoughts.

Questions:

- Would you consider this offender to be in a state of crisis?
- How might you respond to this situation?
- What are some things you might do to follow up and make sure the offender is receiving the appropriate care?

Scenario # 2

You are a counselor on a pre-release unit. You have a 57 year-old male offender who has successfully completed the program and is waiting for his release to parole which may be anytime after the first of next month. Up to this point he has been a model participant, acknowledging his responsibility in the crime he is charged with, and has fully participated in the substance abuse program. This offender is always upbeat and lively. Two weeks ago his mother died. At first he seemed to take the news well enough, but now seems lifeless and withdrawn. He does not seem to associate with anyone, which is very unusual. He just does not seem himself. Other offenders have expressed their concern. You decide to call him in and talk to him.

Questions:

- Would you consider this offender to be in a state of crisis?
- What are you going to say to him? If he does not want to talk, what then?
- Do you just refer him to the unit chaplain?

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We will not answer these questions now. No scenario is going to have a standard answer. It will require adapting to the severity of the situation and adapting to the circumstance. The purpose of this course is to allow you to identify different elements of crisis and adjust and respond in the safest manner possible while effecting the best outcome.

The following material on Crisis Intervention was adapted from an article titled Crisis Management in the Community which appeared in The Medical Journal of Australia – Copyright 1997. Reproduced with permission.

Introduction

"Crisis" was first used as a specific term in psychiatry by Gerald Caplan^{1,2} after considering earlier evidence that survivors of severe trauma, such as those in Lindemann's study of the "Cocoanut Grove" nightclub fire in Boston in 1942, had much better outcomes if they received immediate psychiatric help.³ A "crisis" was seen as a brief non-illness response to severe stress, and "crisis intervention" emerged to detect maladaptive responses to crises and to convert them into effective coping and learning experiences.

	<p>The Cocoanut Grove was a nightclub in Boston, Massachusetts which, on November 28, 1942, burned in what remains the deadliest nightclub fire in American history, killing 492 people and injuring hundreds more. It was also the second-worst single-building fire in American history; only the Iroquois Theater fire in Chicago in 1903 killed more (602). The tragedy shocked the nation and briefly replaced World War II news headlines. The fire led to a reform of fire codes and safety standards across the country and prompted a seminal study of grief. The club's owner, Barney Welansky, who had boasted of his ties to the Mafia and to Boston Mayor Maurice J. Tobin, was eventually found guilty of involuntary manslaughter.</p>
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Caplan's concept of crisis was influenced by the theories of his time. It relied on concepts of disease rather than health, and on mechanistic theories from Freud and General Systems Theory regarding "homeostasis" and "equilibrium". But these limitations were far outweighed by Caplan's contribution in emphasizing the importance of preventive care, achieving mastery of the crisis, the social, cultural and material "supplies" necessary to avoid or resolve a crisis, and his pioneering advocacy of a community mental health approach.^{1,2,4}

What is a crisis?

Caplan's^{1,2} classic definition of crisis is an upset in the person's steady state provoked when an individual finds an obstacle to obtaining or achieving important life goals. This obstacle seems insurmountable, at least for a good while, by use of customary methods of problem solving.

A crisis is a period of transition in the life of the individual, family or group, presenting individuals with a turning point in their lives, which may be seen as a challenge or a threat, a "make or break" new possibility or risk, a gain or a loss, or both simultaneously. Most crises

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are part of the normal range of life experiences that most people can expect, and most people will recover from crisis without professional intervention. However, there are crises outside the bounds of a person's everyday experience or beyond the ability of their personal coping resources which may require expert help to achieve recovery.

The Development of Crisis Intervention

The field of Crisis Intervention has exploded since the 1970's. This growth has not been limited to professional human service workers. Many people and organizations have become involved in offering crisis intervention services (such as churches, community groups, business clubs, and schools) and joined in an effort to assist people who, for whatever reason, are struggling with problems and issues that overwhelm their ability to cope or lack access to available resources. This grass-roots type of development has led to the creation of larger numbers of programs. Examples of these programs include programs for medical problems, teen pregnancy, suicide prevention, rape, addictive behaviors, economic loss, divorce, and loss of relationships. The common element, whether a person is a trained professional or a volunteer, is to help the individual prevent maladaptive responses thereby helping to prevent possible future psychological disorders.

Psychiatric services cannot provide the entire range of crisis interventions required in our society. As communities, we should be encouraged to "look after our own" partly through a network of formal and informal crisis support structures. These should be carefully distinguished from emergency services.²⁴ The same holds true within the Texas Department of Criminal Justice.

Crisis Intervention is an outgrowth of three inter-related phenomena:

1. All people experience a crisis at sometime in life. Tragedy strikes regardless of ethnicity, socio-economic status, or gender; no one can insulate him-or-herself from crisis.
2. The geographic mobility for people in our society is such that people do not live close to their extended families. In the past, people in crisis would turn to family for support.
3. The reason for growth is that professionals have recognized that unless people satisfactorily resolve their reaction to a crisis situation, they may develop more invasive psychological problems.

Some professionals (James & Gilliland, 2001; Hobbs, 1984) believe that trauma has a neurological impact that can result in physiological changes in the brain. If untreated, such individuals may later experience a wide range of diagnosable mental illnesses. Though some dispute this idea, most agree that if a trauma is not treated it may progress into a mental illness or at least a disordered response in future situations.

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Types of crisis

Developmental crises: These are the transitions between the stages of life that we all go through. These major times of transition are often marked by "rites of passage" at clearly defined moments (e.g., those surrounding being born, becoming adult, getting married, becoming an elder, or dying). They are crises because they can be periods of severe and prolonged stress, as described by Tyhurst, another pioneer in this field,⁵ particularly if there is insufficient guidance and support to prevent getting stuck while in transit.⁶ In small-scale cultures, there is a sense of continuity and retained value in transitioning from before birth to beyond death (e.g., becoming an ancestral resource). In Western societies, rites of passage between these stages have become blurred, the extended kinship networks they depend upon for clear expression have become scattered, the cultural value ascribed to such transitions varies with occupational and economic status, and events surrounding birth and death tend to be experienced as clinical termini.⁶

Situational crises: Sometimes called "accidental crises", these are more culture- and situation-specific (e.g., loss of job, income, home, accident or burglary, or loss through separation or divorce).

Complex crises: These are not part of our everyday experience or shared accumulated knowledge, so people have greater difficulty coping. They include:

- **Severe trauma**, such as violent personal assault, natural or man-made disaster, often directly involving and affecting both individuals and their immediate and extended support network, observers and helpers.^{3,7,8}
- **Crises associated with severe mental illness**, which can increase both the number of crises a person experiences and sensitivity to a crisis. Reciprocally, the stress of crises can precipitate episodes of mental illness in those who are already vulnerable. Post-traumatic stress syndromes similar to those resulting from a disaster have been reported in some individuals⁹ after emergency treatment of acute episodes of mental illness.

Developmental, situational and complex crises may overlap, and one may lead to the other (e.g., a train driver distracted by being in crisis may make an error, causing a disaster).

Contention in the crisis literature

Controversy still surrounds the concept of crisis. The term defies consistent definition, and "crisis theory" is just that: mainly theoretical speculation based on descriptive accounts, with the cultural and clinical concepts of crisis deriving from seemingly different fields of inquiry. A personal crisis is not a clinical disorder. However, a severe or protracted response to crisis may lead to one (e.g., major depression; or, more commonly, an adjustment disorder,¹⁰ defined as the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor). Adjustment disorder should be

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distinguished from bereavement and other non-pathological reactions to crises which do not lead to marked distress in excess of what is expected, and which do not cause significant or lasting impairment in social or occupational functioning. Stress is not a synonym for crisis¹¹ as all people face stress as part of the human condition. By no means do all stressful experiences produce crises and the same type of stressor may be linked to crises, or even clinical disorders, in some people but not in others.

In contrast to crisis theory, some crisis interventions have been subjected to rigorous empirical study, demonstrating their effectiveness with specific problems (e.g., individuals and families seriously affected by mental illness).^{12,13}

Crisis intervention can no longer be seen as a unified strategy for care, as many divergent practices in different settings have developed since its origin, from walk-in clinics to mobile home intervention, but Waldron has identified a number of common features.¹⁴ These include rapid service, intense work in the short term, and a practical here-and-now therapeutic focus.

Stages of a crisis

Illustration 1 (pg 7) presents a summary of the main stages, from the pre-crisis steady state, to crisis disequilibrium, to re-establishment of a new steady state, hopefully at an equal or higher level of organization.¹¹ It is often reported that a crisis state lasts several weeks, usually subsiding within one to two months, if successful resolution occurs.

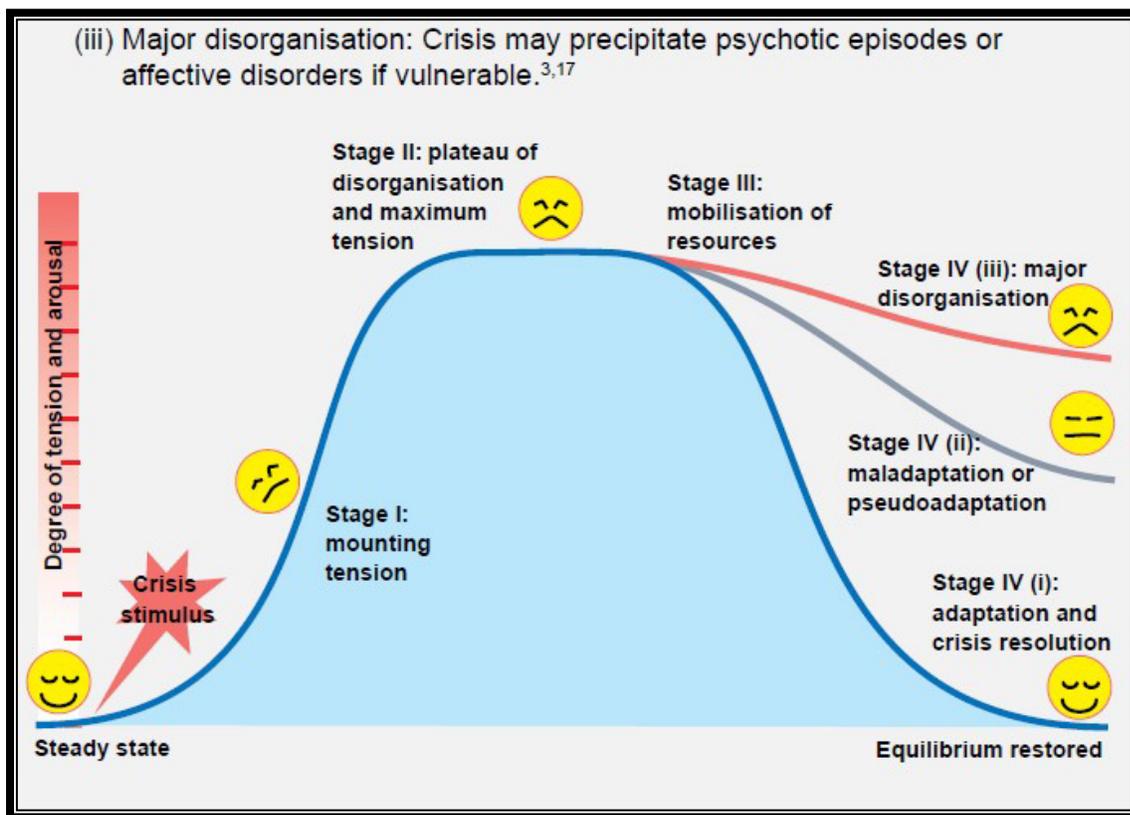


Illustration 1

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Homeostasis or Steady State

Stage I: Mounting tension

- habitual problem-solving responses in an attempt to maintain the person's steady state.

Stage II: Plateau of disorganization

- feeling anxious and ineffectual, "at sea", "chaotic" or "going mad"
- repetitive abortive attempts at problem solving
- stereotyped responses (like "hitting your head against a brick wall")
- increased dependence and ventilation needs

Stage III: Mobilization of all internal and external resources

- maximum arousal, heightened suggestibility, increasing vulnerability to good or poor advice
- emergency methods or creative, novel solutions may be attempted, resulting in a range of possible outcomes

Stage IV: Adaptation or maladaptation

- Crisis resolution: Adaptation to new circumstances. Stability and steady state restored at equal or higher level (most common outcome)
- Maladaptation: Superficial "closure" or reactivation of past crises¹⁵ or recurrent medical symptoms and treatments¹⁶
- Major disorganisation: Crisis may precipitate psychotic episodes or affective disorders if vulnerable.^{3,17}

When to Intervene

Primary prevention: Strategies aimed at preventing the development of psychiatric illness altogether may be appropriate for people experiencing developmental or situational crises who have limited personal, social or cultural resources. Bereavement counseling, telephone counseling services and "How to survive Christmas" seminars¹⁸ are examples of practical primary prevention interventions in the community.

Critical incident counseling may be offered to survivors or witnesses of traumatic events and disasters to prevent emergence of protracted grief reactions or post-traumatic stress disorder (PTSD),⁸ although efficacy in preventing PTSD remains unclear.

Secondary and tertiary prevention: Secondary prevention implies that a psychological disorder has already emerged, and aims at reducing the severity, duration or the risk of

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recurrent relapse. Tertiary prevention is aimed at reducing the disability care for a disorder that is already prolonged. Indications include:

- **People with early or acute mental illness** -- preventing suicide and promoting recovery for individuals whose constitutional vulnerability and life stressors may have tipped them into an episode of mental illness, which can be highly responsive to timely crisis intervention and appropriate treatment.^{9,10}
- **So-called "chronic outpatient attenders" or "chronic crisis repeaters"**, unnecessarily pejorative terms highlighting the frustration and attitudes of clinical staff towards these individuals who make frequent demands on services. It is often more economical and effective to provide intensive intervention at times of acute crisis rather than continuing unchallenging support of a long term sickness role. A significant proportion of these individuals may have been severely traumatized in childhood. Specific interventions to deal with the sequelae (i.e, pathological condition(s) resulting from a disease) of past abuse are still being developed and researched.
- **Patients with severe or prolonged psychiatric disorders** presenting with an acute exacerbation that may be precipitated by or cause a situational crisis. Defusing stressors by prompt crisis management (in conjunction with timely treatment, continuity of care and psychosocial rehabilitation) may prevent the build-up of disturbing symptoms, repeated life-disrupting hospitalizations, or suicide.^{9,12,13,15,17}

Practical management of a crisis

Crisis management is the entire process of working through the crisis to the point of resolution (Illustration 2 (pg 10)). It usually includes not only the activities of the individual in crisis but also the members of the person's social network.⁴ Not all crises require crisis intervention, which is that aspect of crisis management carried out by crisis workers (e.g., clinicians, counselors, police or chaplains).

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The process of crisis assessment and intervention

Assess crisis

- Type, severity and duration
- Psychiatric or physical symptoms
- Risk of harm to self or others

Assess resources available to the person in crisis

- Personal: buoyancy, resilience, experience, confidence
- Social: family, friends, colleagues
- Cultural: repertoire of cultural tools or rites of passage, extended kinship system
- Professional: doctors, counselors, community services. To be used when the person's other resources are insufficient for coping with the crisis. Sometimes people just need further encouragement to draw on their existing resources, and low-key monitoring of progress.

Intervention

(Most effective in Stage II of crisis — see Illustration 1 (pg 7))

Consultation

- Provide ease of access and intensive support, allowing dependence in the short term
- Arrange time to allow “ventilation”
- Encourage patients to express their fears and concerns
- Discourage evasion of the problem and assist in setting realistic goals for a solution
- Encourage patients to explore possible solutions and future directions and to feel empowered to make their own decisions in their own time
- Discuss and agree to a “contract” for managing the crisis — set time limits and specific goals
- Avoid over sedation or premature removal of tension with medication unless symptoms are disabling or medication is indicated for a psychiatric illness — otherwise, you may perpetuate a maladaptive solution

Network

- Maintain integrity of social network (involve family and friends, find substitutes for missing confidants) — this can only be done with the patient's permission
- Provide counseling, education and support to the patient's partner and family as required
- If necessary, coordinate the activities of other agencies to support the patient
- Provide 24-hour availability of patient support, via a rostered team or telephone service

Illustration 2

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Practical points in intervention: (Depending on your job duties, you may or may not be involved in the intervention steps).

- Intervention frequently involves a general practitioner and a community mental health team, possibly including a psychiatrist or inpatient unit. Negotiate early in the process to formally clarify who will coordinate it, and who will do which components of the assessment and intervention (whether general practitioner, mental health worker or psychiatrist).
- A hospital or community crisis service should carefully identify the general practitioner's needs, especially for prompt or extra support, while the general practitioner should respond promptly to the crisis worker's liaison calls.
- Include family or other social or cultural supports in both the assessment and the intervention if possible.
- Collaborate with the individual or family in crisis ("doing with" rather than "doing to") to promote their "ownership" of the crisis, and learning of new coping and communication skills.
- Allow tension -- allowing or even encouraging a tolerable degree of arousal, tension or dependence for a limited time is sometimes functional in promoting crisis resolution.
- The clinician's role in a crisis can sometimes involve undoing previous inappropriate or excessive clinical interventions (e.g., inappropriate diagnoses or types of treatment, or general overmedication causing unnecessary sedation or other side effects).
- When referring a person in crisis to a hospital psychiatric unit, ask for a crisis assessment rather than insisting on hospital admission, as home-based community management often results in a better outcome.
- Home visits, within defined parameters of safety, should be considered for accurate assessment and review, and more direct access to all participants in the crisis.
- A small list of the most important specific goals for the crisis intervention which are realistic and achievable within a limited time frame should be agreed in advance between all participants, with a copy to each, and with an interactive process and date for review.

If acute inpatient psychiatric care is needed, the same mental health professional(s) who engaged with the person in the community should be involved in the inpatient team (if possible) to make the transition easier and to ensure consistency of the clinical management plan agreed with the individual and family.

A crisis is different from an emergency

An emergency is a life-threatening situation demanding an immediate response. A crisis is often not immediately life-threatening and the timing of the response should be such as to include all participants in the crisis and existing or potential personal supports.

Appropriate personnel to respond to an emergency are Police, Ambulance, Fire or Hospital Emergency Departments, or State Emergency Services. Appropriate people to call in a crisis

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include general practitioners, community mental health professionals, community services officers, or lay crisis response organizations.

The appropriate type of early response in an emergency is life preserving: securing physical safety, removing the person from the source of danger, and defusing physical violence. In a crisis, the early response should be crisis assessment and support, defusing stress and interpersonal strife.

The use of the terms "crisis intervention" and "emergency psychiatry" are often confused by clinicians, and used interchangeably in the names and descriptions of services.¹⁷ But what difference does it make to patients and their families when they feel distressed and just know they need help now?¹⁹ In fact, they benefit by more appropriate referrals and settings for intervention when these distinctions are clearly made, while professionals are able to deliver such services more safely and effectively when they know the difference between a crisis response and an emergency response.

Sometimes there is an overlap between a crisis and an emergency. When there is any hint of a crisis turning into an emergency, it is considered a skill, not a failure, if a mental health professional or general practitioner chooses not to work alone and calls for expert advice, police assistance, or other emergency services.

The place of crisis intervention in psychiatric services

The evidence indicates that 24-hour home-visiting crisis response services should be integrated into local comprehensive services for people seriously affected by mental illnesses and their families.^{9,12,13,15,20} The potential for new learning and personal growth in this population and their families has probably been vastly underestimated, often by the clinicians involved.¹⁷ Systematic interventions to promote such new learning out of "using the crisis" of acute psychiatric episodes are being developed to reverse the potentially erosive effects of early psychosis on self-esteem, identity and related maturational tasks.^{9,19} Family problem-solving techniques aimed at acquiring new coping techniques in crisis have been shown to prevent relapses.^{20,21}

The principles of effective crisis intervention are consistent with current good practice in mental health services, regardless of the phase of care. There is evidence that people severely affected by psychiatric illnesses are much more likely to cooperate with interventions which are tailored to their individual needs, and when they feel listened to, are consulted and offered choices regarding types of proposed interventions. Cooperation is further enhanced when they and their families are provided with sufficient information and explanation, when time is taken to negotiate intervention goals, when low-key and low-dose interventions are offered (at home on their own "turf", if possible, rather than ours) and when the traumatizing effects of involuntary hospital admission and heavy sedation are avoided.^{6,9,12,13,22} Inpatient psychiatric care is sometimes essential but should be arranged on a voluntary basis if possible.

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Who should manage crises?

General practitioners, community workers, police, correctional officers, ministers of religion, counselors, as well as mental health professionals, are all in a position to be involved in crisis intervention. General practitioners are particularly well placed to help people in crisis and their families.

Should all crises be referred to psychiatric services? Emphatically no, although psychiatric services are most appropriate for people in crisis who have diagnosable psychiatric illnesses and who may be suicidal.

Firstly, psychiatric services do not have the resources or mandate to handle all crises in the community. There are community services for domestic abuse, children at risk, and sexual assault crises, non-government and church organizations dealing with couple, family, existential and spiritual crises, and networks for bereavement and disaster counseling.

Secondly, many people requiring help with crises do not wish to be seen by a psychiatric service or professional, which they may perceive as stigmatizing, and therefore adding to their troubles. When the crisis is not complicated by significant psychiatric symptoms, it may be managed with significantly better outcome by a general practitioner who has the person's trust and does not need to label the person with a psychiatric diagnosis.²³

Thirdly, some communal voluntary organizations run crisis hotlines (e.g., Lifeline) which may produce more timely referrals to clinical services, or care for people who would not present clinically. Whether they reduce the number of suicides is a more contentious issue. Peer-group and consumer-driven mutual support lines are developing further, via telephone "warm-lines", interactive radio, computer bulletin board chat-lines and the Internet. While these are a potential wellspring of support, they may make the caller feel more vulnerable through public exposure, and the recipients may feel helpless if their concern is ignored or abused by an anonymous caller. Arguably, basic training in crisis support and coping skills should be adopted as essential components of community and school education.¹⁴

Summation

We have covered information that directly impacts positions within the criminal justice system and information that lends understanding to the concept of Crisis Intervention. That said, let us go back to our initial scenarios and review them as Rosen suggests. The suggested responses may not be complete. Again, the majority of people taking this course are not psychologists, they are first responders. The answers try to reflect that.

Scenario #1

You are a counselor on a prison unit. You arrive at work one morning and are met by the Program Director and the Major. They inform you that an offender on your caseload created

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a serious disturbance in the dorm last night. The offender had awakened during the night around 2:00 A.M. screaming, throwing things, and then physically attacked another offender.

When you meet with the offender, he informs you that two weeks prior, offender Doe with the assistance of two other offenders, sexually assaulted him and threatened his life if he told anyone about it. The offender states he is having difficulty sleeping and is having suicidal thoughts.

Assessment and Intervention

Assess crisis

- Type, severity and duration
- Psychiatric or physical symptoms
- Risk of harm to self or others

This is a Complex Crisis associated with a severe trauma that may have occurred two weeks ago. There is obvious psychiatric distress though no immediate evidence of mental illness. There is potential risk to other offenders and to himself.

Assess resources available to the person in crisis

- Personal: buoyancy, resilience, experience, confidence
- Social: family, friends, colleagues
- Cultural: repertoire of cultural tools or rites of passage, extended kinship system
- Professional: doctors, counselors, community services. To be used when the person's other resources are insufficient for coping with the crisis. Sometimes people just need further encouragement to draw on their existing resources, and low-key monitoring of progress.

This offender seems to be in Stage II of his crisis – therefore, may be more receptive to an intervention (this may be why he has decided to open up about the assault at this point). He may be referred to a Security supervisor if he is interested in pursuing charges at this time. Security would have to be notified regardless if you felt the offender presented a danger to himself or other offenders. Since he is likely in Stage II, a referral to a Unit Psychologist may also be appropriate considering the severity of the trauma if you feel additional specialized counseling is appropriate.

Intervention

(Most effective in Stage II of crisis — see Illustration 1)

The offender will likely get little support from his peers – but may. Obviously this cannot be relied upon. Security staff generally has the best resources and experience to deal with a sexual assault. The process will involve a medical exam and written statement which can

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cause embarrassment and additional stress to the offender. However, completing this process, in time, will allow the offender to feel like he has regained some control over the situation. Security is also the best source to gauge any additional threat to the victim or other offenders and have policies on how to respond to such incidents. Again, the threat of suicide may warrant an appointment with the unit psychologist. You may also wish to notify the unit chaplain who also has training in this area. Don't underestimate your worth, perhaps by allowing the offender to disclose his assault it will alleviate his stress. Keep in mind, and notify the offender, if he mentions the names of his attackers you are obligated to report this incident and those names to security.

Consultation

- provide ease of access and intensive support, allowing dependence in the short term
- arrange time to allow “ventilation”
- encourage patients to express their fears and concerns
- discourage evasion of the problem and assist in setting realistic goals for a solution
- encourage patients to explore possible solutions and future directions and to feel empowered to make their own decisions in their own time
- discuss and agree to a “contract” for managing the crisis — set time limits and specific goals
- avoid over sedation or premature removal of tension with medication unless symptoms are disabling or medication is indicated for a psychiatric illness — otherwise, you may perpetuate a maladaptive solution

Depending on the situation, allowing the offender to “vent” and tell their story may resolve the crisis – it may not. It may or may not be appropriate in your position to discuss a “contract” or a plan of action to manage this crisis. It is certainly possible to follow up to see if your recommendations for additional treatment have been undertaken. However, do so with your supervisor’s knowledge so that there is no perception of impropriety or favoritism.

Network

- maintain integrity of social network (involve family and friends, find substitutes for missing confidants) — this can only be done with the patient’s permission
- provide counseling, education and support to the patient’s partner and family as required
- if necessary, coordinate the activities of other agencies to support the patient
- provide 24-hour availability of patient support, via a rostered team or telephone service

Generally in your position working with TDCJ, you will have no control of this “support network”.

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Scenario # 2

You're a counselor on a pre-release unit. You have a 57 year old male offender who has successfully completed the program and is waiting for his Projected Release Date (PRD) which may be anytime after the first of next month. Up to this point he has been a model participant, acknowledging his responsibility in the crime he is charged with, and has fully participated in the substance abuse program. This offender is always upbeat and lively. Two weeks ago his mother died. At first he seemed to take the news well enough, but now seems lifeless and withdrawn. He doesn't seem to associate with anyone which is very unusual. He just doesn't seem himself. Other offenders have expressed their concern. . You decide to call him in and talk to him.

Assessment and Intervention

Assess crisis

This is a Situational Crisis associated with his mother's death. Due to the offender's past behavior, there would appear to be no immediate threat to himself or others. The offender seems to have some social support evidenced by other offender's expressing their concerns.

Assess resources available to the person in crisis

This offender may be in a Stage I crisis but is likely just upset about his mother's death and has chosen to deal with that privately.

Intervention

An intervention here may not be appropriate. It may be appropriate to ask how he's dealing with the death and if he has utilized other resources such as the chaplain. You want to utilize good motivational interviewing techniques to allow the offender to express himself here.

Consultation

In this case, the unit chaplain may be the best person to refer the offender to. The chaplains are trained in grief management.

Network

Generally in your position working with TDCJ, you will have no control of this "support network".

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Scenario #3

As you know, we didn't have a scenario #3. Those of us who have worked for the agency for any length of time have seen an offender in crisis. Most have seen all types of examples from the benign to the extreme. So scenario #3 is your own example. Remember an incident of an offender in crisis and work through the steps. Compare what you did to what you might do now.

Assess crisis

Assess resources available to the person in crisis

Intervention

Consultation

Network

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Non-Violent Crisis Intervention and Verbal Intervention

To this point we have discussed what crisis is, how to identify an offender in crisis, what stage of crisis he may be in, intervention techniques, and some additional staff resources that may be available to you when the crisis deescalates.

Within the prison system, we must also prepare for offenders acting out in violent ways in response to stress. Working in a correctional environment already comes with inherent risk. No person working in a correctional setting should consider themselves immune from offender violence. This holds especially true when dealing with offender's in crisis. So far we have said little about the skills you need to utilize during the conversation with an offender in crisis.

Let's discuss some generalizations about offenders:

- Offenders may not or have not always practiced pro-social values (right living values). This not only relates to their criminal history but their social background (ie. substance use, gang involvement, family violence, etc).
- The "Offender Culture" is generally more violent compared to "general society." This violent tendency may be increased in certain prison setting.
- Offenders may suffer from undiagnosed mental illness. This mental illness may also be intertwined with a significant substance abuse history (Co-Occurring Disorders).
- Offenders are generally under some level of stress caused by their prison environment and pressure created by others around them.

These generalizations do not apply to every offender but they should be considered. It may be difficult to identify the signs that an offender is in crisis so it may also be difficult to identify signs that an offender may be violent or preparing to be violent.

Within the prison setting we are obligated to protect the welfare of our offenders, not only the offender in crisis but the safety and welfare of the offenders around them. We must also protect ourselves and other staff members around us.

This section will focus on the discussion with an offender – how to conduct yourself to lessen the chance of triggering a violent reaction and having a desired outcome.

Practical Steps of Non-Violent Crisis Intervention

The key to successfully implementing non-violent crisis intervention techniques is becoming involved in a potential problem as early as possible, before behavioral triggers and underlying emotional or psychological issues cause the offender in crisis to escalate and act out with violent behavior.

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Separation from the stressor is needed to help the offender in crisis de-escalate. The next step involves using the moment as a teaching situation. Talk the person through the incident in order to help bring his motivations, reactions and behavior into focus.

1. Isolate

Isolate the offender from the stressful situation or from others who may escalate the level of stress.

Remove the offender in crisis from the area. Whether the stressor that triggered the event is a person or situation or is not known, simply escorting the person in crisis from the location may be enough to begin the de-escalation process. This is not always easy in a prison setting but it is vitally important. Just providing the offender space to think is valuable.

Watch for signs that he is beginning to calm--dropped shoulders, unclenched hands, normal color to the face, slowed breathing rate, lowered volume and normal tone of voice. Watch for signs the offender may be getting more hostile or becoming aggressive—clenched hands, red face, raised volume, or anger now directed towards you or other staff.

In a prison setting you are not alone so ask for help—an offender is less likely to become assaultive if there are multiple staff members present. Remember too that security staff has experience dealing with disruptive offenders and has many policies in place on how to respond to these types of situations. If the offender appears to be imminently hostile, let security take the lead and allow them to do what they have been trained to do.

Attitude:

- Be professional
- Monitor Non-Verbal Communication Skills – watch the offenders body language, for your safety - your body language should be used to calm the offender, not to challenge them and escalate the situation
- Personal Anger Management - Stay calm and manage your emotions
- Be polite & respectful
- Be patient
- Be prepared to adapt to diverse people's needs and behaviors
- Carry yourself in a manner that conveys professionalism rather than authority.

Listening skills

- Listen carefully for feelings as well as words
- Note body language cues
- Listen attentively

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Verbal skills

- Create a positive atmosphere, when possible
- State who you are and why you are there
- Speak clearly, using vocabulary the client will understand
- Advise that you are there to help
- If required, set limits that are clear, reasonable and enforceable
- Smile or use humor if appropriate
- Do not argue or place blame
- Use appropriate gestures
- Control the pitch and volume of your voice to demonstrate your calm and control.

2 Talk It Out

Allow the offender to voice his problem.

Remain with the offender in crisis and ask him to describe what led to the behavior in question. Encourage calm body language. Ask the offender to take a breath and to speak slowly so you may better understand. Ask that the conversation be held in a normal speaking voice. These displays of calm will help lead to greater equanimity. Remember this step involves more listening than talking.

Practice active listening. Use the offender's own words to repeat to him what you heard about the problem and the related feelings he describes. Listen without judgment and without correction; the point is to allow him the opportunity to speak freely and express a personal point of view.

Communicate statements of empathy for the problem and the feelings expressed. Statements beginning "I understand you thought..." or "I am sorry you felt..." allow the person in crisis to feel validated, less alone and may help him to open up and provide further details or insight into the situation.

Attitude

- Again, be professional
- Be objective - be prepared and know the facts
- Be polite
- Be respectful of persons
- Be patient
- Be encouraging
- Be positive
- Be prepared to adapt to diverse needs and behaviors
- Stay calm and manage your emotions
- Be open and non-defensive
- Be empathetic, not sympathetic
- Tell them to take a few deep breaths, and exhale slowly

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- Stay calm, and speak in a calming voice
- Let them vent frustrations (In a reasonable manner)

Listening skills

- Listen carefully for feelings as well as words
- Note body language cues (maintain a safe distance)
- Listen attentively
- Do not interrupt
- Keep an open mind

Verbal skills

- Create a positive atmosphere, when possible
- Speak clearly, using vocabulary the client will understand
- Advise that you are there to help
- If required, set limits that are clear, reasonable and enforceable
- Help offenders dismiss unfounded worries so that you can address the problem
- Smile or use humor appropriately
- Allow offenders to vent (In a reasonable manner)
- Do not interrupt unless necessary
- Do not argue or place blame
- Do not accuse, use sarcasm or threaten
- Do not give false reassurance
- Ask open-ended positive questions, (use Motivational Interviewing Skills)
- Clarify where necessary
- Probe to ensure full understanding of the situation. Attempt to get at the reasons for acting out
- Paraphrase to ensure your understanding of the client's perspective. Do not interpret or explain what the client feels, said or did
- Openly acknowledge differences of opinion
- Focus on common ground. Do not get bogged down in differences
- Do not judge
- Do not send conflicting messages
- Have the offenders help generate strategies to address the problem
- Ask for more than one solution
- Focus on solutions, not personalities
- Do not pressure offenders into quick decisions
- Ensure that the pros and cons of options are explored
- Summarize to ensure an understanding of your agreement

Non-verbal communication skills

- Note your offenders' non-verbal cues
- Use appropriate gestures
- Smile or look in control, as appropriate

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- Do not frown, shift nervously or finger tap
- Allow the offender an appropriate amount of space
- Keep eye contact
- Use your body language to indicate you are in no hurry as appropriate
- Carry yourself in a manner that conveys professionalism rather than authority.
- Use tone indicating a positive attitude, authority, or empathy, as appropriate.
- Control the pitch and volume of your voice to demonstrate your calm and control.
- Use silence as appropriate.

3 Mediation

When the offender calms, you need to bring about some sort of resolution. Discuss the specific behaviors involved in the situation, what the offender in crisis was feeling in the moments before and during the behavior and what the person was thinking. Attempt to identify the feelings in order to tie the outward behavior to the underlying or hidden emotion that motivated the behavior.

It is not always possible to solve the offender's problems or reason for crisis. Instead, this situation should be viewed as a "teachable moment." Discuss possible coping skills that could be used if the same situation were to occur again. Explain acceptable ways to express emotion and to work through feelings. Some methods include using a journal to record feelings (instead of allowing them to build to a crisis point), physical exercise (to vent anger or prevent physical outbursts) or crumpling paper (instead of breaking items).

At this point you may be called upon to make some key decisions. Is this offender still a threat to himself or others? Can I put him back in his housing assignment or does he need to be isolated? Do I need a psychological referral?

Mediation techniques

- Tell them to take a few deep breaths, and exhale slowly.
- Stay calm, and speak in a calming voice
- Demonstrate body language shows you are listening
- Explain that you would like to hear each side of the story
- Do not give advice
- Do not solve their problem for them
- Establish the ground rules
- Listen respectfully
- Avoid judgment, blame or ridicule.
- Summarize
- Clarify
- Paraphrase
- Encourage the offender to write down their thoughts to better resolve the problem

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4 Self Evaluation

As we have stated, if you work in a prison setting for any amount of time, you will be exposed to individuals in Crisis. Though every situation is different, this step should be viewed as a competency builder. What did I do right? What did I do wrong? Here are some questions to consider:

Have I prepared myself by:

- developing a plan of action to maintain a professional and non-antagonistic approach
- avoiding "Common Thinking Traps" such as:
 - All or Nothing Thinking – Thinking that “you” can solve the offender’s problems right here and now
 - Thinking “you” can read the offender’s mind and knowing what he will do
 - Emotion Reasoning – you want to believe an offenders crisis is real when evidence suggests otherwise
 - Jumping to Conclusions
 - Destructive Labeling – you don’t help him because you think he is a gang member
 - Magnification – Seeing a situation as something bigger than it really is – therefore your response is an overreaction

Have I handled "Confrontational Points" by:

- not allowing myself to take it personally
- defusing the situation
- staying in control
- recognizing my body's anger signals (i.e. muscles getting tense)
- using breathing and relaxation techniques to stay in control

An Assault is Possible

There may be any number of reasons an offender may assault staff. Three common reasons are:

1. They want to get separated from general population offenders and assaulting a staff member will accomplish that.
2. Retaliation for some “wrong” they feel the staff member has done them.
3. They are in crisis, and hitting someone, including a staff member, is one type of reaction to the stress.

As we have already stated, there is inherent risk when working in a prison facility – especially when dealing with an offender in crisis. Trust your instincts – if it doesn’t feel

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right – it may not be. In this setting your safety comes first. Remember some of these basic rules:

- Call for assistance. Have security or another staff member present.
- Stay well out of striking distance.
- Watch the offender's body language (balled fists, failure to look into your eyes, waving his arms around while he talks, etc.). Ask the offender to calm down and keep his hands by his side while you talk with him.
- Under certain conditions, the offender may need to be restrained (handcuffed) before you should talk to them. Security or your organizational policies should dictate your actions.
- Don't allow the offender to put his hands where you can't see them (i.e., down his pants or behind him) and be constantly vigil for foreign objects or weapons.
- Don't isolate an offender in crisis behind closed doors. Make sure you are always within sight and sound of other staff members.
- Play the "what if" game constantly. (What do I do if....)
- If possible, make sure those other staff members know what your doing before you separate the offenders so they can help you be vigil.
- If required utilize force to protect yourself and the offender. Know, understand, and follow your Agencies Use of Force Policies.
- If you are assaulted – protect yourself as best you can.

The point to this section is to provide you with some tools to keep yourself and the offenders safe. Hopefully the crisis intervention tools taught in this class will allow you to deescalate a crisis before violence occurs. But we can not be naive. We must recognize that a worst case scenario can happen but be willing to utilize the tools to lessen the likelihood that violent incidents occur.

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