

Mental Health Awareness for Prison Staff

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Contents

	Page
List of Illustrations	4
Executive Summary	5
Introduction	8
Context	8
Methodology	10
Procedure	10
Delivery	12
Evaluation	12
Recommendations	13
Developing the Roles	14
Roles in mental health awareness in prisons	14
Developing Training Content	19
Delivering the training to support roles	19
Evaluation	26
Participants	26
Prior knowledge and reasons for attendance	26
Methods of delivery	29
Appraisal of topics covered	34
The learning	40
Influence of training on practice	40
Taking the package further	43
Final comments	44
Recommendations	47
Conclusion	51
References	52
Appendices:	
Example of national roll-out plan	55
Video scenarios	58

List of Illustrations

		Page
Tables	Table 1: Mental health care pathways in prisons (Paton, 2004)	14
	Table 2: National occupational standards for mental health pertinent to the prison environment	15
	Table 3: Development of training content to support roles	19
	Table 4: Changes made during the evaluation to course content, style and delivery	22
	Table 5: Ratings given to topics discussed in mental health awareness training	35
Graphs	Graph 1: Previous knowledge of mental health issues for trainees on the mental health liaison officer course	27
	Graph 2: Previous knowledge of mental health issues for trainees on the assessor course	28
	Graph 3: Reasons given by trainees for attending the mental health liaison officer course	29
	Graph 4: Had participants heard of the ACCT assessment tool? ...	36
	Graph 5: Amount of contact respondents have with prisoners who harm themselves	38
	Graph 6: Practicality of the material describing crisis management	39
	Graph 7: Usefulness of crisis prevention material	39
	Graph 8: 'I think this training will make a difference to the way prisoners are treated'	42
	Graph 9: Overall rating of the mental health liaison officer training package	44
	Graph 10: Overall rating of the assessor training package	45
Diagrams	Figure 1: Procedure adopted in developing the mental health liaison officer role and mental health awareness training for prison staff	10
	Figure 2: Action research framework adopted for the delivery and evaluation of training	13
	Figure 3: Proposed structure of regional prison mental health forums	56
	Figure 4: Mental health awareness for prison staff national roll-out	57

Executive Summary

Background

Mental ill health has a high prevalence in prison populations. It is thought that around 90% of the 74,000 prisoners in the UK suffer mental health problems, substance abuse problems or both (DoH, 2001). The quality and effectiveness of prison health care, and in particular mental health care, is variable and prisoners often do not receive appropriate care (DoH, 2001; Plant et al., 2002). Training and support on mental health awareness is needed for all prison staff, particularly wing-based officers, to help them:

- Identify prisoners at risk of developing mental health problems;
- Identify prisoners experiencing mental health problems;
- Respond appropriately to the needs of these prisoners.

Underpinning this is the notion that prisoners should receive the same level of mental health care as those in the general population.

Introduction

The Institute of Health and Community Studies (IHCS) at Bournemouth University was commissioned by the Department of Health, Prison Healthcare, to develop a training package addressing mental health awareness for wing-based prison officers in order for them to take on the new role of mental health liaison officer.

In addition, material developed for this package was used in conjunction with training for the new Assessment Care in Custody and Teamwork (ACCT) plan and psycho-social assessment tool being developed by the Safer Custody Group.

The three-day training package was developed by IHCS staff incorporating the following:

- Introduction in Mental Health (including general introduction to the course and topics, misconceptions surrounding mental health, legal issues);
- Self-Harm and Suicide Awareness (including the influence of attitudes);
- Skills Training (including interview skills, crisis prevention, risk assessment and risk management);
- Mental Health Awareness (identifying signs and symptoms attributable to mental illness, maintaining positive mental health,

basic types of care/management, referral practices and resources, care plans, and where to find further information).

Delivery

The training (combined with the ACCT Plan material) was initially delivered to five pilot sites: HMP Woodhill, HMP Holme House, HMP Low Newton, HMPYOI Feltham and HMP Wandsworth. The training for mental health liaison officers was delivered to 24 participants from 8 establishments at two central locations (London and Manchester). Evaluation of the course took place concurrently using an action research framework. The preliminary findings generated evaluative data which was incorporated into the package by the facilitators and formed the basis for subsequent training

Evaluation

Knowledge acquisition and use

Participants in the training described their new knowledge as being transferable; not just limited to one personal or professional area but crossing all boundaries and relationships both internal to the prison setting and in external agencies. The training package facilitated new knowledge and insight not just in terms of context of the material presented but importantly in the processes of attending and participating, and sharing good practice. Participants with some previous mental health knowledge (up to degree level) also found the package relevant and useful, in addition to commenting that it was well presented.

Delivery of information

The delivery of information was highly praised by respondents; the listening skills of the tutors were appreciated, especially in relation to concerns about the ACCT tool. The use of slides, group and pair work, and role play was felt to enhance learning as well as providing stimulation. The information was frequently described as being 'pitched' at the correct level for all the participants and delivered at the right pace. Participants repeatedly described enjoying their training days, as well as learning a great deal.

In conclusion, the training package seems to have been successful in targeting and clearly addressing identified learning and training needs within the prison settings. There is strong evidence supporting the use of the package country wide. However, the impact on patient care and the effect on the support and referral of inmates need to be further monitored. This is being undertaken through ongoing evaluation and in-depth case study research.

Further Work

Findings from the evaluation of the course highlighted the following areas for further work:

- Investigate the relationship with other courses;
- Investigate the possibility and feasibility of accreditation;
- Examine how the course could be adapted for other custodial staff;
- Develop a quality video to accompany the course;
- Examine the effects of the course content being tailored to national or local issues;
- Study ways of allowing the course knowledge to become embedded in practice.

Introduction

Context

It has long been noted that standards of health care within prisons do not match those available to the wider population (see Smith, 1984). Reed and Lyne (1997) found that although some prisons had health care of equivalent standard to the National Health Service, many did not. There was evidence of poorly trained doctors, poor quality services and failure to meet standard ethical procedures. The quality of mental health care has been a particular problem (Health Advisory Committee for the Prison Service, 1997; Plant et al., 2002). This is alarming given that the level of need for mental health services is extremely high in prisons.

The Office for National Statistics surveys from 1997 and 1998 state that 90% of prisoners have a mental illness, personality disorder or alcohol/drug dependence. Often, prisoners have a combination of multiple disorders in addition to substance misuse (often referred to as dual diagnosis) (DoH, 2001; Maden et al., 1995; Singleton et al., 1998). Singleton et al. (1998) cite that 9% of male prisoners and 13% of female prisoners suffer with schizophrenia, compared with around 0.5-0.8% of the population in general (Singleton et al., 2001). Furthermore, Singleton et al. (1998) cite as much as 59% of male prisoners and 76% of female prisoners suffer a diagnosable neurotic disorder compared with 13.6% of males in the general population and 19.4% of females in the general population (Singleton et al., 2001). As much as 78% of male prisoners and 50% of female prisoners suffer a personality disorder, compared with 5.4% of males in the general population and 3.4% of females in the general population (Singleton et al. 2001). In addition, 15% of male prisoners and 30% of female prisoners attempt suicide per year and 5% of male prisoners and 10% of female prisoners self-harm (Singleton et al. 1998). With the current prison population being around 74,000 and around 200,000 people flowing in and out of prison each year, the extent of the problem is large.

A recent Department of Health publication *Changing The Outlook* (DoH, 2001) states the need for the National Health Service (NHS) and Prison Service to work in formal partnership to overcome these difficulties, not least in the mental health arena. Standards of mental health care in prisons must meet the criteria set out in the National Service Framework for Mental Health, which states that local services must explore opportunities to 'improve mental health care for prisoners within existing resources' (DoH, 1999, p9).

Paton and Jenkins (2002) suggest that this can happen through:

- Supporting the governor and other staff to develop an environment that supports mental health and well-being (standard 1);
- Identifying prisoners with mental and substance abuse disorders (standard 2);
- Managing prisoners with common mental disorders (standard 2);
- Referring appropriately for assessment, advice or treatment (standard 2);
- Working with diverse groups of patients from many different cultures;
- Providing information and guidance for those who provide regular and substantial care for prisoners with mental health problems – in prison, often staff as well as family members (standard 6);
- Contributing to the multidisciplinary work to prevent suicide (standard 7).

In addition, it is anticipated that, despite the scale of need within the prison population, the majority of mental health issues could be addressed within prison and do not require hospitalisation (DoH, 2001).

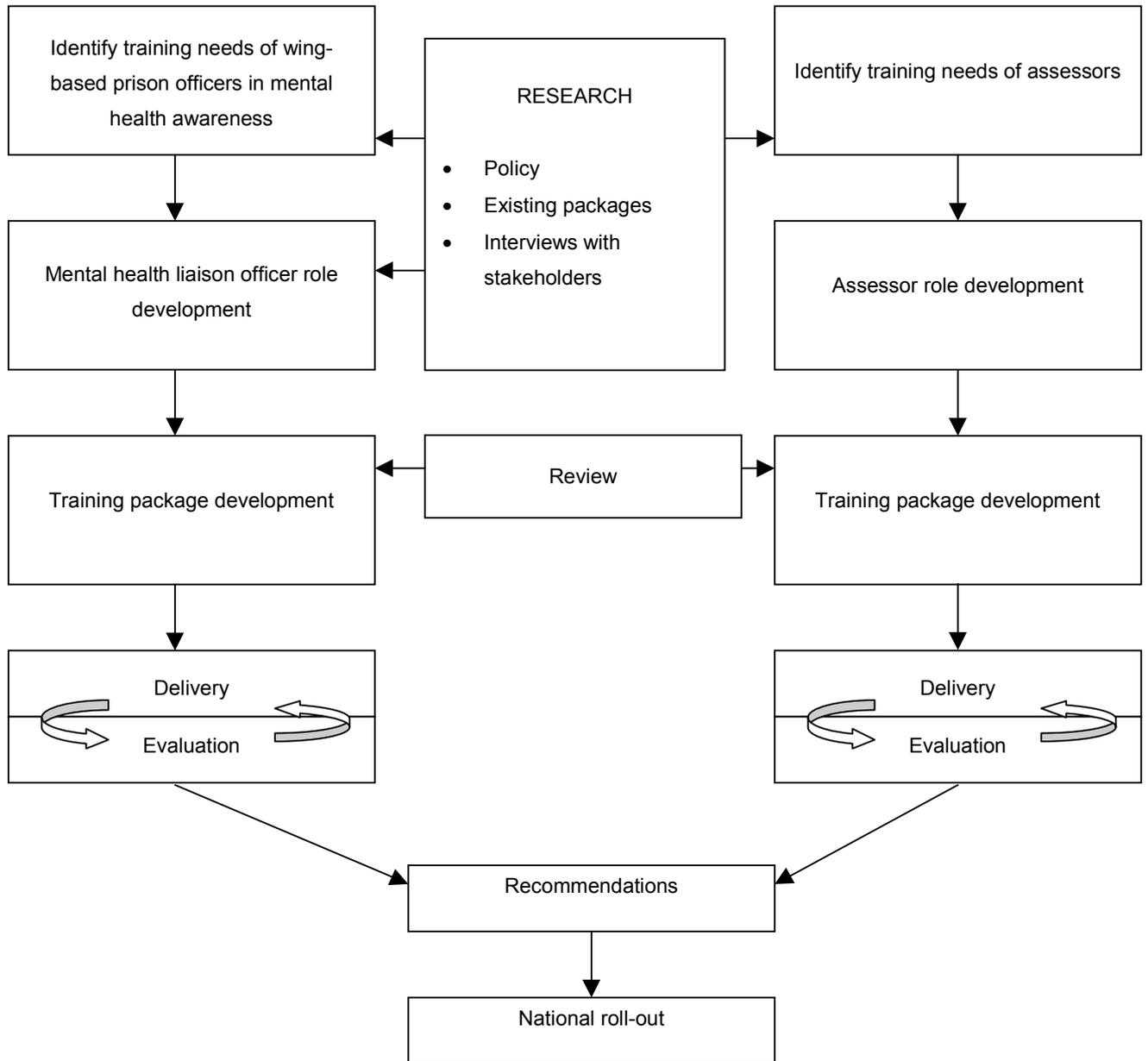
It is argued that there is a need for training and support for all prison staff in mental health awareness. This is a particular need for wing-based officers to help them:

- Identify prisoners at risk of developing mental health problems;
- Identify prisoners experiencing mental health problems;
- Respond appropriately to the needs of these prisoners.

Underpinning this is the notion of equality; that is to say that prisoners should receive the same level of mental health care as those in the general population.

Methodology

Figure 1. Procedure adopted in developing the mental health liaison officer role and mental health awareness training for prison staff



Procedure

The methodology followed the procedure and processes laid out in Figure 1. To identify mental health needs and develop roles, an action research framework was adopted using concurrent data collection methods as follows:

- Scoping exercise of current policy initiative within prison health care, secure environments and policy directives (as outlined in the introduction);
- A review of current mental health packages and literature including:
 - Mental Health Primary Care in Prisons (Paton and Jenkins, 2002);
 - Mental Health Training Pack (Keir et al., 2002) developed for HMP Winchester;
 - Mental Health Training for Prison Staff (Wilson, 2003) developed for HMP Morton Hall;
 - Mental Health Awareness Training for Custodial Staff (Hayley, 2004)
 - Screening for Mental Illness in the Youth Justice System (University of Manchester) developed for the Youth Justice Board;
 - Introduction to Mental Health (Pearson and Sheers, 2003) developed for HMP Bristol;
 - Skills-Based Training on Risk Management (STORM) (Victoria University of Manchester, School of Psychiatry) developed for HM Prison Service commissioned by Safer Custody;
 - Mental Health First Aid Manual (Kitchener and Jorm, 2002) developed by Mental Health Research at the Australian National University, Canberra, Australia;
- Interviews with key stakeholders, including prison staff, mental health trainers, Department of Health Prison Healthcare staff and Safer Custody staff.

An outline of two new roles addressing mental health issues in prison was then developed, these being the mental health liaison officer role (IHCS) and the assessor role (Safer Custody).

Taking into account a review of current training packages, the findings of a previous study mapping the mental health training across the south west region (Musselwhite et al., 2004), and the development of the new roles, a training package was developed to support each of the two new roles. This encompassed the main areas of need with regard to supporting high quality mental health assessment and care in prisons. A final training package was then developed to cover awareness in mental health which supported both roles.

Delivery

An experienced senior clinical nurse specialist was appointed to the role of trainer and delivered the package across all sites. Mental health awareness training for assessors was delivered to 53 trainees on site at five prison establishments; namely HMP Woodhill, HMP Holme House, HMP Low Newton, HMPYOI Feltham and HMP Wandsworth. The majority of participants were aged between 31 and 50 years old. Over a third of participants were prison officers. Other significant groups were nurses/health care officers and those working within the field of psychology.

Mental health awareness training for mental health liaison officers was delivered at two locations away from the prison establishments. HMPYOI Feltham, HMP Bristol, HMP Morton Hall and HMP Birmingham were invited to send staff to the City Inn, London, at the beginning of March 2004. HMPYOI Glen Parva, HMP Hull, HMP Liverpool and HMP Lincoln were invited to involve their staff during late March 2004. A total of 25 prison staff attended the training. Originally, the training was designed to support a role aimed at wing-based discipline officers. However, due to requests from establishments, other discipline officers, health care staff and nurses also attended.

All training was delivered over three consecutive days, totalling around 18 hours of face-to-face contact.

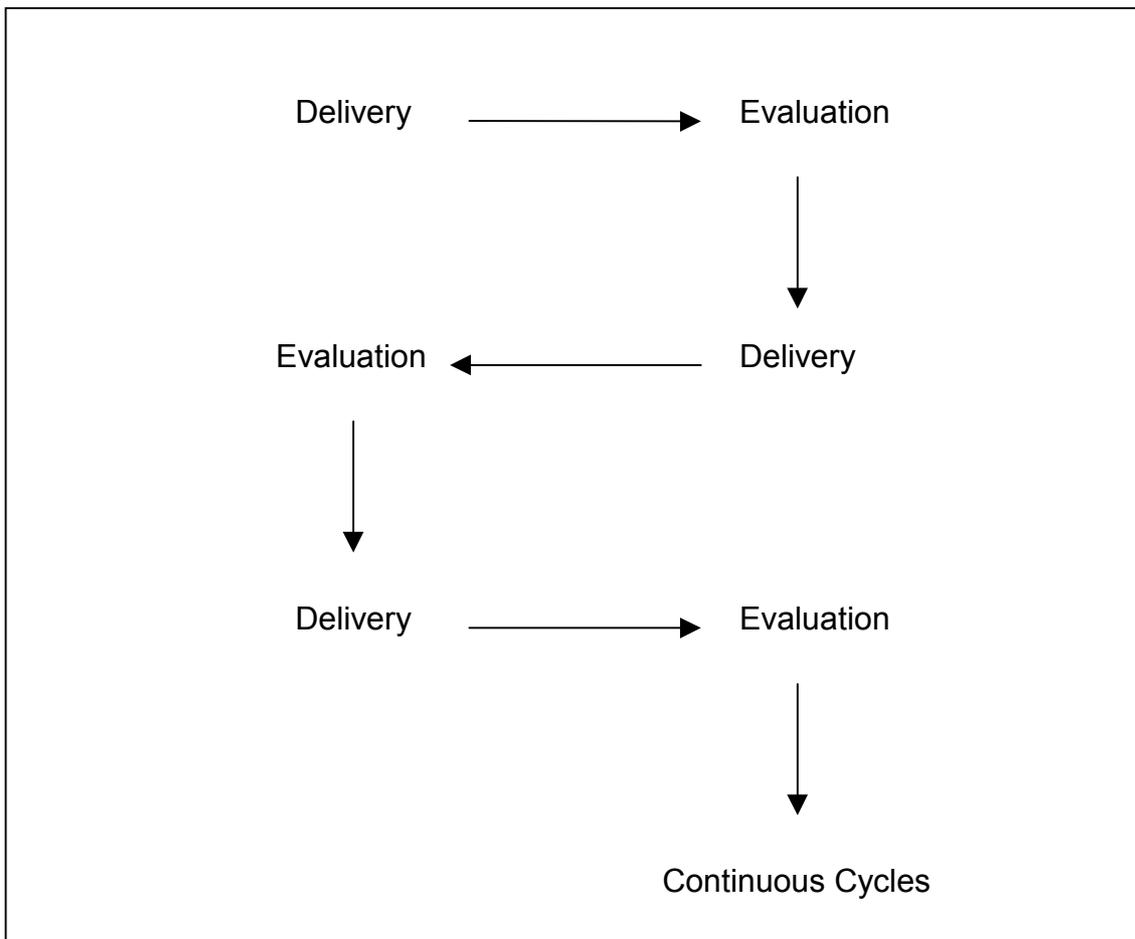
Evaluation

Questionnaires were developed to establish an in-depth evaluation of both types of training. These were given to each participant on completion of training to assess the trainees' attitudes to the following issues:

- Methods of delivery;
- Previous knowledge and experience of mental health;
- Satisfaction with each module and area covered in the package;
- Overall length and logistics of the training days;
- Confidence in being an assessor or mental health liaison officer and how much the training prepared them for that role;
- Confidence in putting the training into practice;
- Overall issues and concerns with the training package.

In all cases, an action research framework was adopted during the evaluation period, whereby evaluative findings from the trainees and trainer were used to inform the development of future delivery through formative action cycles (see Figure 2). Following each training session, data from the evaluation were analysed along with the trainer's opinions. Key issues and concerns informed subsequent delivery of the package in the next training session. On completion of the final pilot training session, a final version of each package was created.

Figure 2. Action research framework adopted for the delivery and evaluation of training



Recommendations

The evaluation highlighted a number of key recommendations for the future development of roles and the national roll-out of such training.

Developing the Roles

Roles in Mental Health Awareness in Prisons

Table 1 outlines mental health care pathways in prisons (Paton, 2004), which suggests that packages aimed at assessors and mental health liaison officers should include all aspects outlined at Levels 1 and 2. In addition, guidance from the Sainsbury *Capable Practitioner, Skills for Health* (SCMH, 2001) document and *National Occupational Standards for Mental Health* (Skills for Health, 2004) have been used to create the roles. *National Occupational Standards for Mental Health* (Skills for Health, 2004) were also included because they have specific standards identified for working in prisons (see Table 2).

Table 1: Mental health care pathways in prisons (Paton, 2004)

Level	Task	Personnel
Level 1: Recognition of mental health problems and of suicide risk	<ul style="list-style-type: none"> • Recognise when someone has symptoms of mental distress/disorder and/or is at risk of suicide • Reach out and engage in a supportive relationship • Identify the presence of suicidal thoughts ◆◆ Facilitate links with people who do first line helping interventions, i.e. with Level 2) 	All staff in contact with prisoners
Level 2: First line helping intervention (assessment and crisis management)	<ul style="list-style-type: none"> • Estimate level of risk • Attend to the person's pain and distress • <u>Work with the person</u> to promote their immediate safety • Address and contain those aspects of the current situation affecting health and safety • Facilitate links with family (if supportive), friends, peer supporters, professional help. ◆◆ Help plan care on the wing/unit (jointly with those at Levels 3 and 1 and individuals themselves) 	Some staff: ACCT assessor teams, mental health liaison officers, senior officers/wing managers, probation, psychologists, chaplains, teachers, workshop managers, general nurses

cont.

Table 1 cont.

<p>Level 3: On-going care (less challenging/ complex cases)</p>	<ul style="list-style-type: none"> • Provide counselling, treatment or therapy ◆◆ Consult with and be a resource for people at Level 2 (and 1?) ◆◆ Obtain information from and pass it to health care providers outside prison 	<p>Primary care RMNs, GPs, primary care mental health workers (e.g. health psychologists), some chaplains, psychologists (who may be offering interventions for self-harm). Some staff will work across the boundary of Levels 2 and 3</p>
<p>Level 4: On-going care (more challenging/ complex cases)</p>	<ul style="list-style-type: none"> • Provide counselling, treatment or therapy • Care programme approach ◆◆ Consult with and be a resource for people at Level 3 (and 2?) ◆◆ Obtain information from and pass it to health care providers outside prison 	<p>Mental health in-reach staff, in establishments with no in-reach, community mental health services</p>

Table 2: National occupational standards for mental health pertinent to the prison environment

<p>H3: Enable people with mental health needs to develop coping strategies</p>
<p>N4: Work with others to facilitate the transfer of individuals between agencies or services</p>
<p>O2: Co-ordinate awareness raising about mental health issues</p>
<p>O10: Represent the agency in courts and formal hearings</p>
<p>B2.1: Enable people to access and benefit from services</p>
<p>B3: Contribute to establishing and running mutual support networks</p>
<p>D5.1: Determine the physical health needs of people with mental health needs</p>
<p>E6: Work with individuals with mental health needs to negotiate and agree plans for addressing those needs</p>
<p>E9.2: Work with individuals to monitor their mental health needs</p>
<p>E9.3: Identify and agree any changes to care programmes</p>

The role of a prison mental health assessor

Safer Custody was responsible for development of the Prison Mental Health assessor role to support the new Assessment Care in Custody and Teamwork (ACCT) policy and procedure in suicide and self-harm assessment.

An ACCT assessor works primarily as a support to residential staff, helping them to decide on appropriate care to meet the individual needs of prisoners and (jointly) making the decision as to who should be referred to healthcare and who should not be.

The ACCT assessor is a member of the multi-disciplinary team made up of discipline officers and other staff, such as chaplains, probation officers, psychologists and nurses. From time to time, in accordance with local procedures, the ACCT assessor will be called to carry out an assessment and, for that period only, will be unable to carry out his or her normal duties. The tasks of an ACCT assessor are to:

- Respond to a prisoner identified as suicidal, who has self-harmed or who is considered to be vulnerable/at risk for another reason (e.g. may have a mental disorder).
- Interview the individual; build a rapport with him or her; explain the purpose of the interview; discuss confidentiality and information sharing; explore the problems he or she is experiencing from their own point of view; explore possible signs of depression, suicidal thoughts, intent and plans; explore the prisoner's views of their strengths, resources and what might help them; and, while carrying out the interview, observe the prisoner for signs of psychosis.
- Before or after the interview, gather risk-pertinent information from wing staff/wing file/core record. For example, received or expecting long sentence; violent offence especially murder of family member; breach; recall; isolated on wing and from health care staff (including current or recent psychiatric treatment); drug/alcohol dependence; and evidence of painful or terminal physical illness.
- In conjunction with the prisoner and the residential manager, estimate the level of risk of suicide (low, medium or high) and draw up a care plan. This should include, where considered appropriate, referral of the prisoner for mental health assessment and care.
- Establish good working relationships with residential staff and with other colleagues, especially those to whom a referral may form part of the care plan, including health care staff.

Staff considered for this role should have the following attributes:

- A commitment and dedication to the role and its development;
- An understanding of the operational procedures relating to this role and how the role will integrate with their normal duties;

- An experience of coming into contact with suicidal or self-harming individuals in the prison setting;
- An interest in personal/professional development, showing a willingness to learn;
- Good interpersonal and interviewing skills;
- A willingness and ability to work in a multi-disciplinary way, sharing information appropriately and sensitively with others.

The following procedures must be in place for an ACCT assessor to be able to work:

- Clear and agreed protocols to allow appropriate relevant information to be shared by health staff with ACCT assessors;
- Agreed referral protocols to ensure fast access to mental health care for prisoners in cases of emergency;
- Procedures that maintain a degree of security of ACCT plans.

Two sets of competencies were outlined: a short 24-hour version of the assessment and a full assessment.

Competencies required to conduct the 24-hour (triage) assessment:

- Initial assessment of crisis, including interview skills, listening skills, initial risk assessment and management;
- Formulation of initial (non-clinical) 'holding' care plan in conjunction with others;
- Communication skills with residential staff and wider team;
- Knowledge base of common mental health problems and ability to undertake brief mental state examination using a structured tool.

Competencies required to conduct the full assessments:

- Working knowledge of mental health problems allowing conduct of a full ACCT assessment using a structured tool (if they have no formal mental health qualifications) or unstructured assessment (if they do have formal mental health qualifications);
- Ability to formulate a primary care plan with clinical elements, in conjunction with multi-disciplinary team/clinical supervisor/health care link;
- Enhanced case management skills – co-ordinate care, hold reviews, formulate care plans for prisoners with primary care level mental health components/needs.

The role of a mental health liaison officer

Staff at the Institute of Health and Community Studies (IHCS), Bournemouth University, were responsible for developing the mental health liaison officer role. In addition to their normal duties, the mental health liaison officer should also be able to:

- Create an awareness of prisoners with the potential risk of developing, and those who may already be experiencing, mental health problems;
- Take a lead on being the first point of contact for issues surrounding prisoners' mental health;
- Offer evidence-based guidance, support, information and knowledge on prisoners' mental health issues to other colleagues on the wings;
- Establish good working relationships, communicate and assist formally and informally with other colleagues such as other discipline officers, health care staff, psychologists and ACCT assessors on mental health issues;
- Respond appropriately, within their sphere of competence, to the mental health needs of prisoners.

The officers considered for this role should demonstrate the following:

- A commitment and dedication to the role and its development;
- An understanding of the integration of this role into their 'normal duties';
- An experience of coming into contact with mental health issues in the prison setting;
- An interest in self/personal/professional development, showing a willingness to learn.

Developing Training Content

Delivering the Training to Support Roles

Table 3 outlines the development of the content, level, context and delivery.

Table 3. Development of training content to support roles

Area of Training	Requirement	Course Content
National Occupational Standards: Content for all prisons	H3: Enable people with mental health needs to develop coping strategies	<ul style="list-style-type: none"> • Management of mental health issues
	N4: Work with others to facilitate the transfer of individuals between agencies or services	<ul style="list-style-type: none"> • Referral processes • Interpersonal skills
	O2: Co-ordinate awareness raising about mental health issues	<ul style="list-style-type: none"> • Mental health promotion • Mental health awareness • Mental illness knowledge • Interpersonal skills
	O10: Represent the agency in courts and formal hearings	<ul style="list-style-type: none"> • Mental health promotion • Mental health awareness • Mental illness knowledge • Interpersonal skills
	B2.1: Enable people to access and benefit from services	<ul style="list-style-type: none"> • Mental illness knowledge • Referral processes
	B3: Contribute to establishing and running mutual support networks	<ul style="list-style-type: none"> • Management of mental health issues
	D5.1: Determine the physical health needs of people with mental health needs	<ul style="list-style-type: none"> • Mental and physical health awareness
	E6: Work with individuals with mental health needs to negotiate and agree plans for addressing those needs	<ul style="list-style-type: none"> • Mental illness knowledge • Management of mental illness • On-going management of mental illness
	E9.2: Work with individuals to monitor their mental health needs	<ul style="list-style-type: none"> • Management of mental illness
	E9.3: Identify and agree any changes to care programmes	<ul style="list-style-type: none"> • Management of mental illness • Care planning

cont.

Table 3 cont.

Area of Training	Requirement	Course Content
Care Pathway: Content for all prison staff	Recognise when someone has symptoms of mental distress/disorder and/or is at risk of suicide	<ul style="list-style-type: none"> • Mental illness knowledge • Suicide risk assessment
	Reach out and engage in a supportive relationship	<ul style="list-style-type: none"> • Interpersonal skills
	Identify the presence of suicidal thoughts	<ul style="list-style-type: none"> • Suicide awareness
	Estimate level of risk	<ul style="list-style-type: none"> • Risk assessment
	Attend to the person's pain and distress	<ul style="list-style-type: none"> • Interpersonal skills • Management of distress • Appropriate attitude
	Work <u>with the person</u> to promote their immediate safety	<ul style="list-style-type: none"> • Management of mental health issues
	Address and contain those aspects of the current situation affecting health and safety	<ul style="list-style-type: none"> • Management of mental health issues
	Facilitate links with family (if supportive), friends, peer supporters, professional help	<ul style="list-style-type: none"> • On-going management and support
Content for assessors	Initial assessment of crisis including interview skills, listening skills, initial risk assessment and management	<ul style="list-style-type: none"> • Interpersonal skills • Risk assessment • Risk management
	Formulation of initial (non-clinical) 'holding' care plan in conjunction with others	<ul style="list-style-type: none"> • Care planning
	Communication skills with residential staff and the wider team	<ul style="list-style-type: none"> • Interpersonal skills
	Knowledge base of common mental health problems and ability to undertake a brief mental state examination using a structured tool, allowing formulation of immediacy of problem	<ul style="list-style-type: none"> • Mental illness knowledge • Practice assessment tool • Interpersonal skills
	Working knowledge of mental health problems allowing conduct of a full ACCT assessment, using a structured tool (if no formal mental health qualifications held) or unstructured assessment (if formal mental health qualifications are held)	<ul style="list-style-type: none"> • Mental health knowledge • Mental illness knowledge • Practice assessment tool
	Ability to formulate primary care plan with clinical elements, in conjunction with multi-disciplinary team/clinical supervisor/health care link	<ul style="list-style-type: none"> • Care planning • Referral processes
	Enhanced case management skills – co-ordinate care, hold reviews, formulate care plans for prisoners with primary care level mental health components/needs	<ul style="list-style-type: none"> • Care planning • Case management skills

cont.

Table 3 cont.

Area of Training	Requirement	Course Content
Content for mental health liaison officers	Creating an awareness of prisoners at possible risk of developing and those who may be experiencing mental health problems	<ul style="list-style-type: none"> • Mental illness awareness
	Take a lead on being the first point of contact for issues surrounding prisoners' mental health	<ul style="list-style-type: none"> • Mental health awareness • Mental illness awareness
	Offering guidance, support, information and knowledge on prisoner's mental health issues to other colleagues on the wings	<ul style="list-style-type: none"> • Mental health awareness • Mental illness awareness • Management of distress
	Establish good working relationships, communicate and assist formally and informally with other colleagues (e.g. other discipline officers, health care staff, psychologists, ACCT assessors, etc.) where appropriate, on mental health issues	<ul style="list-style-type: none"> • Interpersonal skills • Referral processes
	Knowing how to respond appropriately to the mental health needs of prisoners within their sphere of competence	<ul style="list-style-type: none"> • Mental health awareness • Mental illness awareness
Overall level for all prison staff	Training should be at an appropriate level. They often have appropriate attitudes, skills and ability but do not realise it – need to contextualise this	Content needs to allow individuals to develop an awareness and allow prison staff to gain confidence in their knowledge, skills and attitudes
Overall context of training for all prison staff	Training must embed learning in the prison context by using appropriate language and examples	Content should have specific prison examples and use prison language
Overall delivery of training for all prison staff	Clear presentation of material	Aided by handouts and accompanied by PowerPoint slides
	Use of a variety of methods	Different methods of delivery used, including role-plays, case discussions and vignettes.

A thematic analysis was used to address content issues for mental health awareness training and a training package was developed into the following modules:

- Mental Health Introduction – including understanding mental health, mental health promotion, challenging attitudes;
- Mental Health Awareness – including mental illness knowledge, mental and physical health awareness, management of mental health issues, referral processes, interpersonal skills, management

of distress, care planning. Main mental health issues addressed included those most frequently encountered in prisons: anxiety, depression, bi-polar disorder, psychosis and schizophrenia, co-morbidity and dual diagnosis and personality disorders;

- Suicide and Self-Harm – including interpersonal skills, suicide risk assessment, suicide awareness, management of distress, care planning, practice assessment tool.

The ‘assessor’ version of the course contained detailed analysis of the ACCT documentation throughout the package, as opposed to the mental health liaison officer package, which concentrates on general awareness. In all cases, the content is at a level to allow prison staff to gain confidence in knowledge, skills and attitude, and to develop an awareness of mental health within a prison context. Supplementary materials such as handouts and PowerPoint slides accompany the face-to-face training and multiple methods of delivery were used to aid understanding, particularly experiential approaches such as role-plays, case discussion and vignettes.

Following evaluation of the training, a number of areas were changed and updated. Table 4 identifies some of the amendments to the original course content.

Table 4. Changes made during the evaluation to course content, style and delivery

Module	Problem identified in evaluation	How problem was solved
Mental Health Introduction	Language too complex	Simplified
	Level too complex	Simplified
	Clearer emphasis on physical and mental health differences and similarities required	Added diagram on physical and mental health differences
	Handout too long	Shortened handout
Mental Health Awareness	Post-traumatic stress disorder should be covered	Added in section on post-traumatic stress disorder
	Referral section needs to cover when to refer to health care, not just secondary support	Added new sections on referral procedures
	Management section should also include treatment and medication where appropriate	Added new sections on treatment and medication issues

cont.

Table 4 cont.

Module	Problem identified in evaluation	How problem was solved
Self-Harm and Suicide	Too similar to STORM package	Re-wrote training to be less repetitive and highlight new and also complementary areas
	Skills approach too difficult for most individuals	Included more awareness-based approaches
	Case studies need to be prison-based	Put case studies in prison context
	Case studies need learning points to accompany them	Added learning points to case studies
	New introductory exercise needed to help reflect motivations for self-harm	Added in a reflective exercise
	Stress differences in approach for managing self-harm and suicide cases	Added in slides and a narrative highlighting differences
Assessor Package	Assessment tools need to be highlighted throughout not just introduced during self-harm module	Assessment highlighted with examples and exercises throughout
	Need a dedicated module to address 'assessment' issues	Created a separate module on assessment
Additional Modules	Need specialist modules addressing issues pertinent to both female-only establishments and adolescent prisons	Created two new stand-alone modules
Handouts	Need something more in-depth and something to refer to at a later stage	Changed handouts of PowerPoint slides into a proper workbook

Following piloting and evaluation (see Table 4 for a list of the major changes made to the training package) at each participating establishment, a single standardised version of the training package has been developed with generic aims:

- To enable the participant to have a greater understanding and awareness of mental health problems/illnesses and how these may manifest in the prison setting;
- To have a greater understanding of the types of interventions, treatment modalities and management available in HMP establishments for this type of prisoner.

The final package consists of the following three core modules:

Background to understanding mental health and illness

This module aims to enable the wing-based liaison staff and prison staff to have an understanding of the basic concepts of mental illness and mental health within the context of the prison environment.

The background module provides an overview of some of the fundamental issues to be considered when undertaking basic training in

mental health awareness and, as such, is an essential component of the awareness training package as a whole.

At the end of the module the participants should be able to:

- Define mental health/illness;
- Identify the two main categories of mental illness;
- Have a basic understanding of the factors influencing mental health;
- Identify a mental health promotion model;
- Have an awareness of the difficulties associated with social labelling.

Mental health awareness

This module aims to enable the participants to have an understanding of the different 'common' types of mental illness that are frequently seen in the prison system.

This module explores the categorisation and identification of mental illness, what treatments are available, how best to manage individuals on the main wings of the prison and when to seek a referral to other professionals.

At the end of the module, the participants should be able to:

- Identify the signs and symptoms associated with the various anxiety disorders, depression, bi-polar disorder and schizophrenia;
- Have a basic understanding of the issues of a prisoner labelled as dual diagnosis and the implications this has for caring and managing the individual;
- Define what is meant by personality disorder and have an understanding of the importance of managing this prisoner's behaviour;
- Have an understanding of the appropriate treatment that may be available;
- Identify how to manage the individual on normal location and when it is necessary to seek help from mental health professionals;
- Understand the importance of communication skills when referring to mental health professionals;
- Understand the importance of confidentiality.

Suicide and self-harm

This module aims to enable the participants to have a greater awareness of the reasons for and causes of self-harming behaviour, and allow opportunities for exploration of the group's experiences and attitudes to suicide – in particular, fear of being blamed and the view that 'nothing can be done about it' – thus enabling a de-centring of fixed perceptions about actions that prevent suicide.

It seeks to develop the participants' understanding and knowledge about the nature of risk and how to estimate immediate (as opposed to longer-term) risk.

It also provides knowledge of a simple framework of strategies useful for responding to people who are actually or potentially suicidal.

At the end of this module, participants should be able to:

- Identify the possible underpinning mechanisms for self-harm behaviour;
- Plan more effective care for those who self-harm;
- Be more confident about discussing suicide with a person at risk in an open and direct manner;
- Understand the difference between long-term and immediate suicide risk;
- Outline the importance of proceeding at the individual's own pace when talking to them about suicide and related matters;
- Identify the sorts of phrasing and words they would feel comfortable using when talking to a suicidal/self-harming person.

In addition, three optional modules have been developed:

- Adolescence and prisons;
- Women prisoners;
- Assessment and care planning (to support the assessor package).

Evaluation

Introduction

A confidential questionnaire was used to obtain feedback from participants. Respondents answered the relevant section of the questionnaire at the end of each training day, and completed questionnaires were passed to the trainer at the end of the training package. The following analysis shows the main themes generated throughout the evaluation; for those on the assessor version of the course and those on the mental health liaison officer's course. Slightly differing versions of the questionnaire were developed for both courses, but the main themes examined remained the same. The questionnaire asked closed and open questions and the analysis is based on both types of question. In addition, the facilitator wrote detailed comments following each course and these are also included in the analysis.

Participants

All trainees who attended the courses completed an evaluation questionnaire. There were 53 participants on the assessor version of the course. They came from five prison pilot sites, namely Woodhill, Holme House, Low Newton, Feltham and Wandsworth. The majority of participants were aged between 31 and 50 years old, with an almost even gender split, although slightly more females than males attended. Over a third of participants were prison officers. Other significant groups were nurses/health care officers and those who worked in the field of psychology. There were no notable response differences between the five pilot sites. In addition, there were 24 trainees on the mental health liaison officer course from eight establishments: HMPYOI Feltham, HMP Bristol, HMP Morton Hall, HMP Birmingham, HMPYOI Glen Parva, HMP Hull, HMP Liverpool and HMP Lincoln. The majority of participants were aged between 31 and 50 years old; 62% were males, and the most common job title given was that of prison officer.

Prior Knowledge and Reasons for Attendance

Many of the trainees on the mental health liaison officer course had no previous knowledge of the mental health issues discussed (see Graph 1).

Having worked with the mentally ill for three years with no training, I was glad to come on this course. (Prison Officer, male)

I had no knowledge of mental health material before the course, only from my personal experience. (Prison Officer, male)

However, most participants had some prior knowledge of the issues discussed and trainees on the assessor course were much more likely to know more of the material beforehand (Graph 2). Nevertheless, the material acted as an update to their existing knowledge.

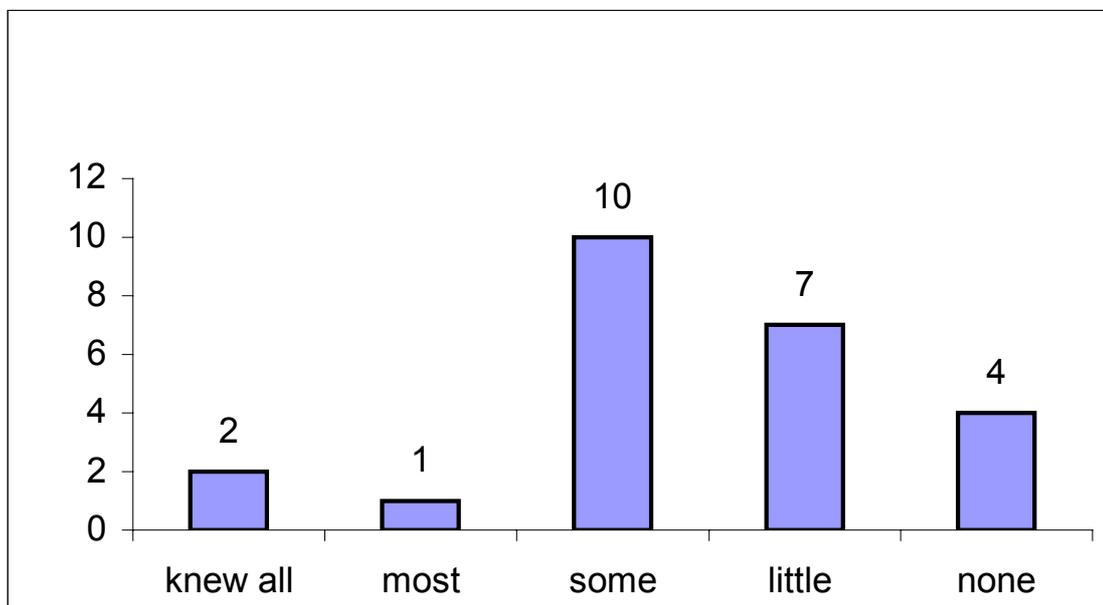
More of a refresher really, although it is the context of the ACCT which is useful and relating more to identification of mental health, rather than diagnostic. (Psychology Assistant, female)

The course also helped to contextualise their existing knowledge.

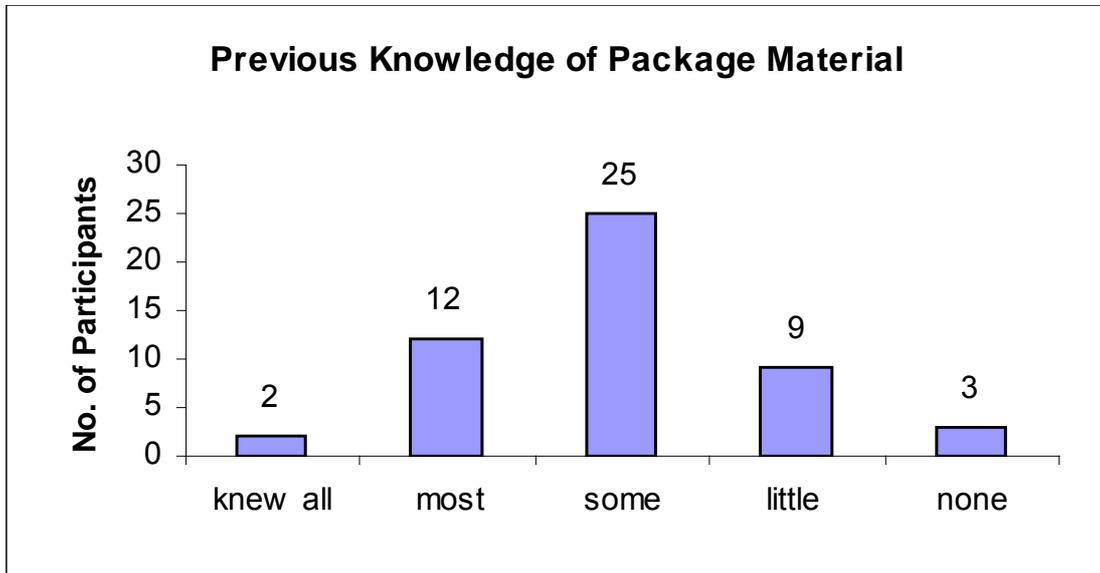
I already had the knowledge but sometimes not very sure how to put some aspects in the prison setting, but [after] ACCT, and the three-day training, I have developed some skills. (Anon.)

...being able [now] to identify situation with illness. (Senior Officer, male)

Graph 1. Previous knowledge of mental health issues for trainees on the mental health liaison officer course



Graph 2. Previous knowledge of mental health issues for trainees on the assessor course



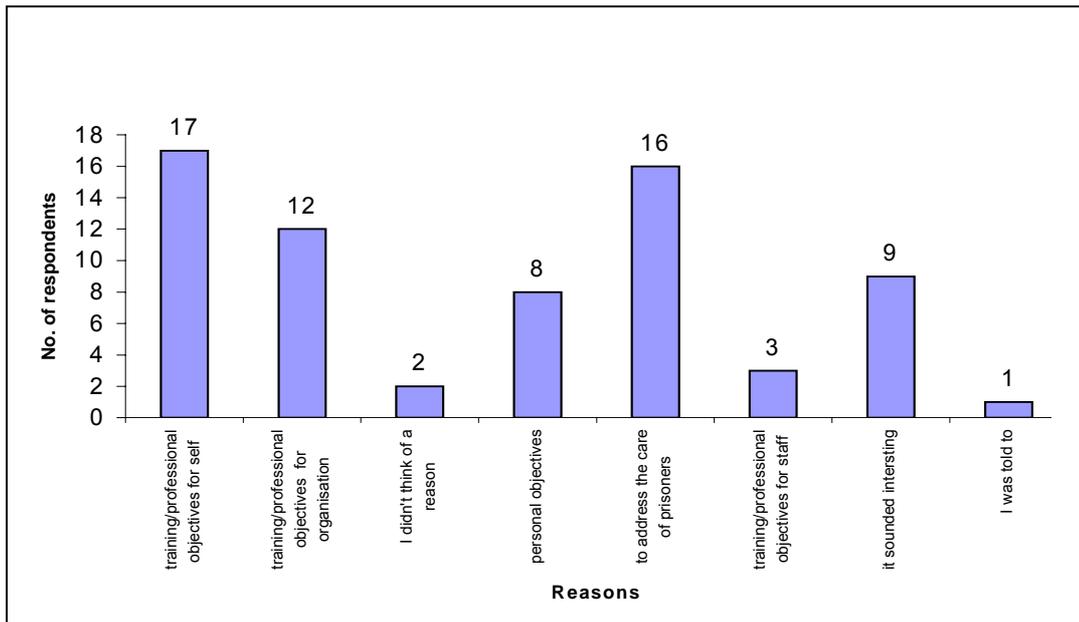
With regards to stating reasons for attending, participants were able to select more than one option from the choices offered. Most commonly, participants attended the course to meet personal training/professional needs and to address the care of prisoners (see Graph 3). It was of note that many were interested in the course itself and participants did not feel under pressure to attend.

Following the mental health training almost two years ago, I knew that the course was only touching the surface and in the prison setting [it] needs to be taken further. (Prison Officer, female)

[Seeking] broader knowledge of mental health issues/disorders and how they come together and affect people. (Prison Officer, male)

All new information is upgrading knowledge on all areas. (Prison Officer, male)

Graph 3. Reasons given by trainees for attending the mental health liaison officer course



Methods of Delivery

Knowledge and skill of the facilitator

Generally, comments complimented the knowledge and skills of the facilitator, for example the delivery of information was dynamic, uncomplicated and clear, was targeted at an appropriate level, and made good use of practical examples.

The 'open-learning' environment between the facilitator and the participants. (Prison Officer, male)

Respondents were also complimentary about the amount and depth of knowledge the facilitator had on the subject and the chosen method of disseminating this knowledge.

Obviously [the facilitator] has excellent knowledge of her trade and puts it over very well; professionally and with humour. (Anon., male)

I thought the package was excellently delivered. The trainer got everything across expertly. (Prison Officer, female)

Relaxed atmosphere and self-disclosure

The facilitator ensured that there was a relaxed atmosphere during training. According to the facilitator, this was vital for the success of the training:

I was eager from the outset, with all of the courses delivered, to promote a relaxed and informal atmosphere for the learning to take place. This was achieved by a simple rearrangement of the furniture, the use of humour, active encouragement for the participants to articulate their points of view from an early stage, and demonstrating empathy and respect for the participants.

(Facilitator, female)

The facilitator also mentioned that exploring issues of confidentiality and empathy at the beginning of the training was important to the informal and open atmosphere, which in turn aided to the success of the training:

We spent time at the beginning of the course talking through issues of confidentiality (with what was disclosed by all of the participants within the group), and the importance of empathy/valuing others' contributions to the content that was to be discussed. If 'neutral' observers or other personnel were present for part of the training then these issues were raised again as a matter of priority. This allowed the participants to feel 'safe' to express some of their fears, woes and concerns about working with people in prison with mental health problems.

(Facilitator, female)

The relaxed, informal atmosphere created an environment where a number of participants disclosed personal issues regarding mental health problems, be it a family member, colleague, friend or themselves. The facilitator needs to be able to address such issues.

Some of the participants chose to disclose to the whole group in a discussion on a topic, others left the room when things 'got difficult' for them and discussed with me their issues on a one-to-one basis. Others disclosed to me after the session, and later disclosed to the rest of the group. I felt privileged to be party to this disclosure, and it brought it into sharp relief the emotional element involved in such a short course. It is a big responsibility for anyone delivering the course to manage this process effectively, without disregarding what is happening, or undermining the individual, or allowing the training to become a therapy group, which it was not. I think this can only be achieved successfully if the facilitator is experienced in dealing with these matters, and demonstrates sensitivity/empathy and shrewdly uses their own vulnerabilities at times. This was the most exhausting part of delivering the course, and probably my most reflective moments about how the course had gone were along

the lines of the emotional element. This personal disclosure, whilst not a therapy group, nor actively encouraged to be one, enabled them to see that the mentally ill prisoners were not so far removed from us, and having an awareness and understanding of these issues can help anyone deal with them more empathetically and in a caring manner. This is of particular importance when dealing with a self-harming prisoner.

(Facilitator, female)

The relaxed atmosphere allowed the training to be delivered in a transcendent manner, where knowledge and experience came from all participants rather than from the facilitator alone. As the facilitator explains:

I saw my role not as lecturer/trainer who was the 'font' of all knowledge, or the 'sage on the stage', but as a facilitator of their knowledge and experience. The awareness training, I believe, is to enable the participants to use their experience to understand the issues that they mostly deal with on a day-to-day basis.

(Facilitator, female)

Case studies and personal experience in the learning

The facilitator drew from her own professional experiences to describe the signs, symptoms and behaviour of individuals suffering various types of mental health problems. Having a facilitator with experience of working closely in prisons with a variety of different members of staff helped the training, as the facilitator describes:

It was invaluable that I have worked in the prison setting on the 'shop floor' because I have a good understanding of their work roles and the difficulties that are particularly unique to caring for these individuals within the prison setting. (Facilitator, female)

All the participants described the actual examples given by the facilitator as a useful learning tool.

Spot on. The facilitator obviously demonstrates a wide range of information, not only by means of knowledge but also from personal experience. (Prison Officer, male)

Gave an insight into the different behaviour of people with mental health problems. (Prison Officer, female)

They were very relevant and could identify totally for the prison setting. (Prison Officer, female)

Often, the facilitator used a case study approach to bring across personal experiences. Nearly all the trainees thought the case study was a useful learning tool.

It is always useful to draw from a person's personal experience, a real case scenario. (Prison Officer, female)

Hearing other people's experiences is always a good tool to expand our knowledge. (Prison Officer, male)

Case study was very useful as we found it quite hard to identify with different issues. (Prison Officer, female)

It is good to reflect. (Prison Officer, male)

The case study provided opportunities for reflection and the sharing of experiences, and facilitated discussion on mental health issues as they may occur in the prison setting. As such, it is congruent with the philosophy of adult learning and learning through reflection on practice (Rolfe et al., 2001; Freshwater, 2002).

Participants also noted the positive aspects of hearing the facilitator's own experiences with regard to working with mental health issues in a prison environment. This supports previous research that highlights that trainees need to know that those who teach them do not just have knowledge of practice but are immersed in that practice and therefore are able to bring their own lived experiences to the learning (Andrewes et al., 1999; Redwood et al., 2002)

Group working

The vast majority of participants enjoyed the group working and working in pairs. It was particularly beneficial as it allowed for shared personal and work experiences, and provided insight into other working roles within the same service.

Helped give an idea of how other people view mental health issues. (Anon., male)

It also helped people from different roles and backgrounds learn different terminology. The prison culture has its own use of language to describe mentally ill prisoners. This is partly to cover up ignorance, create uniformity with colleagues, and instil humour into a situation that can feel threatening to the staff involved (Tracy, 2004). When this was challenged during the course, it helped with their confidence and their perceived ability to express the prisoner's needs to other professionals.

It has given me some useful vocabulary for dealing with other disciplines such as health care/psychology. (Prison Officer, female)

Other comments suggested that the group work developed a team approach to working through the training package and contributed to a fun and relaxed atmosphere:

The people on the course were fun to be with. (Prison Officer, male)

Allows someone else to open up ideas that otherwise might not come up. (Anon., male)

Use of PowerPoint presentation (the slides)

Participants who commented found the slides extremely useful in terms of clarity and conciseness of the package material.

PowerPoint made the presentations clear and easily understood. (Prison Officer, male)

Clear and concise and easy to understand. (Prison Officer, female)

They also commented that the PowerPoint slides were useful for showing the most important aspects of the training, which helped focus on the pertinent issues from group work and discussions.

Very informative, backed up discussions leading into it. (Prison Officer, male)

The presentation was easy to follow and worked well with our paperwork. (Prison Officer, male)

Accompanying workbook

A workbook was circulated to all participants containing a summary of all the material covered in the course. Almost all trainees found the workbook to be valuable and a useful reference tool during the course.

Very detailed, useful and easily understood. (Prison Officer, male)

Good for reference and notes. (Prison Officer, male)

Many of the trainees also mentioned the benefits of having the workbook to refer to following training.

Very useful for future referral [sic] and notes during course.
(Prison Officer, male)

Lots of information given in three days, good to have something to refer back to. (Prison Officer, female)

Many [of the trainees] liked the workbook to supplement their learning, and also took the opportunity in any breaks or at close of day to ask me about mental health issues in more detail.
(Facilitator, female)

Appraisal of Topics Covered

The evaluation asked trainees to appraise the topics covered in the training. Many of the topics were generic across both the assessor and the mental health liaison officer training packages and these are analysed together below. Some topics were specific to the assessor version of the package, such as dealing with skills in risk assessment, crisis prevention and crisis management. Although these were covered in the mental health liaison officer package as well, they were not as salient to the role and were not evaluated as such.

Topics in both training packages

Table 5 shows that there was a favourable response for all topics, with most respondents giving each topic a 'very good' or 'good' rating. Comments echoed the ratings:

As far as I know the information was tip top! (Prison Officer, male)

All information was valuable and well described. (Prison Officer, male)

A very full and comprehensive course. (Prison Officer, male)

I found the whole day very informative and interesting and gained a lot of knowledge on a subject that is not openly talked about. (Prison Officer, female)

The topic covering psychosis and schizophrenia was most likely to achieve 'very good' ratings. This was probably due to the large number of 'eureka' or 'enlightening' moments that occurred during this topic, which resulted from a misunderstanding of schizophrenia prior to the training – many trainees confused schizophrenia with 'split personality'. There was also a low level of tolerance in that many prison officers thought that

schizophrenics were seeking attention through falsifying visual or auditory hallucinations. These myths were discussed and dispelled during training.

The subjects covered were all very much needed, in particular schizophrenia – 10/10. (Anon., male)

The personality disorder module was also likely to receive a ‘very good’ rating. Again, prior to the course, many participants were unclear as to what personality disorder was and how it related to mental illness. The training afforded discussion of these issues and, as such, was an enlightening topic for the trainees.

Had no understanding of personality disorders. Had a good understanding after session. (Senior Officer, female)

The topic of substance abuse and co-morbidity was least likely to receive a rating of ‘very good’. This was in part due to there not being enough time to cover the topic in full, with resources having to be channelled into other topics. Perhaps there is a need for a separate substance misuse course.

[Substance abuse, co-morbidity & mental disorder were] a bit brief for such a major problem within the prison service. (Cognitive Behavioural Psychotherapist, female)

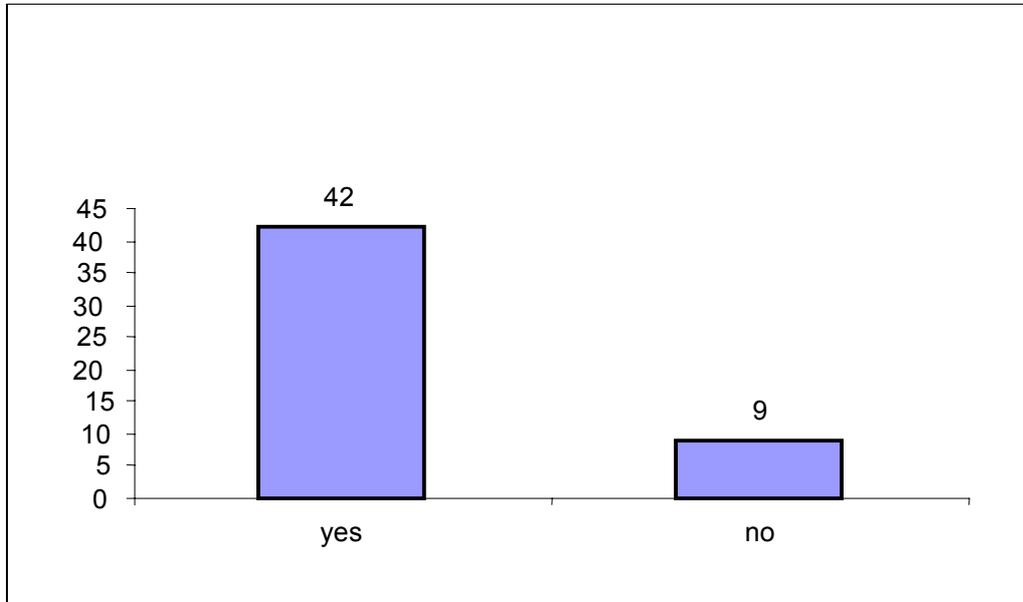
Table 5: Ratings given to topics discussed in mental health awareness training

Rating Topic	5 (v. good)	4 (good)	3 (av.)	2 (poor)	1 (v. poor)	n
Anxiety states	45	28	0	0	0	73
Depression	48	26	1	0	0	75
Bi-polar disorder	48	26	0	0	0	74
Psychosis and schizophrenia	52	18	1	0	0	71
Substance abuse and co-morbidity	40	28	7	1	0	76
Personality disorder	51	20	5	0	0	76
Understanding self-harm	42	29	1	1	0	73

Topics on the assessor version of the course

Topics covering prior knowledge and use of ACCT documentation in line with the assessor role were evaluated. 82% of respondents had heard of the assessment tool prior to the session (see Graph 4), while 88% described thinking that the tool would be or was currently very useful in their place of work.

Graph 4. Had participants heard of the ACCT assessment tool?



When asked how confident they would feel using the tool in their place of work, the majority of respondents (71%) did now feel confident using the tool; only 15% were not so confident. Interestingly, anxieties and reservations were frequently described despite the general suggestion of confidence.

Quietly confident, however I do anticipate teething problems.
(Anon.)

Personally, I feel that I need training at a deeper level, familiarity with options available [in care plan] and closely supervised practice. (Psychological Assistant, female)

[Confidence in using the tool] would depend on release from other duties to concentrate on improving confidence. (Nurse, female)

[Confidence in using the tool] would depend on the impact on other resources. (Anon.)

Further comments on the tool suggested that it was confusing at times with a great deal of paperwork. As a result, further 'practical' sessions were suggested to enhance its use within the workplace.

A small number of the participants' comments reflected anxieties regarding the legal implications of using the tool. For example, if a prisoner died following use of the tool, would the officer involved be held accountable or responsible for the death? This was expressed as a feeling of vulnerability by some respondents:

Were do I stand in relation to legal matters? (Senior Officer, male)

Initially there were suggestions from trainees to allocate more time to the tool within the training package and to move the session to the first day of training. This was subsequently followed through with positive results.

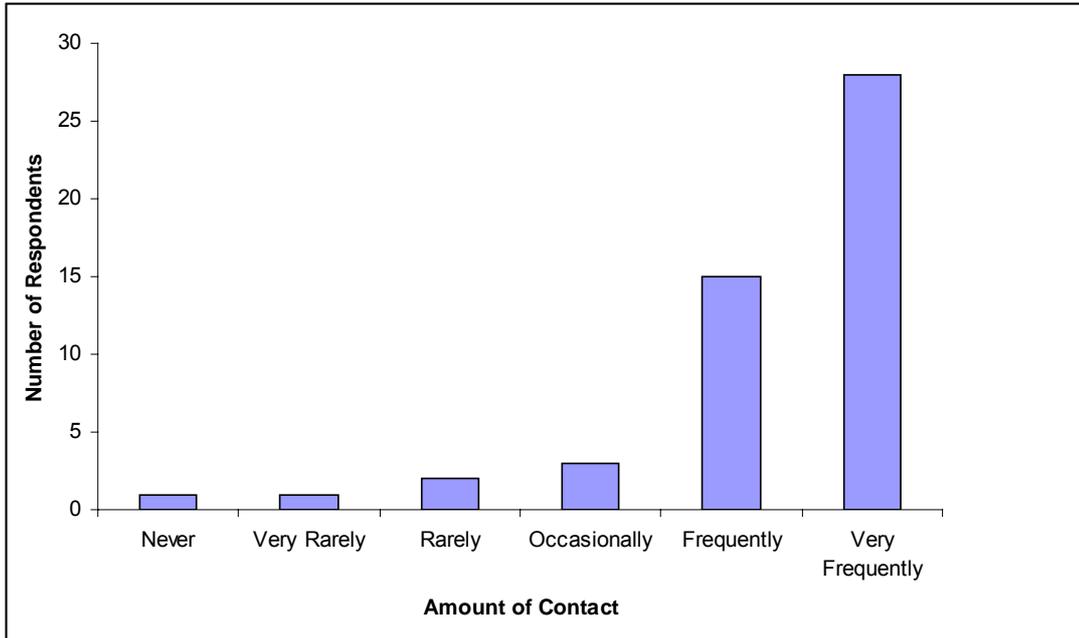
Actually sitting with a qualified RMN and discussing mental illness seems to be very helpful with the tool. (Anon.)

The self-harm and suicide awareness modules varied significantly compared with those in the mental health liaison officer training. They focused heavily on skills for dealing with risk assessment and crisis management, rather than just general awareness.

86% of respondents had 'very frequent' or 'frequent' contact with prisoners who harm themselves; only 0.02% had never had this experience (see Graph 5).

The vast majority of respondents had attended previous training sessions on self-harm, including mandatory suicide training, STORM training, suicide awareness, or counselling courses within chaplaincy. Respondents also cited their practical experience as useful training.

Graph 5. Amount of contact respondents have with prisoners who harm themselves



89% of respondents described the amount of material for this topic as 'about right'. The comments about suicide assessment were generally positive, citing the group-work as beneficial, with the delivery and content described as good and specific. Suggestions were made regarding employing case reviews, with greater attention given to the practical use of the material and reducing the focus on the ACCT material. Similarities were expressed between these sessions and the STORM training.

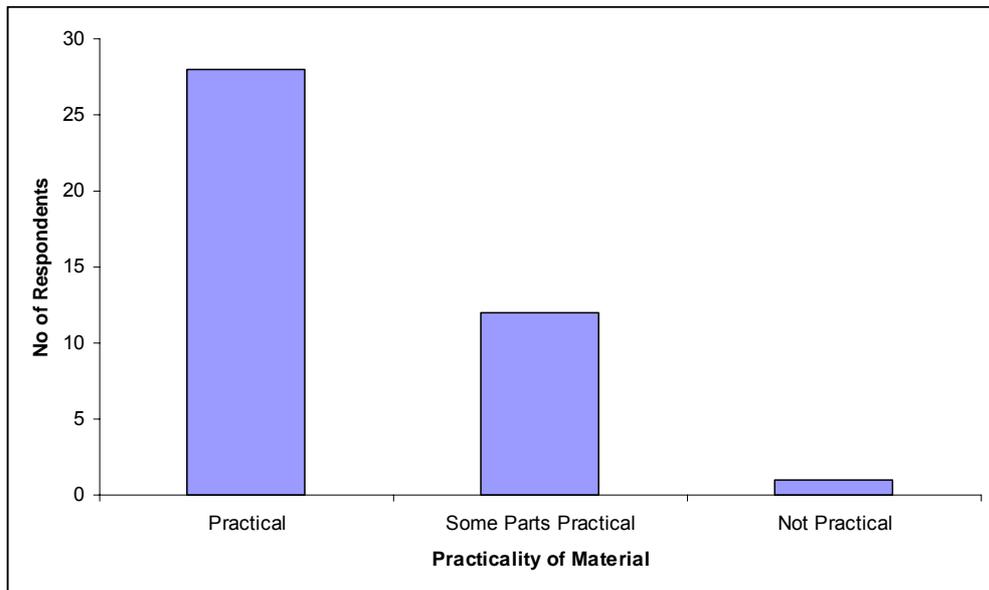
All respondents described the content of suicide assessment as being easy to understand. Positive comments reflected an excellent presentation with good use of PowerPoint software and the delivery of clear guidelines for dealing with prisoners who may be suicidal.

It has made me see that sometimes I need to react differently in certain situations. (RGN, HCC, female)

Good discussion of interviewing skills. (Head of Training, male)

As Graph 6 shows, the majority of respondents believed that the sessions on crisis management were of practical use. Indeed, 68% of respondents described the content of these sessions as 'practical' and that they 'would do what is suggested'.

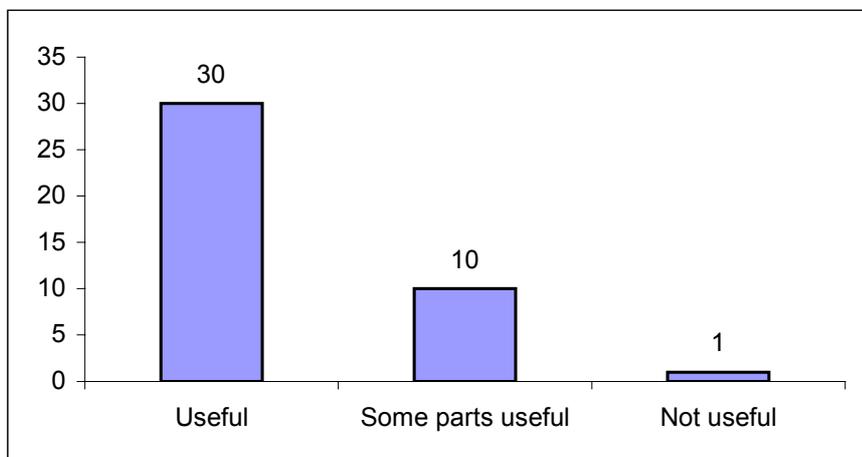
Graph 6. Practicality of the material describing crisis management



As with other questions, a frequent comment was a request for experience with the practical application of the material. Suggestions included using prison officers' experience in applying/developing the techniques discussed for practical application, with the implication that modification may be necessary for use with each individual officer and prisoner.

73% (n=41) of respondents felt that the material discussed in the crisis prevention session was useful, with 24% describing how 'some bits were useful, others were not' (see Graph 7).

Graph 7. Usefulness of crisis prevention material



The Learning

All trainees felt they learned something from the training. Many comments described becoming more knowledgeable about mental health issues generally:

I have gained knowledge and experience that I did not have before. (Prison Officer, male)

I have learned a great deal on this course. It has formalised my knowledge on mental health. (Prison Officer, male)

Other comments reflected increased awareness, a change in attitude and raised confidence in dealing with the mental health of prisoners, addressing aspects such as behaviour, verbal interaction and suicide risk.

The training has changed my views. (Sex Offender Profiler, male)

I feel I have more understanding now. (Prison Officer, female)

All the participants could be described as 'hungry to learn'. They felt that they should have had the course 'years ago', as it was vital to their practice. The training left them with a yearning to find out more:

One of the officers said at the outset of the training that he was only 'here for the beer' and by the end of the three days he approached me, stating it was the best course he had been on because he had learnt so much and how could he do his mental health nurse training. (Facilitator, female)

Influence of Training on Practice

The package was evaluated for the anticipated effects of the training on the trainees' practice in general. Specifically, it was asked whether trainees thought that prisoners would receive better care.

Change in practice

The majority of participants were of the opinion that they would indeed be doing things differently on returning to the workplace. The two that disagreed made no further comment.

A common remark was that they would no longer 'judge behaviour as just bad':

I will have better understanding of mental illness rather than just being 'a nutter'. (Prison Officer, male)

The course addressed some of the misconceptions I had about mental health. (Prison Officer, female)

In accordance with this, further comments suggested that more attention would be paid to disturbed behaviour and that they would not just view it as 'mad'.

...observe behaviour differently as I feel I have a greater awareness. (Probation Officer, female)

An increase in interview confidence was also reported, particularly for those who are to be assessors.

Better care for prisoners as a result of the training

As Graph 8 shows, 88% of respondents felt that the training package would make a positive difference to the way that prisoners were treated. The remainder had no opinion.

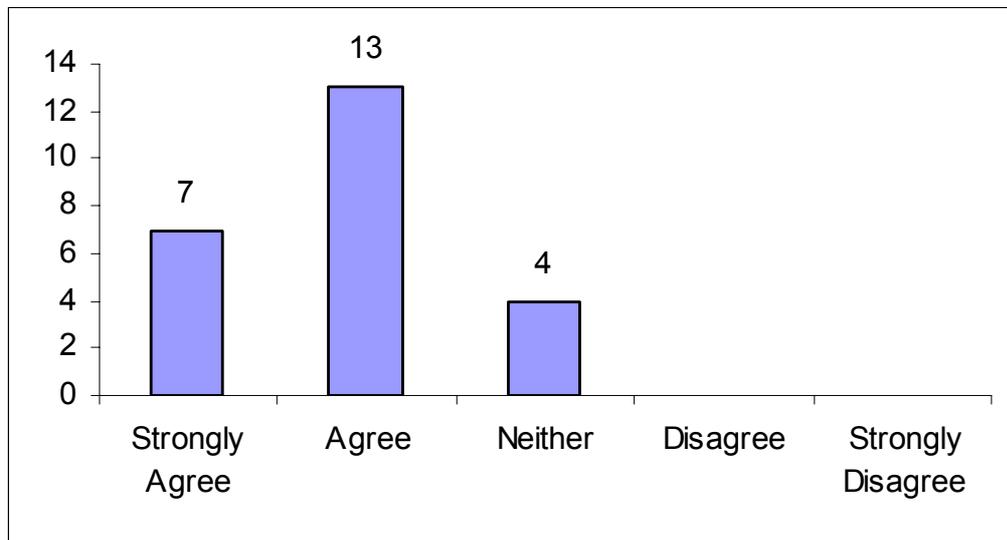
Comments included the benefits from increased knowledge about the motivations for 'self-harm', increased knowledge about mental health generally, more effective care-plans, better care for suicidal prisoners. Reservations cited concerned current time and resources available and, for assessors, a lack of confidence using the ACCT material.

Our expectations of what we can expect verbally and in behaviour from prisoners should change, depending on their mental health. (Chaplain, female)

If the time and resources are given, it will benefit prisoners. (HCO, female)

To help prevent/reduce suicide in prison – to create better, more effective care plans. (Senior Officer, male)

Graph 8. 'I think this training will make a difference to the way in which prisoners are treated'



Sharing best practice

In all of the groups facilitated, participants had what could be described as 'eureka' moments. They identified prisoners they were currently working with, or had worked with previously, who suffered from one of the illnesses described. It unveiled the mystery of why that prisoner was behaving in the way they were. Many discussed the need to talk in more depth to Prison Healthcare about issues that concerned them but that confidentiality was a problem. Discussions took place on how they could manage these individuals on the main wings, which they found most helpful, and led to group members exchanging their 'best practice' ideas.

Surprising moments

Most participants were surprised by what they learned. Those who were not surprised made no comment, although they were more likely to have experience in the fields of health care, mental health or psychology. The majority of comments regarded aspects of mental health and acquired knowledge, for example types of illness, complexity and severity of mental health disorders, responsiveness to treatment, myths surrounding self-harm, and the high numbers of those within a prison setting suffering from mental health problems.

The trainees were particularly surprised about the 'severity of the effects of mental illness' (Discipline Officer, male), 'self-harm, understanding why they do it (Prison Officer, female), and commented that 'myths on mental health were explained clearly and patiently (Prison Officer, male).

Taking the Package Further

Trainees were asked how they felt the package should be taken forwards, addressing who should attend such training in the future and whether they themselves felt they needed extra training.

Recommending package to other staff

All trainees, except for two, would recommend the package to their colleagues:

Handy for most prison staff/areas. (Healthcare Officer, male)

I think this training should be offered to all staff. (Prison Officer, male)

I believe all staff should have this training (mandatory). (Prison Officer, male)

Many mentioned other members of staff they thought the training would appeal to:

The package would be very useful to all discipline staff, chaplains, prison visitors, counsellors. (Chaplain, female)

Especially to general nurses in primary care. (Dual Diagnosis Nurse, female)

Follow-up training

Most trainees thought that there should be follow-up training days. The most common answer was that there should be a refresher course covering the material and that a review would be valuable on return to the workplace.

Perhaps to update, re-fresh [sic] and show how you have developed. (Prison Officer, male)

To keep abreast of new developments. (Landing Officer, male)

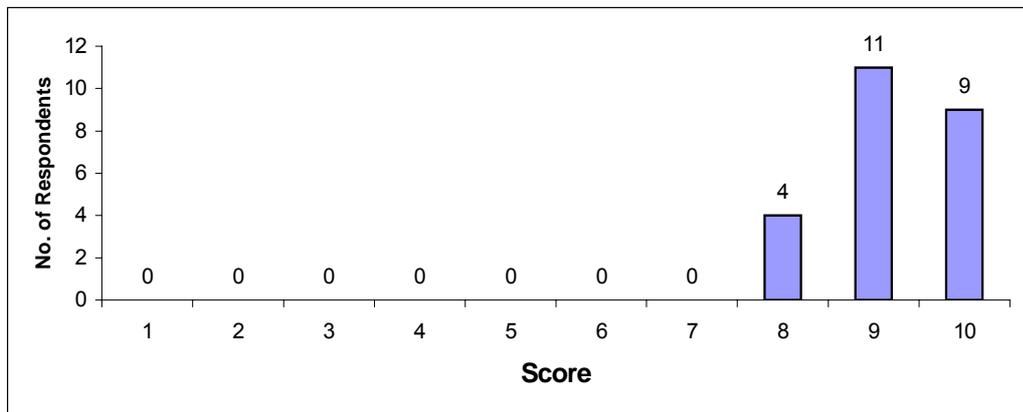
Other comments suggested further discussion groups:

Just an important subject which I feel requires more time. (Prison Officer, male)

Final Comments

Trainees were asked to rate the training package overall from a scale of one to ten (where one was poor and ten was exceptional). Overall, as Graph 9 shows, participants rated the mental health liaison officer training package very highly, with over a third giving it a maximum rating of ten.

Graph 9. Overall rating of the mental health liaison officer training package



Final comments included words of thanks and compliments for the facilitator, as well as re-expressions of enjoyment which echoed the ratings given:

Excellent course and tutor. (Prison Officer, male)

Keep up the good work. (Prison Officer, male)

Very informative and well presented. (Anon., male)

Also mentioned were the benefits of delivering the course in all establishments:

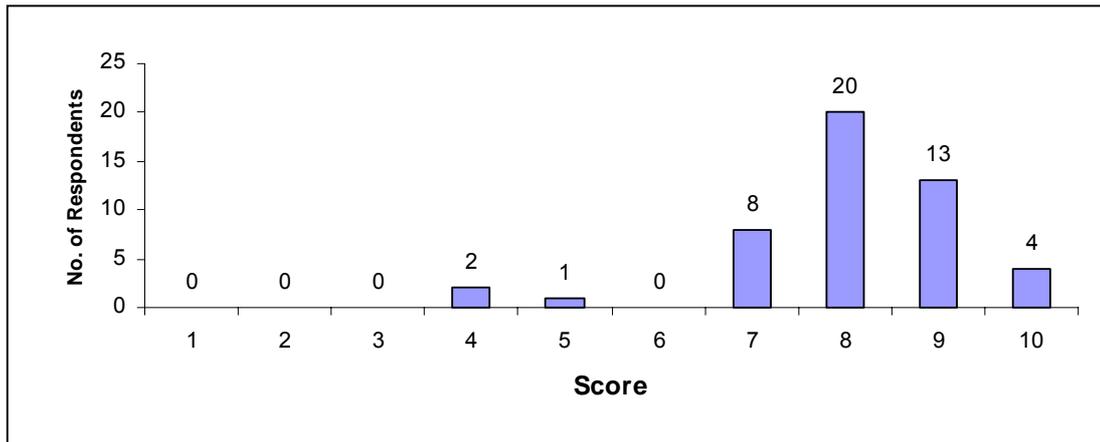
An excellent course that should be made available to all prisons. (RMN, female)

Content was excellent. This training should be rolled out nationally to all prisons and made available to far more prison officers, rather than the ad-hoc, rather unsatisfactory arrangement we have currently. (Cognitive Behavioural Psychotherapist, female)

A very worthwhile course which should be available to all on a mandatory basis. (Prison Officer, male)

Overall, the assessor version of the training package was rated highly, with 77% giving a score of between eight and ten out of a maximum of ten (see Graph 10).

Graph 10. Overall rating of the assessor training package



Again, the comments generally mirrored the high scores given for the training package.

If enough people complete the training and carry out as taught = very useful. (Psychology Assistant, female)

Anything to enhance our role in the care of prisoners can only be for the better. (Senior Officer, male)

Prisoners will [now] be assessed by staff with a limited knowledge instead of no knowledge. (Safer Custody Manager, male)

A good insight into how people behave. (Prison Officer, female)

Conclusions

Overall, the evaluation shows how needed the course was for all prison staff. The Institute of Health and Community Studies at Bournemouth University delivered a mental health awareness course to meet that need, resulting in a favourable evaluation of the course. Throughout the evaluation, trainees repeatedly commented that their new knowledge would be transferred not only to their work with prisoners but to other staff, in particular the assessment of prisoner behaviour in the light of

possible mental health problems. Frequently, respondents cited that they or other staff would no longer 'judge' prisoner behaviour and would avoid labels such as 'mad' and 'bad'. Respondents also commented on how they learned a great deal from a personal perspective, extending their knowledge beyond the confines of their professional life into their private and family life. The evaluation suggests that the success of the training packages relies on a number of important strands:

- Appropriate, up-to-date, relevant and contextualised topics, with practical prison-based content;
- A largely interactive style of presentation with varied methods of delivery;
- Correct 'pitching' of information, meaning the level of the course was appropriate to the audience;
- A relaxed and informal atmosphere to enhance the learning experience;
- A highly competent trainer with considerable experience of working in mental health in prisons who appropriately draws on this;
- A confidential and supportive environment to allow disclosure and discussion of sensitive issues. The facilitator is instrumental in ensuring this environment is created.

It seems appropriate, and indeed many trainees requested, that the training should now be delivered to all prison establishments across the UK. However, a number of issues need to be resolved first, including:

- Addressing what aspects of the current training package could be improved, including looking at possible accreditation and accompanying material (i.e. developing visual material in the form of a video);
- Addressing a roll-out plan of the training, linking it to other training, resources and strategic initiatives in prison health;
- Addressing what additional support is required for training staff (including identifying intervals for refresher courses, and follow-up sessions such as clinical supervision and action learning sets).

These issues are discussed in the following Recommendations section of the report.

Recommendations

Findings from the initial pilot study generated significant interest, and further areas for project work have been identified to enhance mental health awareness training for prison staff.

Recommendation 1: Explore relationship to other courses

IHCS is currently working with a consultant to explore the integration of the mental health awareness course with other similar initiatives and courses currently being developed at present. The key initiatives being introduced by the Prison Health Department and the National Institute for Mental Health England (NIMHE) (some with Safer Custody Group input) are as follows.

Improved health reception screening

This greatly increases the detection rate of prisoners with mental disorders. Research shows that currently around 25% of male and female prisoners fail to have their mental health problems identified at reception (Birmingham et al., 1996; Grubin et al., 2002; Parsons et al., 2001). Effective implementation of the screening involves training staff to carry out the actual screening process, in addition to training primary health care staff to carry out follow-up mental health assessments, providing (as resources allow) some treatment and care for those with less complex disorders, agreeing which prisoners will be referred to mental health in-reach services, and formalising these arrangements in written protocols.

Mental health in-reach services

To achieve the standards set out in the National Service Framework (DoH, 1999) and the NHS Plan (DoH, 2000), primary care teams are responsible for providing mental health in-reach teams in their local prisons. The mental health in-reach teams aim to improve the mental health care provided to prisoners who need it. Such a team comprises additional mental health staff whose role is to provide care for the sub-group of prisoners with the most severe or complex disorders and to support other staff in the provision of care for less ill prisoners. The implementation of mental health in-reach is being overseen separately.

A mental health care pathways framework

This sets out the mental health services that should ideally be in place from pre-reception to release and post-release. This allows those planning how to use the health funds available to them (governors, PCTs, health care staff) to identify gaps and decide on the priorities for filling those gaps.

Guidance to health care staff

About the confidentiality and appropriate disclosure of information.

Key initiatives

In addition, key initiatives being introduced by the Safer Custody Group, with input/support from Prison Health, are:

- ACCT care planning system to replace F2052SH;
- Development of ACCT assessors to respond to officers' concerns about a prisoner who may be at risk of suicide, carry out a formal assessment interview and, jointly with residential staff, decide on referral and management on the wing;
- Training senior officers/wing managers in skills of suicide risk assessment, crisis management and crisis prevention (STORM training);
- Use of a substance withdrawal management screen to identify prisoners who are at risk of suicide or who have outstanding mental health problems after withdrawal, along with associated information for prison staff about how to manage prisoners who are withdrawing;
- Provision of guidance and training on the management of prisoners who self-injure;
- Guidance for residential staff about maintaining prisoner confidentiality and sharing of information.

Recommendation 2: Explore national roll- out of the course

Due to the success of the pilot training, it is recommended that the training should be rolled out nationally across all prison establishments. It is also suggested that the course could be accredited, further enhancing the learning experience and linking to the continual professional development of prison staff. An example of a roll-out plan is included in Appendix A.

Recommendation 3: Training developed for other custodial staff

An investigation is needed to identify the core elements of the mental health awareness package for development into a specific package to meet the needs of courtroom staff, custody officers, security staff, the police force and housing officers.

The possibility of delivering similar training is being discussed with the appropriate organisations through a separately financed piece of research, funded by the Custodial Care National Training Organisation.

Recommendation 4: Video to accompany the course

It is recommended that a new video be developed to accompany the mental health awareness training package. Respondents highlighted a need for visual accompaniment to the training. Much of the mental health awareness training is didactic in nature and could therefore be enhanced through video material, which is a uniquely powerful tool for developing

trainees' skills (in recognising signs and symptoms, body language and behaviour) and professional techniques (active listening, interviewing and assessing). Mental health awareness in a prison setting inevitably involves appreciation of the specific context of behaviour, which can be accurately depicted in video footage. IHCS is currently developing a video with a commercial company which is likely to include a number of important scenarios (see Appendix B).

Recommendation 5:
Course content
tailored to national
or local issues

It is recommended that the mental health awareness training course should be examined for local and generic needs, continually supported to help embed learning in practice, and evaluated to assess the impact of training on practice. Thus, it is recommended that a case study approach is used with a few pilot establishments to help further refine the training.

IHCS is now involved in working closely with HMP High Down, in a project sponsored by the East Elmbridge and Mid-Surrey Primary Care Trust, to develop a localised version of the training package. This case study approach afforded the following methodology to be adopted:

Tailor package to local issues

Reflective interviews with current staff at HMP High Down addressed the functional (how the prison is run as a whole), operational (how the prison operates day-to-day within groups and teams), cultural (global attitudes of staff) and training needs (current competencies and skills) of staff with regards to mental health. The following needs were identified:

- Communication and understanding of principles and practice between healthcare and discipline staff;
- Team working and group behaviour;
- Medication knowledge;
- The distinct needs of remand prisoners.

Develop and embed learning in practice

Develop working groups among the trainees, which may include:

- Clinical supervision;
- Learning action sets;
- Seminars;
- Reflective journal/diary sessions;
- Refresher courses.

Develop confidence in mental health awareness

The above working groups could help develop confidence in individuals who could lead on mental health issues and eventually train other staff in mental health awareness, thus creating a self-sustaining training system.

Evaluation of learning in practice

The case study offers an opportunity for in-depth evaluation to take place alongside the learning, using an action research framework.

Conclusion

The evaluation of the mental health awareness training has shown the importance and timely need for such training within the prison service. This is a challenging and exciting time in prison health care, with many new training initiatives being developed to promote best practice. IHCS is proud to be at the forefront of these changes, by providing help, advice, support, research, consultancy and training in mental health care within the prison setting. IHCS will continue to work with the Department of Health, Prison Healthcare, NHSU and the Prison Training Centres to help achieve better quality and a more integrated mental health care system in prisons.

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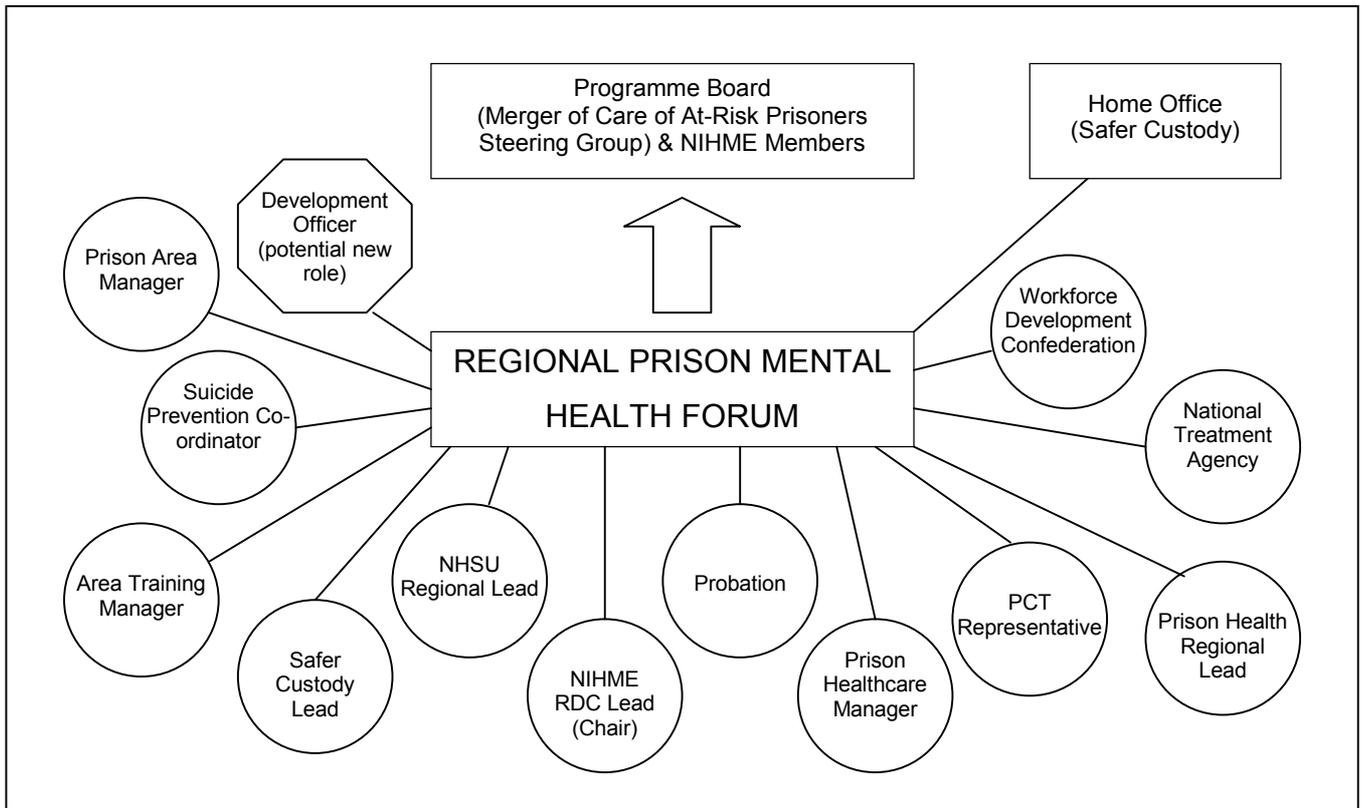
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Appendix A

Example of national roll-out plan

- Nationally, set a series of two or three 'wave' deadline dates, when groups of establishments would change over from using the F2052SH to the ACCT and from using the 'old' to the 'new' health care screen (including provision of follow-up assessments and care).
- Nationally, make a number of 'tools' available to regions/areas/establishments to enable them to make the required changes. These would consist of documents and guidance (ACCT care plan and guidance, substance withdrawal management form, health reception screen plus template follow-on mental health assessment), a co-ordinated programme of cascaded training (suicide risk assessment and management, mental health awareness), and implementation guidance based on the experience of the Care Of At Risk Prisoners (COARP) sites.
- Regions/areas would choose which establishments would aim to join which wave and support them in carrying out the preparatory work necessary (mainly training). The establishments/regions would also choose the order in which they would tackle the various elements of the work. Support for implementation would be provided by a combination of Safer Custody Group (SCG) outreach workers, SCG training staff and (to be appointed/seconded) NIMHE-funded, regional development workers.

Figure 3. Proposed structure of regional prison mental health forums

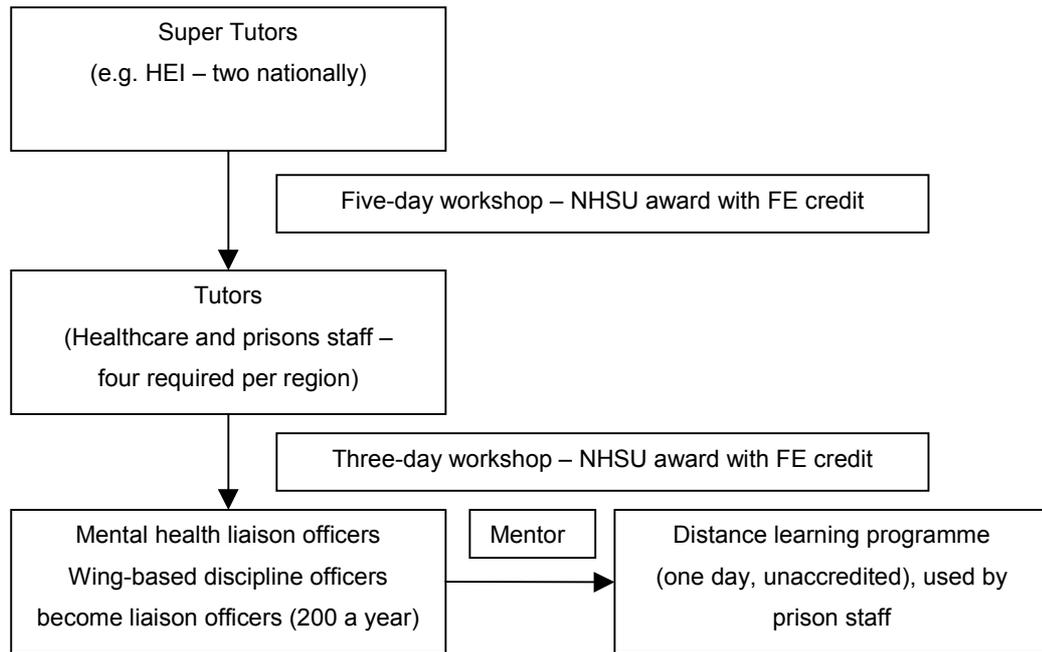


The terms of reference of the regional groups are still under discussion and are likely to be along the following lines:

- To select prototype establishments and agree which establishments will join which wave;
- To support establishments in developing their own implementation/development plan;
- To prioritise and allocate resources against development plans;
- To facilitate training events;
- To ensure establishments meet the deadlines so that the national 'waves' work;
- To facilitate multi-disciplinary and multi-agency working;
- To provide reports to the Programme Board as required;
- To develop models of user involvement.

It is envisaged that the package will be delivered in a suite of training. A five-day course will prepare trainers of the three-day course. The trainees who attended the three-day course will support other prison staff engage in a one-day version of the course via CD Rom. Figure 4 shows this process.

Figure 4. Mental health awareness for prison staff national roll-out



Appendix B: Video Scenarios

Scenario A

Location: Reception area
Prison officer: Black male, 20s
Inmate A: White male, 20s, showing signs of **anxiety, possible PD, possible drug abuse**

Action:

Normal reception sequence as prisoner is admitted (elaborate after prison recce).

Visual/verbal signs:

- No eye contact from inmate, eyes restless – then suddenly staring
- Agitated body language
- Speech staccato, mumbling
- Has collection of rubber bands/odd items in pocket which he doesn't want officer to take
- Shaking, sweating and pale
- Dishevelled and unkempt

Dialogue:

We hear brief sync sound of reception procedure. We hear in voiceover the prison officer's observations of the prisoner, his thoughts/feelings about him:

- Prisoners often show signs of agitation on entry
- But this prisoner is unusual – something really is not quite right – he won't look him in the eye, etc.
- Wonders whether drugs/alcohol are involved
- Decides to get someone from health care to see him
- Decides to keep an eye on him

Discussion points for training:

- Recognising visual signs that make you think you should find out more
- Suggested questions for engaging, ways of talking, appropriate action

Scenario B

Location: Landing office
Prison officer: White male, 40s
Inmate B: White male, 20s, **possible schizophrenia, hearing voices through the radio in cell**

Action:

Angry encounter, which is defused by quiet reaction of the prison officer. Information about hearing voices elicited through questioning and active listening.

Visual/verbal signs:

- Swearing, angry, threatening behaviour – rushes out of cell up to officer
- Wants the officer to do something about insults
- Tells the situation as it appears to him ...
- ... revealing that he is hearing voices through the radio
- Officer comes to cell to take a look
- Finds cell trashed – officer annoyed as it's just before lunch – is this a discipline or a mental health situation?
- Prisoner should clear up mess but is clearly terrified to re-enter cell

Dialogue:

A short, dramatised encounter with no commentary:

- The inmate is clearly furious
- The prison officer is calm and takes the time to find out the facts
- The 'facts' show that the inmate has a distorted view of reality
- This alerts the officer to the possibility of mental illness and guides his reaction to the situation

Discussion points for training:

- Defusing aggression
- Asking 'why?' rather than taking an immediate disciplinary view
- Using active listening

Scenario C

Location: Outside the cell door
Prison officer: White female, 30s
Inmate C: White female, 20s, **self-harm**

Action:

Prison officer told by another prisoner that cellmate is about to self-harm. Prison officer discovers inmate self-harming, gives her something (towel?) to stem the bleeding and contacts healthcare for a dressing; then she sits and talks to the inmate about the self-harm.

Visual/verbal signs:

- Self-harm (arm cutting)

Dialogue:

Inmate tips off the officer that the self-harm is about to happen (sync sound). As the prison officer walks towards the cell, we hear a voiceover that we assume is the prison officer.

- She has had a bad day
- This is the last thing she needs
- She has problems at home
- She sometimes feels she has no-one to talk to about things

The voiceover carries on as we see the officer call healthcare on the radio. She gives the prisoner a temporary dressing (towel?). The officer opens a conversation with the inmate as they wait for the dressing and suddenly it becomes clear that the voiceover was not the prison officer, but the prisoner. The idea is to draw an analogy between the feelings of the officer and those of the self-harmer – they are 'like us' but their response to stress is different. The voiceover then carries on briefly (this time we know it is the inmate):

- She is worried about her children
- She cuts herself when she is stressed
- It's the only way she can make herself feel better

Discussion points for training:

- Trying to understand self-harm and the reasons for it
- Understanding that it is not just 'manipulation' – there can be many different reasons (examples)
- People in prison have few outlets for anxiety and stress
- How to respond to self-harm
- Using your knowledge and information to help reduce the risk of self-harm (examples)

Scenario D

Location: Secure unit for young offenders
Prison officer: White male, 20s and white male 40s
Inmate D: White male, 20s, **ASPD, very violent, manipulative and unpredictable**

Action:

Monologues, to camera, by two prison officers – one is a young, inexperienced officer and the other has many years' experience. They are talking about a particular prisoner. We cut away to see them with the prisoner.

Visual/verbal signs:

We cut away from monologues to see the prisoner conforming to normal prison routine. The signs are subtle, but a well-chosen close-up, a glance, a move, tells us that this prisoner is potentially dangerous. He is charming to the younger officer, smiling and joking.

Then we see the young prison officer refusing a request from Inmate D or perhaps playing a game of snooker with him (depending on filming logistics) when a comment or action suddenly inflames the prisoner. The prisoner suddenly turns on the young prison officer and hits him.

Dialogue:

Their descriptions of Inmate D – and their interpretation of his behaviour – are startlingly different. The young prison officer says:

- Inmate D is a 'good' prisoner, always co-operative
- He responds well to him personally
- The inmate never cuts himself or 'kicks off' when he is on shift
- Inmate D says he has helped him
- He tells him that other officers are not as understanding as him

The more experienced prison officer says:

- He has seen this type of prisoner before
- They are violent and unpredictable
- They play the 'screws' off against each other
- He is wary and won't 'play ball' when the young man tries to make friends with him

Discussion points for training:

- Manipulative behaviour of inmates with borderline personality disorders

Mental Health Awareness for Prison Staff

- Commonly cause conflict between staff and between departments
- Key strategy for dealing with this is for staff to work together in a multidisciplinary way