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Editorial

The contribution of education and training to the development of appropriate mental health service provision for those in contact with the offender health system

Charlie Brooker
Guest editor, The Journal of Mental Health Workforce Development

Epidemiological research has shown that as many as nine out of 10 prisoners display evidence of one or more mental disorders in the UK (Singleton *et al*, 1998). Rates of co-morbidity are also remarkably high, with 80% of the prison population having more than one of the following categories of disorder: personality disorder, psychosis, neurosis, alcohol misuse or drug dependence. Early detection of mental illness at reception to prison has been found to be ineffective, with many mentally ill prisoners both undetected and untreated (Birmingham, 2003). Clearly better and accessible services need to be provided to mentally ill prisoners who need them.

In 1996 the HM Inspectorate of Prison's *Patient or Prisoner* report considered health care provision to prisons in England and Wales. This report highlighted the shortcomings of the prison health service despite their efforts to provide a service equivalent to the National Health Service (NHS). It argued for equivalence, namely that *'Prisoners are entitled to the same level of health care as that provided in society at large'* and that they are, *'given access to the same quality and range of health care services as the general public receives from the National Health Service'* (HM Inspectorate of Prisons, 1996). *'Those who are sick, addicted, mentally ill or disabled should be treated, counselled and nursed to the same standards demanded within the National Health Service. Failure to do so could not only damage the patient but also put society at risk.'* The main recommendation of this report was that the NHS should take over responsibility for health care in prisons. A decade later, the formal commissioning of health care in the criminal justice system became an NHS responsibility in April 2006.

In relation to mental health, the National Service Framework for Mental Health was published in 1999 setting national standards for mental health care for adults. In 2001 an additional joint report by the Department of Health and Her Majesty's Prison Service was published, *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons* (Department of Health & HM Prison Service, 2001). The aims, outlined in these reports, were to:

- recruit at least 300 new staff to provide the new in-reach services
- treat at any one time at least 5,000 prisoners suffering severe and enduring mental illness
- ensure that every prisoner with a serious mental illness has a care plan on release and a care co-ordinator to help the prisoner/patient engage with services once back in the community.

Mental health 'in-reach' teams were described as the main vehicle for the improvement in mental health services for prisoners and were established with the aim of improving mental health care for prisoners with severe and enduring mental illness. While in-reach resources have been small, the original intention was to restrict in-reach services to those with a serious mental illness. In reality, many teams have strayed from these criteria, largely because such straightforward presentations are rare with many clinical pictures made more complex with the presence of personality disorder and substance misuse (Brooker *et al*, 2006). However, the routine care and treatment of people with complex presentations of mental illness is compounded by a series of factors:

- in-reach teams are small with a median team size of three; subsequently prisoners receive little more than assessment (Brooker *et al*, 2006)
- prison staff receive no introductory training in any aspect of mental health
- prisoners who do not consent to treatment for an acute mental illness cannot be treated forcibly under Mental Health Act legislation.
- NHS commissioners are highly inexperienced in prison health care commissioning

- historically, the investment in education and training for mental health staff working in prisons is negligible
- mental health research in prisons is scant (Brooker *et al*, 2002)
- the relationship between specialist mental health services and primary care in prisons can be ambiguous.

In this context, the delivery of appropriate training to all concerned staff should be a high priority, but as the papers in this edition show, such funding and delivery poses formidable challenges. Also, the phrase 'offender health' has clear implications beyond prisons, where other salient settings include the courts, police cells/stations, NHS secure provision and the community in general. In this wider sense, the workforce consists not just of prison and in-reach staff but mental health staff working in the mainstream NHS, the voluntary sector, offender managers/probation officers, court officials and the police.

The six papers in this edition of *The Journal of Mental Health Workforce Development* consider various aspects of the education/training agenda for the offender mental health workforce. Hughes (2006) reports on the outcome of a dual diagnosis training package developed for staff working in prisons with service users with both a diagnosis of a psychosis and a substance misuse problem. The pilot programme was implemented in five London prisons and its development was helpfully informed in consultation with service users and a training needs assessment completed by staff. The programme was formally evaluated and this showed that staff perceptions of self-efficacy significantly improved, as did their attitudes towards these clients. One of the key findings in the report was the vast improvement in organisational communication reported by all staff involved in the care of this client group, from a variety of diverse perspectives ie. in-reach, primary care and CARATs teams. Unfortunately, this programme was commissioned as a 'one-off' and routine delivery of the course across the country seems unlikely. This is very disappointing given the investment in the production of the training materials.

Sirdifield (2006) describes the impact of several pilot schemes that have attempted to introduce the role of the health trainer in the criminal justice system. Health trainers are recruited from local communities, use a set of competencies, and aim to signpost individuals into appropriate local health services. There is vast scope for such a role in prisons, for example, where many prisoners have led unhealthy lifestyles that are often compounded by the prison environment, eg. poor standards of diet. It is clear from this paper that there are significant opportunities for health trainers to engage in mental health promotion including: diet, exercise, weight management, smoking cessation and stress management. The prisoners that become accredited health trainers also increase their own employability on release, thus improving their own mental health prospects. However, again the long-term sustainability of these programmes is unknown.

Hayes and Lever-Green (2006) examine the role that another innovative training programme has played in aiming to reduce suicides in prisons. The paper explains that historically, the prevention of suicide in prison has been driven by the identification of suicide risk using a system, largely paperwork-orientated, known as F2052SH. Following clamours from professional bodies, and citing the findings from the Confidential Inquiry into Suicide and Self-harm, the prevention of suicide in prison became organised more systematically and included: new meaningful assessment forms, the creation of care pathways, and the introduction of Assessment, Care in Custody and Treatment (ACTT). Hayes' paper provides a telling commentary on STORM (Skills-based training and risk management). While this package has been evaluated in a very positive manner funds can no longer be found to support its expert implementation.

Brooker and Sirdifield (2007) report on an evaluation of the mental health awareness training workbook for prison staff that was rolled out by the CSIP patches 2006–2007. The workbook was based on a two to three day training programme developed for face-to-face training (and often incorporated into ACTT training). This evaluation was not positive on a number of levels. As has been shown in previous national training initiatives (see Brabban *et al* and the *10 Essential Shared Capabilities*, 2006) self-directed learning, while seemingly an attractive, low-cost solution to training, is evaluated badly by students and leads to little impact generally. This was unfortunately the case with the mental health awareness training workbook. When learning was supported by experts even partially (as in Hughes' paper earlier), the outcomes were much more positive. There are serious organisational obstacles to running any type of training for prison officers, not least of which is obtaining

permission from their managers to 'take time out' from understaffed rotas. Thus, many of the students identified for the regional workbook programmes were asked to undertake training at home and in their own time. It was clear from this evaluation that apart from one or two very enthusiastic officers, this simply did not happen.

Durcan (2006) reviews mental health service provision in prisons more generally and dissects a number of the workforce issues. He argues that very few of the current policy initiatives have been 'evidence-based', and the development of a mental health care pathway aside, that there has been little policy implementation guidance. Thus, he argues that there is no accepted or understood model of mental health care delivery in a prison setting, nor has the workforce been prepared for the task. In his conclusion, Durcan tempers some of these understandable criticisms by agreeing that in-reach teams especially, have been a positive development, but that there is little internal pressure within the health care system ie. through commissioning, to drive up the quality of care. In addition, he is disappointed (a disappointment that many would share) that prison mental health care development seems to be considered outwith the mainstream NSF for mental health, and thus the National Institute for Mental Health's (NIMHE) more general workforce programme.

Offender mental health is a late-comer to the party inasmuch as primary care trusts only assumed formal commissioning responsibility for these services in April, 2006, and indeed, improving services for offenders might not be regarded as an attractive local political imperative. There are other factors that mitigate against a coherent workforce policy in this area: the extent of multi-agency working, the probable loss of CSIP as the service improvement/implementation arm of the DoH, the need to identify the evidence base in order to inform training content, the lack of funds available for new sustainable funding, the seeming non-alignment between the NIMHE workforce programme and offender mental health, and the organisational barriers to overcome within prisons themselves. In 2007, the Department of Health will produce a new strategy for offender health and it will be interesting to see what focus, if any, there will be on the need to develop the workforce.

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A pilot study of dual diagnosis training in prisons

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Abstract

People with dual diagnosis have complex needs and vulnerabilities that may lead to incarceration in prisons. Mental health and substance use services in prisons should have the capabilities to address their needs while incarcerated and facilitate the transfer of care to community services on release. In order to develop these capabilities, a training programme is required.

A pilot training programme for dual diagnosis was developed and piloted in five London prisons. The training was based on a training needs assessment of prison staff and consultation with service users. It was delivered in two forms: a five-day classroom based course, and a 'blended learning' method that comprised a manual and three sessions of supervision. The course was evaluated by a brief questionnaire that included items on attitudes, self-efficacy and knowledge about working with dual diagnosis.

The evaluation of the training revealed that all workers, no matter what method of training they received increased their perception of their skills (self-efficacy) and increased their attitudes. Knowledge remained the same (although the scores pre-training were high). There was no difference between the two types of training when mean scores were compared at post-training. There was also no difference between the mental health and substance workers regarding their mean scores at follow-up, apart from knowledge.

The conclusion is that the training pilot was evaluated positively and did indicate that it has some effect on attitudes and self-efficacy. More rigorous evaluation of the impact of the training is required, using a robust methodology and assessing the impact on clinical skills and service user outcomes.

Keywords

prison; mental health; dual diagnosis; training

Background

Addressing the needs of people with dual diagnosis (mental health and substance use problems) has been identified as a major challenge for mental health services in England (DoH, 2005). The outcomes for people with dual diagnosis are likely to be poor and they are likely to have a substantial amount of unmet needs. Areas of vulnerability include increased risk of suicide, violence, victimisation, health problems (such as blood borne infections), poor adherence to treatment, and homelessness. People with dual diagnosis often fail to receive appropriate care due to a combination of difficulties with engagement, lack of clarity around service responsibilities and lack of capabilities of the mental health and substance use workforce. The lack of engagement and the complexity of their problems can result in criminal behaviours and ultimately imprisonment.

While there are no actual figures of the prevalence of co-morbid substance use and mental health in the prison system, it is estimated that the level of dual diagnosis is likely to be significant (Brooker *et al*, 2003). Surveys (ONS, 1997; 1998) estimate that 70% of prisoners have at least one diagnosable mental illness or substance use problem. Often prisoners have multiple diagnoses. These prisoners are at high risk for suicide. Shaw, Appleby and Baker (2003) reported that 32% of people who committed suicide while in prison had two co-morbid diagnoses. Re-offending rates are also high as co-morbid mental health and substance use compound the difficulties (lack of housing, support, access to care etc.) associated with release from prison that most prisoners experience (Social Exclusion Unit, 2002; Home Office, 2004). For example, around half of people with mental illness who are released from prison lack stable housing (Revolving Door, 2002).

Despite the modernisation of both mental health (DoH/HM Prison Service, 2001) and substance use services (HM Prison Service, 1998; 2000) within prisons, there is a lack of clarity as to who should be providing care for prisoners with both mental health and substance use problems, and a lack of skills and knowledge among workers to provide that care.

The Sainsbury Centre for Mental Health (SCMH) (2006) found that in their review of prison mental health in-reach teams, there was a 'big gap' in service provision for dual diagnosis, and mental health and substance use teams tend to refer people on to other services, rather than seek to work jointly. SCMH (2006) suggests that given the high level of co-morbidity, addressing the needs of these prisoners should be core business of the mental health teams.

The Practice Implementation Guide for Dual Diagnosis (DoH, 2002) advocates that care for people with serious mental health problems should be delivered by mental health services with some help and support from substance use services ('mainstreaming'). People with primary substance use problems who have minor mental disorders (such as anxiety or depression) should be managed primarily by substance use services with some support from mental health if required. The implication is that workers in both settings will need to be able to work holistically and comprehensively with everyone with dual diagnosis. Therefore, they should possess the appropriate capabilities. This policy guidance equally applies to prisons. However, the prison substance use workers are not likely to have a mental health background, and therefore can't take the role that the community drug and alcohol services provide outside the prisons. In addition, it is likely that many mental health workers in prison lack skills in substance use interventions.

Therefore, in order to address the issue of improving care for people with dual diagnosis within prison, the first step should be to improve the way mental health and substance use services interface, and to improve the capabilities of workers in these services to detect, assess, and intervene using an evidence and values-based framework of intervention.

Prison dual diagnosis training pilot project

The overall aim of the project was to develop and pilot a set of relevant and effective training materials that will assist mental health and substance use staff in their care of people with dual diagnosis within the prison service. The target groups for the training were those who spent the most time working therapeutically with prisoners with dual diagnosis, namely health care staff, prison substance use counsellors (Counselling, Assessment, Referral, Advice and Throughcare Services – CARATS), detoxification staff, primary care, and mental health in-reach staff. Prison officers were invited to participate if they had a specific role in health care.

Method

The first stage of the project was to engage the prison sites for the delivery of the training. All health care managers, in-reach team managers and substance use service managers at all London prisons were contacted (via email and telephone). The project manager met with key personnel at these prisons to explain the aims of the project and to discuss whether it could be implemented at their institution, and by which method. Most of the prisons agreed to participate: HMP Wormwood Scrubs, HMP Wandsworth, HMP Belmarsh, HMP/YOI Feltham and HMP Highdown. An information sheet was provided for trainees, which outlined the project aims, methods of delivery, and the dates for the training at their own establishment. The link worker at each site co-ordinated the recruitment of trainees, and the booking of suitable training venues.

The second stage of the project was the training needs assessment. This comprised a semi-structured questionnaire asking about a range of issues relating to the care of dual diagnosis prisoners and the perceived training needs. The aim of this instrument was to gain an understanding about:

- how staff currently worked with people with dual diagnosis
- what they regarded as the needs of people with dual diagnosis in prison
- their views on the ideal content of a training package.

Of 80 questionnaires distributed by the link workers at each prison, 23 were completed and returned, and this represents a response rate of 29%. This is not unusual for postal-return method of prison staff (Brooker *et al*, 2006). A more effective method would have been face-to-face interviews but given the time-frame and the difficulties of accessing staff within prisons, this seemed to be the most pragmatic method. Although the respondents represented a good cross section of the services that would be targeted for the training, the low numbers make it difficult to generalise the results across the service. The breakdown of respondents was as follows:

- CARATS workers – 5
- RAPt (rehabilitation of Addicted Prisoners Trust) – 1
- mental health (in-reach and inpatient services) – 10
- detox – 7
- health psychology – 1.

Despite the low numbers, their responses gave an initial understanding of the perceived training needs.

They reported that the most common mental health problems encountered were schizophrenia, then depression and drug-induced psychosis (no mention of personality disorders). The most common substance use problems encountered were heroin and alcohol followed by crack cocaine. They usually offered assessment and referral to prisoners with dual diagnosis and lacked a framework for interventions. They were able to identify appropriate values and attitudes and general interpersonal skills that should be used, but didn't mention more specific skills such as motivational interviewing or cognitive behavioural interventions for psychosis. They thought that multi-agency working could be good, but often poor communication and a lack of clarity about roles and responsibilities acted as barriers to this. They mentioned that resource issues (lack of staff and time) acted as barriers to providing anything more than brief assessment. In addition, security requirements of the prison restricted the access of health professionals to prisoners on the wings. The respondents reported very little previous training relevant to dual diagnosis. Generally, if people had accessed training it was in the form of brief one-day workshops or lectures. None of the addictions workers who completed the questionnaire had any previous mental health training, and mental health workers had little previous substance use experience.

The conclusions drawn from the training needs assessment were:

1. Mental health and substance use workers work together infrequently and there is a lack of communication and sharing of information between services in prison (and outside).
2. The respondents understood little about each other's role and how a person with dual diagnosis should be navigated through these services both within the prison and outside.
3. They identified general basic skills, knowledge and attitudes for work with people with a dual diagnosis, but lacked a theoretical framework on which to base their interventions.
4. They lacked an overall strategy or framework that could guide care.
5. There was a significant lack of clarity about their own training needs apart from an acknowledgement that they wanted to know more about dual diagnosis issues.
6. The respondents lacked basic training in mental health and substance use awareness, as well as the more specific dual diagnosis issues.

Service user consultation

A group of four service user consultants with some experience of a mental health and substance use problem (some also had personal experience of the criminal justice system) attended a consultation meeting. They were asked a series of open-ended questions. A transcript was produced and the participants were given a copy to approve before it could be included in the report of the project.

From the discussion, it emerged that the service users felt that workers from mental health and substance use services lacked competence and confidence in dealing with the complexity of dual diagnosis. Thus, they had found themselves excluded from help from a particular service until they had got the other problem sorted out. One participant described how he had been told that he could not continue with his psychological therapy for his mental health problem until he had stopped drinking. He felt that in order to stop drinking he needed help with his mental health problems. The service users felt that things could be improved if services were more willing to work with someone 'where they were at' in terms of motivation and lifestyle choices rather than forcing treatment options on to them. For example, rather than just offering detoxification, services could offer counselling to help motivate people before they make the decision to reduce or stop their substance use. They also felt that more counselling ('talking therapies') should be available. When asked about the knowledge, skills and values for helping people they talked mostly about the importance of the right attitudes (empathy, non-judgemental, acceptance). This would assist in the engagement process. They also talked about the importance of identifying and helping with social issues. Examples of important social issues were helping people find safe housing, and helping with the move away from an unhealthy peer group. In

contrast the staff training needs responses did not mention social issues.

The service users thought that a training course should explore attitudes and should include drugs and alcohol awareness. Training should attempt to break down the 'them and us' barrier and help staff to see that 'we are all service users' of some kind or another. They wanted training to increase staff empathy. They also thought that training should help the workers to help the service users manage relapses better, not seeing lapses as treatment failure or lack of motivation, but utilising them as a learning experience. They also thought that role-play was an important way for staff to learn, and that service users should be involved in the delivery. They thought that staff should be evaluated by using case-studies and that they should be directly observed in practice.

In terms of ongoing support and learning, the service users thought that the trainees should be able to access supervision, and work alongside experienced workers. Workers should have a learning plan that maps out their development. They felt emphatically that service users should be involved in all aspects of training including delivery and evaluation. They felt that prisoners should be consulted about what they want.

In conclusion, the service users thought that a training package should address attitudes, increase empathy, and help workers to offer integrated care rather than referral elsewhere. They felt that training should be experiential and that there should be ongoing learning and supervision afterwards. They also emphasised the importance of service user involvement in all aspects of development and delivery of training.

The training materials

The training materials were developed from a five-day course that had been developed over the past five years at the Institute of Psychiatry, King's College London. This course had been used in two research trials of training for community mental health workers, and in a London wide dissemination project across most of the mental health NHS trusts (Brewin, 2004). The content was modified to be relevant to the prison settings. The training resource combined evidence and government policy relating to the care of people with dual diagnosis as well as relevant prison research and strategy documents including the *Dual Diagnosis Good Practice Guide* (2002), Integrated Treatment Approach, Motivational Interviewing, Cognitive Behavioural Techniques, and Relapse Prevention. In addition, the *10 Essential Shared Capabilities* (2004) were also used as a basis for the values and ethos of the course. Feedback from the training needs assessment information and service user consultation also informed the content and delivery of the materials.

The training pack was designed to be delivered in a flexible way either as a traditional classroom based course, or as self-directed work-based learning (blended learning). It is divided into 16 modules, each module representing one to two hours of classroom teaching or self-directed learning sessions. The course could be delivered over five days or in smaller units over a longer period. Each module consists of a title page with an aim and approximately four objectives, and is mapped to specific capabilities from the Dual Diagnosis Capability Framework (Hughes, 2006). There is also space for participants to add their own personal objectives. There are sections of background reading about the specific subject, a small group discussion exercise, and a role play/skills practical (depending on the subject). The module ends with recommended further reading.

The manual is intended to be clinically relevant, simple to use and easy to read. It is not intended to be an exhaustive resource for dual diagnosis as there are already products in the public domain that serve this purpose (eg. the Rethink Dual Diagnosis Toolkit, undated internet resource). Neither is it intended to be a heavily referenced academic piece of work. Further reading and useful websites have been referenced at the end of each module for people to seek out if they so wish.

Training content

Module 1	Introduction
Module 2	Drug and alcohol awareness
Module 3	Mental health awareness
Module 4	Interaction of mental health and substance use
Module 5	Assessment process
Module 6	Comprehensive assessment
Module 7	Physical health and assessment
Module 8	Risk
Module 9	Treatment models
Module 10	Stage 1 engagement phase
Module 11	Stage 2 persuasion: building motivation to change
Module 12	Resistance
Module 13	Stage 3 active treatment
Module 14	Stage 4 relapse prevention
Module 15	Multi-agency working and service delivery
Module 16	Practice development

Implementation and evaluation

Training was piloted at the five London prisons. Two prisons received a five-day (one day per week) classroom course (n=23) and three received 'blended learning' (n=40), which consisted of three supervision sessions that occurred fortnightly, plus the manual to work through.

The training was evaluated using a short questionnaire that included items about dual diagnosis attitudes, confidence in skills, and knowledge. Each item was rated on a five-point Likert scale, 1 representing disagree strongly and 5 agree strongly. The questions were adapted from questionnaires used in previous evaluations of dual diagnosis training (Hughes *et al*, in submission).

A total of 63 questionnaires were completed pre-training. The questionnaire was redistributed on the last day of training. If people were absent on the day, questionnaires were left with colleagues for the missing people to complete and post back.

A total of 44 follow-up questionnaires were received (70%). This gives an attrition rate of 30%. However, 13% of the attrition can be accounted for from one prison site (blended learning). The data from the questionnaires was entered onto a database and analysed using SPSS 14. The maximum possible score for attitude and confidence was 40, and maximum score for knowledge was 7.

Analysis of data

As this was a scoping project, the data collected was limited to a brief questionnaire. Therefore the findings serve as indications only as to the effectiveness of the training methods. More rigorous research methods would need to be adopted to provide more definitive results.

All participants (no matter what method of delivery they were exposed to) were compared on the means of the subscales at baseline and follow-up using a paired sample t-test. Overall, there was a significant improvement at follow-up on attitudes and confidence in their skills towards people with dual diagnosis (see ***Table 1***, overleaf). Knowledge scores remained unchanged, however, the scores were reasonably high at baseline with an average of five out of seven correct. The knowledge questionnaire would need to be expanded to include more items covering more of the overall content of the training if this were to be repeated as a part of a larger more formal research exercise.

Table 1: Mean scores for all participants' baseline and follow-up

Subscale	Baseline (s.d.)	Follow-up (s.d.)	t	df	P value
Attitude	28.90 (3.52)	31.29 (3.22)	3.839	40	P=0.01
Confidence	22.23 (4.94)	25.44 (2.77)	-6.03	62	P=0.001
Knowledge	5.36 (1.36)	5.75 (1.22)	1.52	35	NS

Table 2: Mean scores for blended and five-day groups' pre and post-training

Subscale	Pre-training blended (s.d.)	Post-training blended (s.d.)	Pre-training five-day (s.d.)	Post-training five-day (s.d.)	T (difference post training)	P value
Attitude	29 (3.28)	31 (3.66)	29.50 (3.37)	31.55 (3.34)	0.423	NS
Confidence	22 (5.12)	26 (3.32)	21.40 (5.93)	25.38 (3.32)	-0.120	NS
Knowledge	5.56 (1.09)	5.95 (1.27)	5.20 (1.32)	5.60 (1.35)	-0.905	NS

Table 3: A comparison of mental health and substance use worker mean scores post-training (irrespective of type of training)

Subscale	Mental health workers mean (s.d.)	Substance use workers mean (s.d.)	t	P value
Attitude	30.78 (4.20)	31.29 (3.25)	0.421	NS
Confidence	26.16 (2.73)	25.00 (2.97)	-1.474	NS
Knowledge	5.13 (1.40)	6.08 (1.17)	2.275	P=0.05

Table 4: Mean scores for manual and training evaluation

	Manual items mean score (s.d.)	Range	Training/supervision items mean score (s.d.)	Range
Blended learning				
Highdown	24 (3.0)	21–29	22 (1.5)	17–25
Wandsworth	24 (4.2)	16–28	22 (2.6)	17–25
Belmarsh	28 (2.1)	26–30	22 (1.5)	21–24
Five-day training				
Feltham	27 (2.1)	25–30	29 (1.1)	27–30
Wormwood Scrubs	27 (2.2)	24–30	28 (2.4)	24–30

Figure 1: Attitudes scores pre-training and post-training

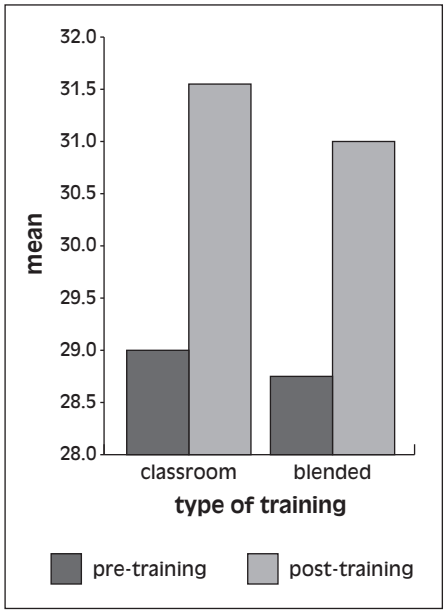


Figure 2: Self-efficacy scores pre-training and post-training

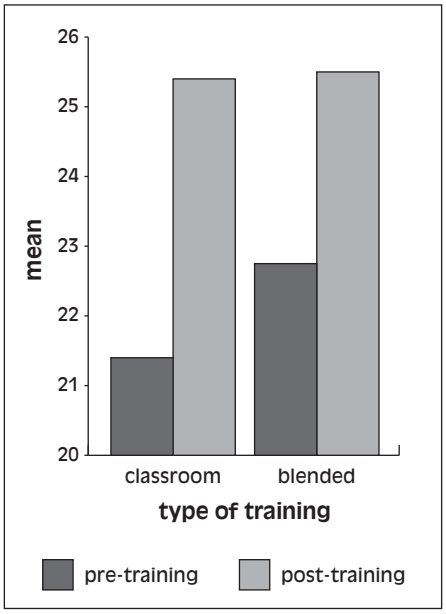
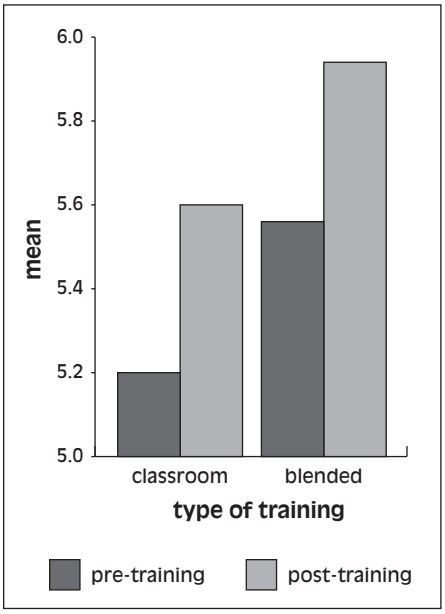


Figure 3: Knowledge scores pre-training and post-training



The mean scores for the sections on attitude, confidence in skills, and knowledge were compared between the two training groups (see ***Figures 1, 2 and 3***, above).

Independent t-tests were performed to compare the follow-up means for the two groups and the differences were not statistically significant (see ***Table 2***, opposite).

Those in a mental health role and those in a substance use role were compared on how they responded to the training. Other roles such as psychology, prison officers and general nurses were excluded from the analysis (this excluded six people only). This resulted in 24 staff in the 'substance services' group and 14 in the mental health group. An independent samples t-test compared mean scores for substance use staff and mental health staff at follow-up (see ***Table 3***, opposite).

The only significant difference between substance use and mental health workers was on knowledge. This could be a reflection of the types of items included in the seven items. The items were biased towards substance use issues and therefore it could be hypothesised that the substance use workers were more likely to get these items correct.

In addition to the questionnaire, an evaluation form was devised for the project. This comprised questions relating to the manual, and questions relating to the five-day training or supervision sessions (five items) in the blended learning. It also included some open-ended questions to obtain qualitative information. The overall score for the manual and the training items was out of a maximum of 30, and the score for the supervision sessions was out of 25.

The prison groups were combined to compare all participants who had completed the five-day training with all that had completed the blended (see ***Table 4***, opposite). An independent sample t-test was performed to compare the mean scores for the manual. The mean score for the blended training was 24.85 (s.d. 3.54) and for the five-day training was 27.23 (s.d. 2.07). The five-day training groups evaluated the manual slightly higher than the blended, and this difference was statistically significant (t=2.650, df39, p=0.012).

For the qualitative questions they were asked what had they found most useful. Six themes emerged (in order of most frequent response):

- the manual itself
- motivational interviewing techniques
- role-play
- theoretical models and intervention tools
- combining mental health and substance use workers for training
- group discussion.

Least useful:

- drug awareness/knowledge (mentioned by substance use workers)
- time limits (blended learning only)
- role-play.

Role-play was mentioned in both the 'most useful' and 'least useful' categories but this is not surprising given that some people dislike it and others find it useful.

When asked what was missing from the training that should have been included, the themes were:

- more on mental health, both in the manual and the training
- personality disorders
- attention deficit
- Asperger's syndrome
- exercises and case studies
- information on mental health medications.

It is likely that those people who wanted more on mental health would be the substance use workers, and perhaps this training need may be met by the prison mental health awareness training. When asked what there should be less of, there were few responses, and these consisted of:

- fewer discussions
- drug awareness/knowledge (this was from the substance use workers).

When asked what there should be more of people mentioned:

- role-play and exercises
- discussions
- mental health.

Finally people were asked to give 'any other comments':

- positive comments using terms like 'enjoyable', 'interesting', 'excellently researched', 'useful'
- people were very positive about the manual and felt it would be a useful on going resource
- people who did the blended learning mentioned that time given for the supervision sessions could have been longer or more frequent
- people expressed a wish for further training, and about extending this training to prison officers.

The service user consultants reviewed the training manual and the overwhelming response was very positive. They thought it was clearly set out, simple to read, and succinct. One service user commented that it mapped out the process of working with someone with dual diagnosis very well; it read like a 'journey'. They agreed that the values that they had discussed at the first meeting were clearly represented. They thought that the manual would be accessible to anyone, including service users and carers. They liked the case examples, thought they were credible, and felt there could be more of this.

Some people commented that it was the first time that representatives from the substance use and mental health prison services had sat in a room together for training. They felt this was a real strength of the training, and felt that they got different perspectives on clinical problems as well as sharing expertise and learning about each other's roles.

Discussion and recommendations

This project has demonstrated that, even given a relatively brief timeframe, it is feasible to set up and deliver dual diagnosis training for prison mental health and substance use services. In addition, the training materials that were developed were evaluated positively by both workers and service user consultants.

The training needs assessment highlighted that prison mental health and substance use staff may lack the capabilities to provide co-ordinated and evidence-based care for people with dual diagnosis. Therefore, it is imperative that a national prison dual diagnosis initiative is implemented to rectify this situation in order for prison services to be able to deliver on government targets (DoH, 2002; DoH, 2005).

Analysis of the outcomes on the knowledge, attitudes and confidence questionnaire (the DDAQ – Dual Diagnosis Attitudes Questionnaire [Hughes *et al*, in submission]) suggests that overall, the training materials facilitated some positive benefits for the participants. Attitudes and confidence in their skills improved significantly. Knowledge remained unchanged and this has implications for future adaptations of the DDAQ.

The feedback from the two methods of delivery (classroom and blended) suggested that on balance the classroom method was preferable. In addition, the classroom group evaluated the manual more positively. This was perhaps because they had been able to use it

more thoroughly and in a more structured way. The advantage of the classroom-based training is that groups of workers from different disciplines can work on clinical problems together thus sharing expertise, and learning about each others' roles. This is something that people felt was particularly useful for them.

Further research is required to evaluate the training using more robust methodology. In addition to the evaluation of trainee reactions to the training, it is important that training can demonstrate that it changes practice and in turn improves outcomes for service users. Other important outcomes of training could be at the organisation level, and could be measured by increased effectiveness of multi-agency working.

Dual diagnosis training should be mapped to the prison dual diagnosis strategy that is currently being developed. This will help clarify roles and responsibilities between the agencies and how they can work together. Dual diagnosis training should not represent an end point in itself. It is likely that attendees will identify learning needs as a result of it, and there should be opportunities within the prison and outside to pursue these. This could include the establishment of a forum for the discussion of dual diagnosis issues, and an opportunity to update peoples' knowledge with regular presentations and case presentations.

There is a dual diagnosis training package in development that will be nationally disseminated by Care Services Improvement Programme (CSIP). This will be an advanced training module following on from the 10 Essential Shared Capabilities Framework. This is being developed by the same team who developed the prison pilot project. It is expected that the prison dual diagnosis training would be developed in line with the content and philosophy of this product. This will ensure that prison dual diagnosis training is developed in parallel with other national mental health training initiatives. In addition, both training products will be mapped to the Dual Diagnosis Capability Framework (Hughes, 2006).

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Piloting a new role in mental health – prison based health trainers

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Abstract

Prisoners in the UK are in a poor state of health compared to the wider population, often experiencing numerous physical and/or mental health problems. Many prisoners have had little contact with health services, and research suggests that the standard of health care provided in prisons is not equivalent to that provided in the community. This article introduces Care Services Improvement Partnership Health Trainers – an initiative aiming to provide prisoners themselves with the skills to address health inequalities among their peers. Initially, it discusses the origins of these Health Trainers. It then examines prisoners' views on how training as a Health Trainer has influenced their attitudes and behaviour, and outlines possible implications of providing this kind of training to prisoners in terms of them using their knowledge to influence other prisoners' mental health.

Keywords

prison; mental health; Health Trainer; peer-education

Background

UK prisoners generally lead unhealthy lifestyles including misusing drugs, smoking and misusing alcohol (HMPS/DoH, 2001). Consequently, prisoners are in a relatively poor state of health compared to the wider population, often experiencing multiple physical and/or mental health problems. Research shows that the incidence of mental health disorders is much higher in the prison population than the wider population with up to 90% of prisoners exhibiting signs of a mental health disorder (Singleton *et al*, 1998; Brooker *et al*, 2002). For example, Brugha *et al* (2005: 774) estimate the weighted prevalence of probable functional psychosis in the general UK population to be 4.5 per thousand, while in the prison population, they estimate it to be 52 per thousand – over 10 times higher. Similarly, Singleton *et al* (1998) estimate the incidence of neurotic disorders at between 40% and 76% in the prison population compared to just 17.3% of adults of working age in the wider population.

Prisoners are unlikely to have had much contact with health services while in the community (Department of Health, 2004: 129), and for some individuals, time spent in prison may be the only time that they engage with health services. However, the prison population is continuing to increase (HMPS, 2006) and research shows that despite prison reception screening, in many cases mental health disorders also go undetected while an individual is in prison (Birmingham *et al* 1996; SEU, 2002). Pressure on prison health care services is likely to increase as the population continues to rise.

In 1996 Her Majesty's Inspectorate of Prisons argued in *Patient or Prisoner: a new strategy for healthcare in prisons* that prisoners should receive an equivalent standard of health care in prisons to that provided in the community. However, in 2002, the Social Exclusion Unit stated that:

> *'Despite isolated examples of good practice by the Prison Service, NHS and voluntary sector organisations, most prisoners with mental health problems are not currently receiving the care and treatment they might expect outside. Research suggests that prisoners are twice as likely to be refused treatment for mental health problems inside prison than outside'* (SEU, 2002: 71).

Thus, there is a greater need for mental health care services in prison than in the general population, but the service provision is not adequate to meet these needs. Many individuals are not receiving the care that they need which may increase their chances of re-offending and lead to increased costs for the NHS further down the line.

In order to improve this situation, there is an increasing need for prison staff to be able to recognise the signs and symptoms of mental illness. Some improvements have been made already – including the provision of prison in-reach teams and NHS-led primary care teams to assess prisoners' mental health (Brooker *et al*, 2005). Additionally, a self-directed mental health awareness workbook has been

rolled out to a number of prison staff as part of ACCT (Assessment, Care in Custody and Teamwork) training through the CSIP (Care Services Improvement Partnership), and Health and Social Care in Criminal Justice Programme (HSCCJP) (Brooker, 2006). Furthermore, in April 2006 responsibility for the provision of health care services in prisons moved from the Home Office to the NHS.

However, one could argue that relatively little resource has been allocated to educating prisoners to recognise the signs and symptoms of mental health disorders. This article provides an introduction to a new initiative that is beginning to do just that – CSIP Health Trainers. This initiative aims to provide prisoners with the skills to address health inequalities among their peers. Initially, this article provides an overview of the progress made during the first eight months of a pilot project in terms of adapting core Health Trainer competencies for use in prisons and designing a training course to teach these competencies to prisoners. Second, the sections of the course relating to mental health and well-being are described in more detail. Third, the results of a focus group conducted with Health Trainers at one prison are presented to show these prisoners' views on how the course is influencing their attitudes and behaviour, together with possible implications of providing this kind of training to prisoners in terms of Health Trainers' ability to influence other prisoners' mental health. Finally, recommendations are made regarding the focus of future research on this topic.

What is a Health Trainer?

The 2004 white paper *Choosing Health: Making Healthy Choices Easier* aimed to reduce health inequalities by supporting the public in making more healthy and informed choices regarding their health. The government particularly emphasised working in disadvantaged areas and with previously excluded and marginalised groups to enable them to make faster improvements in health, and thus reduce health inequalities. Rather than disseminating advice from on high, the government proposed that responsibility for improving health should lie with communities themselves. Consequently, they introduced the role of a Health Trainer into deprived communities.

Initially, Health Trainers were recruited from these deprived communities, using a draft set of core competencies and job descriptions that were trialled in 12 early adopter sites. These sites were areas of the UK, which the government identified as being the most disadvantaged. Health Trainers were employed to signpost individuals into relevant local health services. They were also trained to support individuals in making and following personal health action plans to achieve goals such as weight reduction or quitting smoking. The boundaries of the role were very fluid in terms of the types of population worked with and the areas of health (eg. healthy eating/smoking/sexual health) that were focused on. This has resulted in a wide variety of Health Trainer models being implemented across the country. A number of local-level evaluations of these early adopter sites are now underway, and there are proposals for a national evaluation of the Health Trainer role.

CSIP Health Trainers

After the core competencies and job descriptions had been trialled in the early adopter sites, a project led by CSIP adapted them for use in the prison environment. The project team aimed to train prisoners in a variety of types of establishment as Health Trainers. The project was advertised across England, resulting in five prisons and one probation area volunteering to take part in the pilot – namely HMP Drake Hall, HMP Stafford, HMP Wandsworth, HMP Kingston, HMPYOI Swinfen Hall and Portsmouth Probation area.

Representatives from the University of Portsmouth, Prison Health (Department of Health), CSIP, PCTs, and Prisons and Probation worked together over approximately six months to revise the community-based job descriptions and to develop a training package based around the Department of Health core competencies.

The general content of the community-based Health Trainer job description was deemed to be quite acceptable for use in prisons, but some of the wording was changed to reflect the fact that the Health Trainers would be operating in a prison environment, and to make it more user-friendly for the prisoners being trained.

The finished training package covers areas such as communication skills, identifying professional boundaries, promoting health and well-being, behaviour change, healthy eating, physical activity, smoking, and mental health and well-being. Its design accounts for prisoners' likely literacy levels and attention spans. Consequently, it is a mixture of formal teaching and hands-on exercises that can be taught in short sections over a number of weeks. The flexibility in the way in which the programme is delivered recognises the need to book group rooms and to

have staff free to escort prisoners to and from the course. Additionally, accreditation is being sought from the National Open College Network (N/OCN) to make it comparable with other prison-based programmes. Prison staff felt strongly that this was an important factor in motivating prisoners to attend the course, and in making the programme relevant to resettlement objectives.

The approach taken to recruiting Health Trainers varied in each establishment, reflecting differences in terms of establishments' population size, layout, resources and security issues. Thus, in some prisons, the role was advertised through a flyer, and prisoners were invited to complete formal applications, while in others particular prisoners that staff considered to be trustworthy and motivated were selected for the role. In all cases, tutors agreed that Health Trainers would need good communication skills, an interest in health promotion, and to be motivated enough to complete the course. Additionally, it was deemed inappropriate to recruit sex offenders into the role. In prisons implementing an 'open' application process, they aimed to recruit one Health Trainer per wing/two houses to ensure that all prisoners have equal access to the service and in order for each Health Trainer to have a manageable number of potential clients. For example, in Drake Hall one Health Trainer was recruited per two houses meaning that each Health Trainer would have approximately 39 potential clients. This figure varies between establishments, and changes as the total population of the establishments fluctuates.

Description of the training programme/course

Several sections of the course may have implications for the mental health and well-being of both the Health Trainers and their peers. The content of these sections is briefly outlined below.

The section of the course relating to exercise outlines:

- anatomy and physiology
- definitions of 'fitness'
- how to plan, implement and evaluate a personal exercise programme
- a range of exercises that it is possible to do in a cell and/or the prison gym
- types of fitness training
- recommended levels and benefits of exercise
- exercise safety.

The section on healthy eating outlines:

- general dietary guidelines, nutrition and food groups
- how to reduce intake of fat, sugar and salt, and increase intake of fibre
- weight management.

The section relating to mental health and well-being covers the following topics:

- what stress is
- positive and negative aspects of stress
- how to recognise the signs and symptoms of stress
- physical, emotional and behavioural effects of stress on health
- causes of stress (including prison)
- stress management techniques
- how to make a stress management action plan.

Evidence from a focus group with Health Trainers at one prison suggested that the knowledge that they gained from these sections of the Health Trainer course had already started to change their attitudes and behaviour in these areas. These prisoners were already making changes to their own behaviour and beginning to influence other prisoners' behaviour, which may have implications for their mental health as outlined below.

Methodology

The research aimed to investigate the views of several Health Trainers at one establishment on the effect of their training on their attitudes and behaviour. Gaining access to interview prisoners is often problematic, and may divert staff from their everyday duties. However, a range of individuals' views can be captured at one time using focus groups. Furthermore, many prisoners have low levels of reading and writing skills (Home Office, 2001) making it difficult for them to complete surveys. Therefore, a focus group was employed as the method of data collection for this study as it allows the views of several individuals to be gathered in a relatively short space of time and does not discriminate against individuals with basic skills difficulties (Kitzinger, 1995).

Moreover, focus groups promote in-depth investigation of participants' perspectives on a topic, empowering participants to create their own priorities for discussion rather than being led completely by the researcher. Thus, for example, prisoners were asked what effect the course

had on their level of knowledge about health topics, and were then asked whether it had changed their attitudes in any of the areas of health that they discussed, rather than areas pre-determined by the researcher. Additionally, focus groups encourage participants to question each other's opinions rather than answer the questions one at a time, allowing the researcher to gain a sense of not only what participants' opinions are, but examples of why they hold those opinions (Kitzinger,1995).

The focus group was part of a wider piece of work examining prisoners' views on the effectiveness of the Health Trainers' course. Therefore, a list of open questions was formulated regarding the following areas of investigation:

- what motivated the prisoners to train as Health Trainers
- prisoners' views on the course – what they liked best and least, and how they thought it could be improved
- the effect of attending the course on the prisoners' attitudes and behaviour.

The results of the latter area of investigation are reported in this paper.

The focus group was conducted with an opportunistic sample of prisoners attending the Health Trainer course at one prison and lasted for around an hour. Participants were informed of the purpose of the study and given assurances regarding confidentiality and anonymity. The focus group was tape recorded and transcribed verbatim with the prisoners' permission. Unfortunately, only two of the eight Health Trainers approached to be part of this study consented to be interviewed on the day. Therefore, due to the small sample size, data was then manually coded into key concepts/themes. Initially, the data was categorised according to the three areas of enquiry detailed above. It was then broken down into sub-themes/concepts such as 'pro-social modelling' or 'behaviour change' (Coffey & Atkinson, 1996).

Findings

Analysis of the focus group data shows that the Health Trainers believe their training has influenced their own attitudes and behaviour in a number of ways. The prisoners believed that there was a need for pro-social modelling:

1: *'They've got to be erm good about themselves as doing the right thing with themselves.'*

Int: *'Yeah.'*

1: *'Even if they're not doing everything.'*

Int: *'Yeah.'*

1: *'They're putting things into practice.'*

2: *'Mmm.'*

1: *'And they do… they're starting that goal that erm.'*

Int: *'Yeah.'*

1: *'Because you've got… if you're gonna give advice and you're to tell people you've got to have good knowledge of it yourself.'*

Int: *'Yeah.'*

2: *'You have to be living the part.'*

Consequently, some of the Health Trainers were making changes to their behaviour. For example, learning about nutrition on the course had led to one Health Trainer changing their diet:

1: *'So I looked at what (name) was eating and since I've started eating that, just little things like lentils… and I've never ever eaten that before.'*

Int: *'Would you have thought of that before you did the course?'*

1: *'No.'*

Int: *'Would you not have looked at (name) and thought…'*

1: *'No it wasn't until we did the nutrition about.'*

Int: *'Right.'*

1: *'I knew that you've got to eat your five fruit and veg.'*

Int: *'Yeah.'*

1: *'But I… I'm now counting how many I eat and also colourful vegetables (laughs) I've got that in my brain. I'm getting quite actually addicted to all this!'*

Additionally, one Health Trainer had given up smoking:

1: *'And doing things. I was a heavy smoker as well.'*

Int: *'Oh right yeah.'*

1: *'A very heavy smoker erm, I'm in the process of giving up now.'*

Int: *'OK.'*

1: *'So I'm on the patches I don't smoke during the day.'*

Int: *'Right.'*

Research from the Natural Justice Project based at the University of Oxford has linked disruptive and offending behaviour with poor nutrition. Therefore, if Health Trainers are able to improve prisoners' diets there may be the potential to reduce their offending behaviour and improve their mental health. This is an area that Health Trainers were already beginning to influence:

1: *'I mean I heard that the cake on Saturday had the icing on top wasn't real icing, it was made by margarine, which is just like lard.'*

Int: *(laughs)*

1: *(laughs) 'And then I'm saying to everybody "OK do you really need that cake? Can you get a piece of fruit?" "No we want the cake…we've been waiting all week for this cake." "OK so take the top off the cake!".'*

Int: *(laughs)*

1: *'"Just slice it off" OK and they were all like slicing it off.'*

CSIP Health Trainers will also be able to recognise the signs and symptoms of stress in other prisoners, and give them advice regarding stress management techniques. Arguably, prisoners are more likely to recognise these signs in their peers than staff are. Moreover, research suggests that prisoners may prefer to discuss problems with another prisoner rather than a member of staff, and would be more likely to take a prisoner's advice on board (Devilly *et al*, 2005). Comments from the Health Trainers reflected this view:

2: *'So to for us to then say "oh it's difficult, it's hard".'*

Int: *'Mmm, mmm.'*

2: *'They, the person opposite you is going "yeah it is difficult, hard" but then you can say ah but there's this and this and this that you can do.'*

Int: *'Yeah.'*

2: *'Then the response is far better from the person.'*

Int: *'Do you think?'*

2: *'Because they can say "ooh well if you're saying it's OK then maybe it is OK" erm if you're doing it, maybe I can do it too.'*

Feedback from Health Trainers may also highlight factors inherent in the prison environment that have a negative effect on prisoners' mental health, but it may not always be possible to change these factors. Therefore, there is a need for this role to be carefully managed and for there to be clear boundaries on the role so that they refer individuals on to prison health care services as necessary, rather than trying to tackle problems that are beyond their level of skill/learning themselves (Devilly *et al*, 2005). There is also the possibility that prisoners trained as Health Trainers could abuse the system and use information that a prisoner has confided in confidence against them. This was reflected in the comments from the prisoners interviewed:

2: *'And so the most important thing of all is about respecting the confidentiality erm…'*

Int: *'Yeah.'*

2: *'If a Health Trainer can't do that then they can't be in that role, not at all.'*

Moreover, there is the possibility that training prisoners as Health Trainers would result in power imbalances between them and other prisoners. Thus, in order for the Health Trainer role to be successful, care needs to be taken in how it is managed and implemented, as discussed below.

Discussion

Health Trainers are being employed in a variety of ways in communities and prisons across the country to signpost

individuals in deprived communities into appropriate health services, and to produce personal health improvement action plans with them. While no one single intervention can be said to be responsible for improving prisoners' mental health and/or reducing re-offending, early observations presented in this article demonstrate that the new CSIP Health Trainers in one establishment have the potential to contribute positively to both of these agendas through engaging fellow prisoners in work relating to areas such as healthy eating, exercise and stress management as outlined below.

Improving prisoners' mental health

Prisoners interviewed in this study had almost completed their training, and were already making positive changes to their own attitudes and behaviour. This reflects research on peer educator projects that suggests that they can result in a change in the behaviour of the peer educators themselves (Parkin & McKeganey, 2000).

Additionally, they were also beginning to change the behaviour of their peers, for example, beginning to influence their diets. Research suggests that maintaining a balanced diet and the inclusion/exclusion of certain foods/nutrients can have a direct effect on mental health. A report by the Mental Health Foundation suggests that:

> *'As well as its impact on short and long-term mental health, food plays an important contributing role in the development, management and prevention of specific mental health problems such as depression, schizophrenia, attention deficit hyperactivity disorder, and Alzheimer's disease'* (2006: 5).

Similarly, Mind's Food and Mood project examines the effect of diet on the way that people feel and states that making changes to what you eat can result in improvements in areas such as depression, insomnia and anxiety (Geary, 2004).

Thus, changes that Health Trainers make to their own and their peers' diets may have a positive impact on their mental health. However, there are limits to the extent to which prisoners can vary their diet in prison, and meals are usually provided at set times, so learning from this section of the course may be of more benefit to prisoners when they are released. The extent to which prison Health Trainers successfully improve their peers' diets should be investigated in further research.

As part of the course, prisoners were also learning about the benefits of exercise and the variety of exercises that can be done in prison. This may lead to an increase in the amount of exercise that Health Trainers and their peers undertake. Research shows that engaging in exercise can be an effective treatment for depression (Dunn *et al*, 2005; Dimeo *et al*, 2001). Therefore, over time this may lead to a reduction in the numbers of prisoners experiencing depression and may contribute towards a reduction in self-harm/suicide among prisoners.

There are also a number of possible positive implications of training prisoners to recognise and manage stress. Prisoners undergoing the training should be able to recognise the signs and symptoms of stress in themselves, and be able to manage them positively. Therefore, individuals participating in the course may actively change the way that they respond to stress, which could arguably lead to improvements in their mental health. It may change the way that individuals react to stressful situations, which may contribute to reducing the likelihood of these individuals re-offending.

Additionally, a reduction in prisoners' stress levels may lead to staff spending less time managing incidents on the wings, and to fewer demands being placed on prison health care centres to treat stress-related illnesses. As in peer-education schemes, this may mean that health care staff have more time to treat more 'complex' cases (Devilly *et al*, 2005).

Thus, prisoners may represent an untapped resource for reducing health inequalities and promoting access to services for a marginalized group. However, one must note that this is based on a focus group with prisoners at only one establishment and the role may be arguably less successful elsewhere. It may be inadvisable to generalise from the results of this small study beyond this establishment.

Reducing re-offending

Research demonstrates that offenders on probation are unlikely to be in employment (Mair & May, 1997) due to issues such as low levels of qualifications and literacy problems. However, finding employment vastly reduces an individual's likelihood of re-offending (HM Government, 2005). Long-term, there are hopes that the CSIP Health Trainer project will play a part in addressing this problem as individuals trained to act as Health Trainers in prison will be released with an N/OCN

qualification and will then be able to be employed as Health Trainers in the community.

Additionally, research indicates that personal factors such as health problems, low self-esteem and self-confidence, and low levels of qualifications can also act as barriers to offenders finding employment (Rolfe, 2001). Health Trainers' work with prisoners may contribute towards removing some of these barriers through improving their health and increasing their self-esteem. Thus, training prisoners as Health Trainers can contribute to the government's plan to reduce re-offending through skills and employment (HM Government, 2005).

However, as highlighted by the Health Trainers themselves, there is a possibility of prisoners abusing this role. Research on other peer-education schemes suggests that in order for it to be successful, careful consideration needs to be given to how Health Trainers will be supervised. The types of advice that Health Trainers give and/or referrals that they make need to be carefully monitored with clear procedures for accountability (Devilly *et al*, 2005). Prison staff should ensure that prisoners receive adequate training for the role, receive regular supervision, and know the limits of their capabilities (Devilly *et al*, 2005). Discussions between Health Trainers and their clients should remain confidential. However, as Devilly *et al* (2005) state, prisoners also need to be aware of when confidentiality should be breached (eg. threat of harm to another), and there should be clear procedures for cases where confidentiality is breached inappropriately. Prison staff should also monitor the impact of Health Trainers on service provision, and ensure that enough Health Trainers are trained to allow equal access to the service for all prisoners. If these recommendations are followed, CSIP Health Trainers may successfully improve their own health and that of their peers, and may also have an increased chance of finding employment on release, which may reduce their chances of re-offending.

Conclusion and recommendations

This paper has summarised progress made on a pilot project aiming to adapt the community Health Trainer role for use in prisons. It has briefly outlined the training package produced by this project, paying particular attention to the parts that may have an influence on prisoners' mental health. Findings in this study suggest that training prisoners as Health Trainers has the potential to enable prisoners to make positive changes to their own attitudes and behaviour and to be able to influence their peers' behaviour too. Changes that Health Trainers make in areas such as diet, exercise and stress management may impact positively on prisoners' mental health. Offenders infrequently access mainstream health care services and may arguably see a CSIP Health Trainer's advice as more credible than that of a 'professional'. Thus, prisoners themselves represent an untapped resource for improving offender health. Moreover, it may be possible for prisoners to be employed as Health Trainers on release, which may reduce their chances of re-offending. However, this study was conducted at a relatively early stage in the pilot CSIP Health Trainers' project, investigating the views of prisoners at just one establishment.

The Health Trainer role will begin to be implemented across the prison estate on a larger scale later this year. At this point, in order to see whether the findings of this small-scale study are reflected elsewhere, further research should be conducted into the effect of both community and prison-based Health Trainers on individuals' mental health (both their clients and their friends/family). This could focus on areas such as:

- the cost effectiveness of Health Trainers compared to other professional groups
- the potential ethical issues of training prisoners as Health Trainers – in relation to any power imbalances/breaches of confidentiality that may occur between prisoners as a result
- the effectiveness of different models of supervising/managing the Health Trainer role
- investigating the types of health issues that clients discuss with Health Trainers – to add another dimension to existing (prison based) health needs assessments; how do the issues that prisoners discuss with CSIP Health Trainers compare with those that they discuss with health care staff? Is there any evidence that prisoners prefer to seek advice from a peer rather than a professional?
- the impact of referrals from Health Trainers on health service provision – do the number of referrals to particular services dramatically increase? If so, does this result in longer waiting lists, or in changes to the way in which services are provided in order to meet the increased demand? Do Health Trainers really increase the numbers of individuals from deprived

areas accessing health services? Will the introduction of prison-based Health Trainers really reduce the number of stress-related referrals to health care staff, allowing them to devote additional time to more 'complex' cases?

- the extent to which Health Trainers are able to produce and maintain positive behaviour changes in their clients eg. change of diet, and the impact of these on their clients' mental health
- Health Trainers' career pathways – what types of employment do community-based Health Trainers move onto? What proportion of prison-based Health Trainers find employment in this area when they are released?

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Developments in suicide prevention training for prison staff: STORM and beyond

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Abstract
Suicide prevention is a priority issue in HM Prison Service of England and Wales. Past training in this area has concentrated on the completion of paperwork over direct interactions with suicidal people. HM Prison Service commissioned STORM, a training scheme focusing on interviewing skills and the identification of risk factors, successfully used in community health settings, piloted it in five prisons and retained it as part of its compulsory training for prison assessors of suicide risk. Although from spring 2007 STORM will no longer be compulsory, its impact has been shown in plans for future development of training.

Key words
prisons; training; suicide; self-injury; evaluation

Suicides in prison
The prevention of suicide in custody has been a priority for HM Prison Service for a number of years (eg. HM Prison Service, 2001; Home Office, 1999). The rate of suicide in prison is much higher than that of the general population (Singleton *et al*, 1998) and has continued to rise (Royal College of Psychiatrists, 2002) until recently. New figures show a dramatic reduction in prison suicide rates of over a third in the period 2004–2006 (figures obtained directly from the Home Office), coinciding with new initiatives to identify and manage suicide risk. Training of staff is key to the identification and management of prisoners at risk of suicide and self-injury, and there have been several previous packages designed over the last 14 years to improve this.

Suicide prevention training for prison staff 1993–2005
The prevailing system for the care and management of prisoners at risk from suicide and self-harm from 1993 to late 2005 was the F2052SH policy. This policy outlined how a prisoner could be identified as being at risk from suicide, and how this could be managed while at risk. The accompanying F2052SH document contained assessments from the unit manager, doctor and health care staff, details of case reviews held at least fortnightly, and a record of any interaction between staff and prisoner.

One focus of this policy was interdisciplinary working and an emphasis that suicide was an issue for all prison staff, and not just health care staff. Thus, any member of staff could open an F2052SH document, identifying a prisoner to be at risk of suicide, and any member of staff having contact with that prisoner while the document was 'open' would record details of this contact.

At the time that the F2052SH was rolled out, a new training package was disseminated among prison staff in England and Wales entitled *Caring for the Suicidal in Custody* (HM Prison Service, 1993). The training consisted of 14 hours of training across seven modules and was developed in close collaboration with the Samaritans. At its centre was the new policy and use of the F2052SH form. The methods of training used were lecture-style presentations, videos exploring issues arising from the modules and dramatisations of real cases, group discussions and 'syndicate exercises' in smaller groups.

This training was criticised on the grounds that too much emphasis was placed on the completion of F2052SH paperwork. In 1999, a thematic review was carried out by Her Majesty's Chief Inspector of Prisons (HMCIP; Home Office, 1999) reporting that there was limited provision of training in local prisons, and further stating that *'there should be more of an emphasis on skills than an emphasis on risk factors, and rather than how to fill in forms'* (sic). The Royal College of Psychiatrists were asked to respond to the thematic review, and their report (2002) backed up HMCIP's views. They stated:

> *'We give the strongest endorsement to the review's recommendations on staff training',*
>
> and also that:
>
> *'Training should clearly aim at increased suicide awareness among all prison staff'.*

In 1999 it also became clear that many staff were not being trained when a Board of Visitors study showed that 67% of local prison staff had received no suicide prevention training (cited in Home Office, 1999).

With the publication of an improved strategy (HM Prison Service, 2001), the Prison Service again drew attention to the importance of training for suicide prevention, stating that:

> *'Equipping staff with the skills necessary to work in the very difficult area of suicide prevention is vital and training is fundamental in this respect'.*

Their recommendation for improvement in this area was that:

> *'All staff in all types of establishments should undergo basic and, where applicable, suicide prevention refresher training as a matter of urgency'.*

The primary reason that staff were not receiving training in suicide prevention was and remains the operational difficulty of releasing staff for training (Paton, personal communication, 5 January, 2007). In response to this and in an attempt to ensure that all staff received at least some training, a 'core module' of suicide prevention was developed. This was of two hours' duration (a reduction in training by 12 hours). On examination of the training manual and the suggested timetable, it can be seen that the two hour session still included one hour and 10 minutes on the use of the F2052SH form, leaving only 50 minutes for discussion of why people harm themselves, risk indicators, some myths about suicide and self-harm, and interviewing skills.

Of particular interest in this training manual was the section regarding the opening of an F2052SH document. Using a case study approach, trainees had to decide at which point in a vignette they would open an F2052SH document. The options for when to do this appeared to be based predominantly on observations of behaviour such as *'cell is observed as lacking his normal family photos'* or *'very upset after a visit from her mother'*. Only in the later options was any interaction with the prisoner reported regarding suicidal behaviour. Therefore, it can be argued that this new training ultimately reinforced the culture of observation over interaction and remained reactive to suicidal incidents or expressions of intent rather than proactive. While it is very important for prison staff to understand the suicide prevention policy and to be able to use the F2052SH form, the training offered little encouragement for staff to approach suicidal prisoners, or those potentially at risk.

Subsequently, the requirement for suicide prevention training was removed in 2003 with the abolishment of centralised mandatory training for all prison staff (HM Prison Service, 2003). Anecdotal evidence suggests that the overall provision of training declined further in the period immediately following the thematic review's findings and up to 2005.

Suicide prevention training for prison staff has been mentioned in several other high-profile documents. The first report by the Centre for Suicide Prevention at the University of Manchester (Shaw, Appleby & Baker, 2003) on deaths in custody recommended that *'All prison officers should be trained in suicide prevention and risk management with a refresher course every three years'*. Further, being sensitive to the difficulties in providing training in the Prison Service, they also recommended that:

> *'Suicide prevention and risk management training courses should be designed to allow more flexible implementation; for example, with the introduction of modular courses tailored to working hours'.*

In addition, in the NHS National Service Framework (NSF) for mental health (Department of Health, 1999) standard seven relates to the prevention of suicide. This states that *'local health and social care communities should prevent suicides...support[ing] local prison staff in preventing suicides among prisoners'* and, *'ensur[ing] that staff are competent to assess the risk of suicide among individuals at greatest risk'*. This last point clearly relates to training among staff. To date however, there has been no dedicated training by PCTs on suicide prevention in custody, although aspects of suicide prevention are included in other courses.

The care of at-risk prisoners project

In 2001, as a response to the thematic review, HM Prison Service expanded its suicide prevention capacity creating the Safer Custody Group. New initiatives were developed by the Safer Custody Group in an effort not only to overhaul the F2052SH system, but to improve the care and management of all vulnerable prisoners (known as the Care of At-Risk Prisoners Project). Care pathways were developed from reception into custody to take a more

proactive approach to the identification of suicide risk. New documentation (ACCT: Assessment, Care in Custody & Teamwork) was devised to replace the F2052SH forms, which had an emphasis on individualised care and formal care planning. The multidisciplinary emphasis of F2052SH was retained with involvement from all staff groups, but with ACCT, care was designed to be responsive to prisoners' individual needs and case reviews were attended only by staff relevant to planned care.

Two new roles were created by the ACCT system, assessors who would conduct semi-structured, comprehensive needs assessments within 24 hours of concern being raised, and the second new role of case manager who would ensure that elements of prisoners' care plans were designated to specific members of staff and then completed. Improved training in suicide prevention was seen as an important aspect to the overall project, and in 2002, the Safer Custody Group commissioned Manchester University to develop a version of an existing suicide prevention training package known as STORM for HM prison staff (including uniformed officers) on the basis of its demonstrated efficacy in community health care. Thus, the piloting and evaluation of STORM in HM Prison Service took place in the context of the larger evaluation of the 'Care of At-Risk Prisoners Project', conducted and evaluated in five prisons between 2003 and 2004 (Shaw *et al*, 2006). Recommendations from the evaluation were to advise any roll-out of successful aspects of the project to the wider prison estate.

STORM

Skills-based Training On Risk Management (STORM) is a training package in suicide prevention emphasising interviewing and assessment skills. Evidence shows that STORM is successful in developing the skills, confidence and attitudes of front-line health professionals (Morriss *et al*, 1999; Appleby *et al*, 2000; Gask *et al*, 2006). Since its conception in 1996, STORM continues to be implemented successfully across the UK and Republic of Ireland. Further evaluation of its dissemination is currently taking place.

The package is modular based with the opportunity to be flexible and adaptable to the needs of the organisation. It utilises evidence-based teaching methods known to improve skills and confidence: Role-rehearsal as well as the gold standard videotaped role-rehearsal with structured feedback (Gask, 1998). Four modules cover the assessment of suicide risk, crisis management, problem solving and crisis prevention. Each module focuses on specific key skills to practice in role-rehearsal.

There have been two versions of STORM to date. Version one of STORM was developed as a generic package (Gask & Morriss, 1996). Version two of STORM was developed to reflect practice changes (Lever-Green, 2007). The content remains generic and is designed to be adaptable to local and professional needs. The demonstration DVD includes vignettes covering specific areas of practice in primary care, crisis resolution/A&E, substance misuse and the elderly. A stand-alone section has been adapted for children and young people services. An additional section of the package on self-injury is currently being piloted.

Prison STORM was adapted from version one and included a demonstration video comprising prison specific vignettes and accompanying materials (Gask & Lever-Green, 2003). The package was commissioned for HM Prison Service by the Safer Custody Group as a stand-alone package to sit alongside the ACCT documentation. The aim of Prison STORM was to help develop the skills needed to perform suicide assessment and management. It is this version of STORM that is currently in use. As in version one, Prison STORM consists of four modules, each of approximately two and a half hours' duration.

Lessons learned from the STORM pilot

The evaluation of the 'Care of At-risk Prisoners Project' included a process evaluation of the various pilot initiatives. This study aimed to identify and explore those factors that inhibited and promoted change at the pilot sites. Staff from each participating prison with involvement in the introduction of the project were interviewed including governors, health care managers, suicide prevention co-ordinators, as well as health care and discipline staff. Interviews were semi-structured and analysed thematically (for a full description of the methodology see Study 6 *[A Qualitative Evaluation of the Change Process Interviewing Prisoners and Staff at the Five Sites]* in Shaw *et al*, 2006).

The success of the pilot project was perceived differently at each site. However, staff from all sites remarked on the importance of adequate training before introducing any changes to working practice within the prison. Indeed, some suggested that this was the single

most important aspect to any new initiative. It should be noted that the training package provided by HM Prison Service, with support from the National Institute for Mental Health England, included mental health awareness training as well as STORM, of which staff were particularly appreciative (Shaw *et al*, 2006).

Ultimately, each site delivered a training package suitable to their individual requirements. At one site, the first two STORM modules were combined with locally developed 'empathy building sessions', while trainers at another rewrote all role play vignettes to be applicable to their client group of young males. Only one site used videotaped feedback as standard. The reasons given by trainers at the other sites for why this was not used in their sessions included not enough time, no access to the necessary equipment, and a perception that trainees would not like/accept being videotaped.

This may have had a significant impact on the success of the training, given the importance of videotaped feedback to the philosophy of STORM. However, the quantitative evaluation of STORM showed no differences in efficacy between the five sites (Hayes, 2004).

STORM-trained prison officers frequently commented that they possessed the skills taught in the training, but that it was useful to have these validated, and to hone and practice these skills in a supportive environment. The interactive format (as opposed to lecture-style presentations) was praised as involving trainees and forcing them to think about their own skills and experiences. Some found acting in role plays in front of their peers to be uncomfortable, but a number appreciated the benefits of this, despite their discomfort.

One criticism of STORM was that it did not neatly fit into the new roles created by the ACCT procedures. The training showed how to assess risk and decide on action to address this, which was most relevant to those taking the assessor role. However, the stand-alone nature of STORM meant there was no information as to how the interviews demonstrated in the videos related to the Assessment and subsequent Care and Management Plan in the ACCT paperwork. Staff felt they needed further instruction to bring the two systems together in practice. A further perceived limitation was that STORM did not include information on self-injury.

A key part of STORM is the encouragement to ask direct and detailed questions regarding thoughts and plans of suicide. Several trainees described their initial unease at this, but with practice, felt it had been a worthwhile activity, and one that had changed their subsequent interactions with prisoners at risk of suicide or self-harm. All staff interviewed felt that STORM should be provided to every member of prison staff, and several commented on the need for refresher training (also indicated by the quantitative evaluation; Hayes, 2004).

Roll-out of training

An interim evaluation of the 'Care of At-risk Prisoners Project', conducted by the Safer Custody Group (Safer Custody Group, unpublished), revealed the need for some changes before the various initiatives were rolled out to the wider prison estate of England and Wales. Training was identified as being of key importance, particularly on the new ACCT roles and the ACCT documents themselves. Therefore, three packages were developed for various staff groups with minimum levels of training completion before ACCT could be introduced to a new site.

'Foundation' training was devised by the Safer Custody Group, suitable (and compulsory) for all members of staff. This was three hours' duration and covered background information on suicide and self-harm in prison, and a description of the new ACCT processes and roles as compared to the F2052SH system. Groups were limited to 15 as the format included a case study and role play.

Staff acting as case managers completed an additional training package lasting one day. STORM had been a part of this package in the pilot project, but was later removed in favour of more detailed sessions on care planning, case management and mental health awareness. This was a response to the interim evaluation (Safer Custody Group, unpublished), which revealed notable deficits in these areas. However, the first two modules of STORM were retained as an optional module, so that individual prisons could decide on its inclusion.

Finally, assessors had a revised training package of three days' duration. This included sessions on mental health awareness, care planning and ACCT roles. In addition, staff were required to complete either STORM or an alternative skills-based training programme (ASIST, Applied Suicide Intervention Skills Training), though the majority of Prison Service areas chose STORM). This brought the duration of the course to either four days (with STORM) or five days (with ASIST).

As indicated by the evaluation of the pilot project (Shaw *et al*, 2006), refresher training was planned and is now in the development stages. Refresher training is likely to be available later in 2007 for each of the three training packages, and recommended on a yearly or two-yearly basis.

Current developments

Late in 2006, a decision was made to remove STORM as a compulsory element of the assessor training. This was because money could no longer be found to support the training of 'STORM consultants', who delivered the training on a regional basis. STORM will be available as a training package, but it is predicted that it will gradually fade out of use (Paton, personal communication, 5 January, 2007). Instead, a package will be created in-house by the Safer Custody Group. At the time of writing, this is under development, but expected to focus on the requirements of the ACCT policy as well as practical skills in the assessment and management of risk of suicide and self-injury.

STORM methods will continue to be used in the new training in the form of demonstration videos and role play, with attention paid to interaction with at-risk prisoners. The introduction of STORM appears to have made a major improvement to how staff have been trained in suicide prevention, even though it will not remain a staple of HM Prison Service's training packages. However, past training showed an over-reliance on procedure, and the new package must ensure that training remains focused on practical skills. Staff cannot capably manage suicidal prisoners without understanding the person and their individual needs and experiences. Suicide prevention training must continue to be focused on people, not paperwork.

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Mapping the introduction of a mental health awareness in custodial settings self-directed workbook across eight care services improvement partnership patches

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Abstract

Approximately 90% of prisoners experience mental health problems, substance misuse problems or both. However, prison reception screening tools are not always effective in enabling staff to identify mentally disordered prisoners. Therefore, to ensure that these individuals get access to appropriate care, custodial staff should be trained in recognising the signs and symptoms of mental health disorders, and in effectively working with these individuals. This paper charts the pilot implementation of a mental health awareness workbook designed for use in custodial settings across England. It examines the variety of approaches adopted to implement the workbook, staff views on the usefulness of the workbook, and barriers to implementation encountered in each area. Recommendations made for best practice in delivering the workbook in other areas suggest a need for changes to its format, but also that time should be ring-fenced for staff to participate in this training, in groups led by experts such as in-reach team members.

Key words

prison; mental health; training; education; criminal justice

Background

As recent media headlines point out, UK prisons are currently at nearly full capacity with over 79,000 people imprisoned in January 2007 (Travis, 2006; Travis 2007; HMPS, 2007). Research suggests that a large proportion of these individuals will be experiencing mental health problems, substance misuse problems or both (DoH, 2001). The NHS and the Prison Service are now working in partnership to ensure that the standard of health care provided in prisons is equivalent to that provided in the community (NHS Executive & HM Prison Service, 1999). However, research shows that many instances of mental ill-health are not identified by prison staff during reception screening (Birmingham *et al*, 2000). Additionally, prison is designed as a punishment and this goal may conflict with the goal of providing health care to prisoners. In order to ensure that mentally disordered offenders obtain access to appropriate services, there is an increasing need to train prison staff in both recognising the signs and symptoms of mental disorders, and in effectively working with mentally disordered offenders.

This paper charts the pilot implementation of a Mental Health Awareness Training workbook over a period of six months through the Health and Social Care in Criminal Justice Programme (HSCCJP). The workbook was rolled out across eight Care Services Improvement Partnership (CSIP) Regional Development Centres (RDCs). It examines the method used to implement the training in each area, staff views on the usefulness of the workbook, and the barriers to implementation encountered in each area. Additionally, the paper uses information gained from the pilot to make recommendations for best practice in delivering the workbook in other areas of the country.

What is the workbook?

The workbook was produced by Offender Health Care Strategies and aimed to 'provide skills in managing individuals who present with behaviour that may be the result of mental health difficulties' (Offender Health Care Strategies, 2005). It was produced as a printed hard copy and as a CD-rom, and included topics such as:

- influencing factors on an individual's psychological well–being
- causes and types of mental health problems
- factors that may affect an offender's mental health
- stigma
- observation
- communication
- managing behaviour
- referring on.

Initially, it was estimated that it would take staff between eight and 12 hours to complete this learning and each CSIP RDC was given the opportunity to roll out the training in a way in which leads considered most appropriate to local circumstances.

Methodology

The approach taken in implementing the training was different in each of the RDCs. Thus, a quantitative approach to data collection was deemed inappropriate as this would simply demonstrate factors such as the number of workbooks distributed and completed, and would not reflect differences in the styles adopted by each area. Additionally, the researchers were aware that there are severe time restraints on prison staff. Thus, the implementation process was captured using several qualitative approaches to data collection, namely:

- interviews with each of the eight CSIP leads
- further semi-structured interviews with staff working in each area
- analysis of email correspondence following interviews to provide further detail on implementation plans
- participation in a one-day workshop involving seven of the eight CSIP leads
- an analysis of a small sample (n=32) of evaluation forms in region one
- telephone interviews with participant prison officers in one patch.

For the purpose of anonymity, the names of the regions and prisons have been converted to numbers in this article.

Findings

The approach taken to rolling out the training in each of the RDCs is detailed in the sections below.

CSIP region one

At the start of 2006, the area training manager, area safer custody manager and the area suicide prevention forum met at the area prison office to discuss the implementation of the workbook. Following this, three of the 16 prisons in this area were identified to pilot the roll-out. These were prison one – a category 'C' male training prison, prison two – a category 'B' male local prison and prison three – a women's prison. The workbook was to be introduced into a different area of each prison – the Segregation Unit at prison one, the Drug Dependency Unit at prison two and the Care and Segregation Unit at prison three. Responsibility for the roll-out of the workbook and ensuring that evaluation forms were completed and returned was given to the local suicide prevention co-ordinators.

The governors at each establishment identified officers to distribute the workbooks. These officers were guided through the manual by a CSIP lead and 30 copies of the workbook were then distributed at each establishment. This approach resulted in 100% take-up at prisons two and three, but only 33% take-up at prison one. Thus, a total of approximately 70 staff in this region engaged with the training.

CSIP region two

The second area began by producing clear aims and objectives for the implementation of the workbook together with an exit strategy to ensure sustainability. It was estimated that it would take three months to implement the workbook. Two prisons were sought to pilot the workbook with specific staff groups in this area. These prisons were selected through seeking support from heads of training, heads of health care and commissioning primary care team (PCT) prison leads (preferably mental health promotion leads).

Pre-implementation meetings identified a need to target the workbook with the First Night and Induction Unit staff, the Substance Misuse Service, the PCT and the Segregation/Care and Separation Unit. Both prisons were asked to identify a lead from each of the above areas to record progress and motivate staff to participate. No specifications were made regarding the grade that this member of staff would need to be at. This resulted in senior officer grades and an F grade nurse being selected at prison four, while at prison five wing leads ranged from POs to SOs, and a staff nurse also became a lead.

Facilitated sessions were then planned for leads and managers to:

- raise awareness of mental health problems and coping skills through teaching and group work
- introduce the principles of the workbook
- look at the means of implementation in each area
- outline the role of the leads in gathering evaluation information and ensure that they were happy to lead for their area
- outline support links available.

These sessions were well attended by representatives from both prisons. Twenty-five staff from C wing, Substance Misuse Service, CSU and primary care at prison four then attended a session to go through Module One – 'Mental Health Difficulties' through reflective group work. Following this session, all areas in the prison four pilot agreed to devote an hour a week for all staff to get together and work through the exercises in the workbook using prisoners on the wing at the time as examples. This impacted on the prison regime as only essential tasks could be completed during this hour. However, local managers and governors thought this was outweighed by the fact that staff skills could be greatly enhanced by completing the workbook.

By September 2006, 60 out of 70 workbooks had been distributed at prison four and around 20 prison officers had fully completed them. At prison five, around 50 workbooks were distributed and 15 prison officers had completed all five modules. An internal qualitative evaluation at prison four showed that very little activity had taken place in the Segregation Unit as the senior officer had been off sick.

CSIP region three

Unfortunately, roll-out of the workbook had failed to commence in this region during the time allocated for data collection. However, this area planned to deliver training on a 'patch' basis rather than at individual establishments. They proposed running sessions once a month with a maximum of 30 participants from several prisons attending. The sessions would have started with a three-hour seminar focusing on skills in recognising prisoners with mental health problems, and introducing the booklet and learning requirements. The booklet would then have been distributed to staff together with the offer of support through a helpline and a follow-up seminar. Overall, this would allow up to 360 custodial staff to be trained in a year. The course organisers would be responsible for quality assurance in terms of trainer observation, registration information and evaluation. Staff would have been tested on the knowledge that they had gained, and would have discussed compliance with training and barriers to effective implementation. The roll-out would then have been evaluated using feedback from course participants. The CSIP lead in this area feels that face-to-face expert input is needed for successful training in mental health. Therefore, so far the workbook has only been distributed as an *aide-memoire* for staff who have already undertaken Assessment Care in Custody and Teamwork (ACCT) or mental health awareness training.

CSIP region four

In this region the workbook was delivered as part of ACCT assessor training. Roll-out was planned by the area safer custody co-ordinator and was delivered in three phases encompassing 14 establishments. An initial ACCT training event was held at a central location and attended by staff from several establishments. These staff were then trained as trainers so that they could offer in-house training at their individual establishments.

When data was collected all phase one establishments were running the training and were aiming to train 20% of front-line staff. The prisons looked set to achieve this target as between 10% and 15% of front-line staff had been trained when the data was collected. These prisons are also beginning to target other groups of staff such as first night officers, non RMH health care staff and segregation staff. This is being supported by NIMHE and HMPS supplying trainers.

Training was also underway in five of the phase two prisons, but was yet to commence in the phase three prisons when data was collected. By January 2006 a total of 214 staff had completed the mental health awareness training – all of which were ACCT assessors.

CSIP region five

The CSIP lead and the area suicide prevention lead agreed to pilot the workbook in this area, and discussed it with the suicide prevention area team forum and the regional prison mental health in-reach steering group. They agreed to pilot the workbook in four prisons and to offer it

initially to 25 officers in each prison with training managers from each prison leading the dissemination.

The pilot was well advertised – it was highlighted by the governors of each prison during their staff briefings and the mental health in-reach team managers were contacted to request their teams' support for officers using the workbook. A letter was also attached to each workbook explaining the nature of the pilot and the support and advice that was available to staff through the in-reach teams and the CSIP lead.

Despite this, take-up in this region was minimal. Mental health awareness training was already offered across prison six by in-reach staff. Initially, the workbook was offered to segregation staff, but they considered it to be below their level of training need. Subsequently, it was offered to a wider range of staff and three officers consequently used the workbook. Telephone interviews were conducted with these staff, the results of which are discussed later.

At prison seven the workbook had been issued to nominated officers by the training committee. However, only three (younger) prison officers had attempted to complete it. This was said to be due to the workbook having an over-serious tone and a lack of colour in the printing, and also the fact that it did not provide interaction with other people.

This latter point was reiterated at prison eight where although four officers completed the workbook, benefits were felt to be minimal as learning was considered to be most effective in peer group settings. Additionally, staff in this prison found it difficult to find time to complete the workbook at work and felt that expecting individuals to complete it outside of work was unrealistic. Moreover, staff felt that the workbook was disjointed and stated that there was no reliable way to assess whether staff had gained any knowledge and/or changed their attitudes.

CSIP region six

In January 2006 establishments in this area were planning to roll out the training in a number of ways. For example, prisons planned to offer the training via the in-reach team/ the PCT lead/ the RMN/ a support group. Often this would be with modular support from CSIP. Unfortunately, in September 2006, many prisons reported that they had not understood the link between the workbook and ACCT training so had only delivered the latter. Additionally, some prisons were reluctant to engage with the workbook as training was already provided by the in-reach team. However, training had taken place in five establishments with at least one hundred prison officers being trained.

CSIP region seven

The workbook was widely distributed in this region and most people agreed that it would be a useful *aide-memoire* for ACCT trainees as well as people being inducted to work in the wider criminal justice system. A more dedicated roll-out also occurred at one private prison in this region. By the end of the evaluation period this resulted in 35 prison officers using the workbook in this prison. Moreover, the workbook has now been incorporated into the 13-week induction training at the prison (although prison officers are still expected to undertake the course in their own time). Additionally, the workbook is being introduced in joint training between police and probation staff working in approved premises, and it has been reviewed for use in prisons by suicide leads, prison listeners and the Samaritans.

CSIP region eight

In January 2006 this region planned to roll out the workbook in one prison to a group of 25 staff including wing-based prison officers, the chaplain and staff from the psychology department. They aimed to use the workbook as an adjunct to face-to-face mental health awareness training. By September 2006 a total of 37 copies of the workbook had been distributed at this prison. Seventeen mental health nurses within prison settings in this region had agreed to facilitate mental health awareness training using the workbook as an adjunct, but no prison officers would be using the workbook in a 'self-directed' manner.

Discussion

Thus, the workbook has been implemented in a wide variety of ways. Engagement with the pilot has been led by a variety of staff groups including training managers, safer custody managers, heads of health care, in-reach teams, PCT leads and RMNs. The different approaches adopted to rolling out the workbook have resulted in a wide range of staff engaging with the training including Segregation Unit staff, Drug Dependency Unit staff, ACCT trained staff, prison officers, First Night and Induction Unit staff and PCT staff.

However, the rate of 'success' in implementing the training in each region has been mixed in terms of the number of staff engaging with the pilot, their views on the usefulness of the workbook, and the number of barriers encountered in implementing the training. Staff views on the workbook and barriers to implementation are outlined below.

Staff views on the usefulness of the workbook

Staff views on the usefulness of the workbook were obtained in six of the eight regions. In region one a total of 32 formal evaluation forms were completed and returned – 3/30 from prison one, 6/30 from prison two and 23/30 from prison three. These forms asked participants to rate the workbook on a scale of 1–6 where 1 was 'poor' and 6 was 'excellent' in each of the following areas: ease of use, readability, information, usefulness, accuracy, workplace specificity and the exercises.

Overall, participants scored the workbook highly. The most poorly rated areas were 'exercises' and 'readability', which both received a mean score of 4.25. Scores were dichotomous in relation to 'workforce specificity' with 20 prison officers rating the workbook as 5/6 in this area, and another 12 giving much lower scores. The majority of the latter group came from prison three.

In region two, feedback on the usefulness of the workbook was obtained at prison four. Here respondents stated that the workbook had raised staff awareness of issues and promoted discussion on the wing. However, some staff on the wing felt that the exercises were patronising, and had struggled at times to hold group discussions as they did not have enough background knowledge of the issues. In contrast, in primary care the workbook was regarded as an excellent revision guide, but staff felt that they had insufficient time to complete the exercises in the manner demanded in the workbook.

Feedback from the evaluation in region four was very positive – showing increases in staff knowledge, skills and confidence. The Mental Health Awareness Training had been voted the most valuable section of the ACCT training and further training had been requested. However, here the workbook was delivered alongside face-to-face mental health awareness training delivered as part of the ACCT programmes and feedback reflects this. There were also plans to introduce the workbook to all staff regardless of their professional background, but staff reported that there was reluctance to engage in self-directed learning and consequently no staff had been trained in this region using the workbook alone.

In region five, three staff had been willing to use the workbook in a self-directed manner. Telephone interviews with these staff showed that the first interviewee – a prison officer with 15 years' experience thought that the language used in the workbook needed to be simpler and that it was difficult to complete the workbook alone without anyone to discuss the issues raised/the exercises with. This view was reflected by the second interviewee – an ACCT assessor with 10 years' experience who felt that the material had been written at too advanced a level for most prison officers given their low level of mental health training. He had found the workbook to be very readable himself, but agreed that more would be achieved from learning in a group. This view was reinforced by interviewee three who had successfully completed the entire workbook in his own time, but felt that he would have learnt more from it in a group learning situation.

Additionally, at prison seven in this region, the workbook had been issued to nominated officers by the training committee. However, only three (younger) prison officers had attempted to complete it. This was said to be due to the workbook having an over-serious tone and a lack of colour in the printing, and also the fact (in reflection of the comments above) that it did not provide interaction with other people. This latter point was further reiterated at prison eight where although four officers completed the workbook, benefits were felt to be minimal as learning was considered to be most effective in peer-group settings. Additionally, as stated earlier, staff in this prison found it difficult to find time to complete the training at work and felt that expecting staff to complete it outside of work was unrealistic. Moreover, staff felt that the workbook was disjointed and stated that there was no reliable way to assess whether staff had gained any knowledge and/or changed their attitudes.

In contrast, in region seven comments on evaluation forms showed that staff found the workbook to be helpful in understanding symptoms and behaviours of mental illness. They also used the workbook to help them to think through specific situations. Four respondents thought that the exercises produced repetitive answers and one participant stated that the workbook did not allow for personal skills to be applied. Most of the

respondents found the training useful, but staff nurses found it to be basic when compared to those without medical experience.

Finally, responses in region eight reflected those in region five. They saw the workbook as an adjunct to face-to-face mental health awareness training, but did not consider self-directed learning to be effective for this topic.

Evaluation forms showed the workbook was generally regarded as reasonably readable. However, dichotomous views were expressed in relation to the exercises. Some staff found them patronising while other (less experienced) staff were much more positive and expressed a need for expert guidance for learning in this area to be effective for them. This view was reflected in telephone interviews with prison officers who stated that it took 12 to 15 hours over two or three months to complete the training alone, and it would have been more beneficial to have expert guidance. Additionally, these staff stated that this type of training should be given to individuals early on in their careers.

Barriers to implementation

Feedback from across the regions showed that there were several main barriers to implementation. These included:

- difficulties in obtaining sufficient hard copies of the workbook
- many prisons were unable to ring-fence time for staff to undertake the training in groups
- senior management viewing compulsory training as a priority
- staff that were motivated enough to complete the workbook in their own time feeling that using the workbook in this way was not as effective as using it in a group learning situation
- attempting to implement the workbook at a time when many staff were on leave – making it impossible for remaining staff to be released from duties to attend the training
- running the training alongside (but not in partnership with) other training courses
- a perceived lack of a link between the workbook and ACCT training
- internal clashes with training already provided by in-reach teams
- difficulties in communication caused by internal management rotation
- a lack of a reliable way to gauge how valuable the training had been
- problems in deciding at what level it would be best to pitch the training.

Some of these barriers need to be overcome in order for implementation of the workbook to be successful in other establishments as outlined below.

Conclusion and recommendations

Prison officers generally recognise that their introductory training ill-prepares them to work with prisoners with mental health disorders. While a significant number of prison staff have received mental health training as part of the ACCT initiative, the workbook was introduced to further improve on these numbers using a self-directed approach to learning. The implementation of the workbook across pilot prison settings could be regarded as disappointing. However, such an outcome is not dissimilar to the central initatives where it had been anticipated that self-directed learning would be of value (see for example, Brabban *et al*, 2007). Despite attempts to overcome organisational barriers, very little training appears to have occurred in some of the RDCs. Nonetheless, some custodial staff found the workbook to provide useful training or to act as a good *aide-memoire* to previous training. Preliminary evaluation forms and telephone interviews even suggest that in some instances the training has actually changed staff attitudes towards mentally disordered offenders. However, we must keep in mind that this conclusion is based on a small number of forms and interviewees who may not be representative of the wider staff population.

There are also several measures that could be put in place to increase the success of the training in other establishments (and thereby ensure that it is more cost effective). This evaluation has demonstrated that internal time-constraints have been a barrier to implementing the workbook in many prisons. In establishments where prison officers have attempted to complete the workbook in their own time, take-up was minimal and learning was not supervised by experts. Therefore, despite the apparent difficulties, in order for the workbook to be truly effective it would be better employed as an adjunct to face-to-face training/in a group facilitated by a local specialist in mental health, which staff have ring-fenced time to

attend. Additionally, changes need to be made to the design and content of the workbook. Data from the pilot suggests that it may be beneficial to produce two versions of the workbook pitched at different levels of training need. Staff also stated that the content of the workbook should be made more applicable to the prison context (to reflect issues such as the likelihood of co-occurring disorders in the prison population). Finally, any amendments to the workbook need to take into account changes that have been made, more generally, to introductory prison officer training.

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Equivalent to what? Mental health care in Britain's prisons

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Abstract
Prisoners are supposed to receive health care that is equivalent to that provided in the community. There is a high prevalence of mental ill health in prisons, and prisoners tend to have complex needs. Prison mental health care has received only limited attention until recently. The impact of the new in-reach teams appears to have been positive, but primary mental health care is weak across the prison estate and the vast majority of prisoners with mental health problems still receive little or no service. The development of prison mental health care has not been evidence-based and there has been no policy implementation guidance that compares to that provided for reforms in services for the wider community. There is no model for prison mental health care and the role of the prison mental health practitioner is not well defined, nor is the health care workforce prepared for the task.

Key words
prison; mental health; training; workforce

Introduction
This paper considers the continued development needs of prison mental health services, particularly with regard to the prison health workforce. It is based on both existing literature and the Sainsbury Centre for Mental Health's (SCMH) own studies of prison mental health provision in London (Durcan & Knowles, 2006) and the west Midlands (unpublished).

The National Service Framework for Mental Health (Department of Health, 1999a) and the NHS Plan (Department of Health, 2000) presented a national model for mental health provision for England, this being further detailed by policy implementation guidance (eg. Department of Health, 2002). Among its key features was comprehensive service provision, driven by need and with the service user's voice central to its development.

At the same time, reforms have taken place in prison mental health provision. Underpinning those reforms has been the principle of 'equivalence' (NHS Executive & HM Prison Service, 1999), ie. that the services provided to prisoners should be equivalent to those provided to the wider community. However, equivalence is not being achieved. These reforms have been partial and have not had the sort of evidence base that has formed the foundation of reforms to the wider community's services.

It is well known that the mental health of prisoners had by and large been neglected until very recently. Her Majesty's Inspectorate of Prisons (HMIP) have consistently reported poor standards of health care, including mental health care (eg. HMIP, 1996; HMIP, 1997; HMIP, 2003; HMIP, 2005; HMIP, 2006a; HMIP, 2006b & HMIP, 2007). Other research has confirmed this view (eg. Durcan & Knowles, 2006; Rickford & Edgar, 2005; Rickford, 2003; Reed, 2003; Reed & Lyne, 2000 and Guite & Field, 1997). From 1996 (HMIP, 1996) government recognised these deficits publicly, later stating that much of the mental health service requirement in prisons should be provided at a primary care level but that this needed the support of specialist mental health services (Department of Health, 1999b). Both high quality primary care and specialist input were largely absent at the time.

Prison health care has been transferred to the NHS with primary care trusts responsible for commissioning. Virtually every prison now has access to a prison-focused specialist mental health service (prison in-reach team).

The growing prison population
The English and Welsh prison population, while fluctuating from day to day, grows year on year. The population on 22 December 2006 was 79,627 (NOMS, 2006) just over 4,000 more prisoners than at the same time the previous year (NOMS, 2005), which in turn was just over 1,500 more than for the same period in 2004 (NOMS, 2004).

Prevalence
Mental ill health in the prison population is significant. Singleton *et al's* (1998) study for the Office of National

Figure 1: Mental health problems in prisons and the general population

	Prevalence among prisoners	Prevalence in general population
Psychosis	6%–13%	0.4%
Personality disorder	50%–78%	3.4%–5.4%
Neurotic disorder	40%–76%	16.5%
Drug dependency	34%–52%	4.2%
Alcohol dependency	19%–30%	8.1%
	Source: Singleton *et al* (1998)	Source: Singleton *et al* (2001)

(adapted from Durcan & Knowles, 2006)

Census of psychiatric morbidity in adult prisons found that approximately 90% of prisoners have some degree of mental ill health, personality disorder or substance misuse problem (for young offenders the figure is 95% - Lader *et al*, 2000). Additionally, the study revealed that seven out of 10 prisoners had a combination of at least two of the above problems and those with a psychosis were likely to have three or four other concurrent problems. Rates of dual diagnosis (ie. a mental health problem coupled with a substance misuse problem) are significant in prisons.

Self-harm, attempted suicide and suicide are frequent events in prison. Shaw *et al* (2004) established that the period of greatest risk for prisoners is their first seven days in prison.

Tackling mental health problems is further complicated by the fact that the experience of imprisonment exacerbates mental health problems (eg. World Health Organisation & International Red Cross, 2005; Nurse *et al*, 2003). Evidence to the Joint House of Commons and House of Lords Committee on Human Rights (JCR, 2004) reported that *'Prison appears to be a good greenhouse for developing mental health problems'*.

Prisoners are a socially excluded group

Estimates of prevalence of mental ill health in prisons miss something of the complexity of need presented by prisoners with mental health problems. Offenders both before and after the experience of imprisonment are a particularly socially excluded group. Prisoners are disadvantaged in many ways: 67% are unemployed before coming to prison (Social Exclusion Unit, 2002), 70% will have no employment or placement in training/education on release (Niven & Stewart, 2005), 51% of short-term prisoners have housing problems prior to prison (Lewis *et al*, 2003), 42% of released prisoners have no fixed abode (cited in Williamson, 2006), 49% of people with a mental health problem have no permanent residence on release (Revolving Doors Agency, 2002), 65% of prisoners have numeracy skills at or below the level of an 11-year-old and 48% have reading skills at or below this level (Social Exclusion Unit, 2002). Prisoners are significantly more likely to have been in local authority care during childhood and to have truanted and faced exclusion from school than the non-prisoner population (Social Exclusion Unit, 2002). Fifty per cent on release have no GP (cited in Williamson, 2006), 67% are reconvicted within two years (78% of young offenders) (Cuppleditch & Evans, 2005), and a third of offenders' debt problems worsen in custody (cited in Williamson, 2006). There is growing evidence that prisons are not effective at reducing offending (Home Office, 2004; Social Exclusion Unit, 2002) and that the costs (financial and social) of containing people in prison without resolving issues of access to appropriate health and social care, education, training, housing and employment are too high (Social Exclusion Unit, 2002). All of these circumstances conspire to make prisoners with mental health problems at any level, moderate or severe, a challenge to support and treat.

Existing provision and workforce

All of England's 138 prisons have access to some general health care provision, approximately half with an inpatient unit and nursing staff on site day and night

(Dale & Woods, 2001). However, most of the prisoners in these inpatient units are admitted for reason of their poor mental health (Reed & Lyne, 2000) and a small number of prisons have dedicated mental health beds in recognition of this (eg. HMP Brixton, HMP Belmarsh – source: http://www.hmprisonservice.gov.uk/prisoninformation/locateaprison/).

The make up of the workforce varies considerably by prison. Primary care services are provided by general practitioners (GPs) and prison health care nurses (and visiting clinicians such as dentists). All prisons have access to GPs, some being dedicated to a particular prison, others through a variety of arrangements being served by community GPs local to the prison. However, quite a number of prisons are served by locum GPs, and such arrangements were reported in the SCMH's study in the west Midlands to be associated with problems of continuity of care.

Nurses are the largest single discipline in prison health care, numbering well in excess of 1,000. They perform a variety of roles including primary and inpatient care. It has been reported that nurses with mental health training comprise approximately a third of the total prison nursing workforce (NHS Executive & HM Prison Service, 2000), but most prisons employ nurses in a generalist's role regardless of training.

Some prisons' discipline staff have undergone training and specialise in prison health care, as health care officers (HCOs), some of whom will also have undergone nursing training.

In public sector prisons, the transfer of prison health care to the NHS was to have been completed by April 2006 and in many cases the employment of health care staff (ie. GPs and nurses) has transferred to primary care trusts.

Historically, many prisons have only had very limited access to psychiatry (Smith, Baxter & Humphreys, 2002) and few psychiatrists provided sessions to prisons prior to the creation of in-reach teams, and most of these were forensic psychiatrists (Birmingham, 2002). The introduction of in-reach services has meant that psychiatrists (a mixture of general and forensic) attached to these teams provide sessional work more widely across the prison estate.

Psychology in prisons (forensic psychology) is different to that provided in mental health services. Forensic psychology is largely concerned with running programmes to modify offender behaviour, psychometric testing and offender profiling. Clinical psychology in prison settings is envisaged as part of the multidisciplinary mix of professions that should form part of in-reach teams (Department of Health & HM Prison Service, 2001). The extent that in-reach teams have been able to incorporate psychology nationally is not clear, but few teams encountered by SCMH in London or the west Midlands had clinical psychologists among their ranks.

Changing the Outlook (Department of Health & HM Prison Service, 2001), a key policy document on prison mental health care reform places great emphasis on social care. Social workers appear to have been recruited to many in-reach teams, including four out of the seven London teams and all of the west Midlands teams SCMH studied.

In-reach teams

The most significant change in specialist mental health provision for prisons emerged from *Changing the Outlook*. This proposed the introduction of mental health in-reach teams modelled along the lines of community mental health teams, ie. multidisciplinary teams working with those with severe and enduring mental health problems. Most prisons in England and Wales have access to an in-reach team. In-reach teams are one of several new specialist teams that have come in the wake of the recent reforms to mental health services.

However, unlike the new teams in the community, such as assertive outreach and crisis resolution services, there was no evidence base for their introduction (from the UK or internationally). Furthermore, no implementation guidance has been published to guide the teams and those commissioning them. Consequently, there is no standard model for these teams to follow. While the teams were intended to be multidisciplinary, some have largely consisted of mental health nurses.

Working arrangements for in-reach teams vary considerably. The teams are provided by local NHS mental health trusts. Some are dedicated to a particular prison and based within it, others have external bases and still others service several prisons, providing sessions in each.

The impact of prison in-reach teams is yet to be established, though SCMH found evidence of significant improvements in London since their introduction (Durcan & Knowles, 2006).

Continuity of care

Prisoners on release experience poor continuity of care. In both the London and west Midlands studies many prisoners were released with no registration to primary care in the community.

Changing the Outlook envisaged the Care Programme Approach (CPA) as a vehicle for ensuring continuity for those with marked mental health problems, care co-ordinators in the community maintaining contact when a client enters prison, and in-reach enacting CPA should a prisoner meet criteria to ensure continuity of care post release. All of the in-reach teams SCMH encountered expend considerable energy in attempting to link with community mental health services. In both London and the west Midlands, in-reach teams experienced difficulties in engagement particularly if community services were out of region. SCMH also found that CPA was being applied inconsistently across and within prisons, meaning at times poor information exchange between different in-reach teams on transfer and lack of engagement of prison health care staff in CPA in some prisons.

The current Department of Health review of CPA (Department of Health, 2006) provides an opportunity to consider its application in prisons. The introduction of the new Offender Management system (OM) across the prison estate provides another opportunity. Careful thought needs to be given as to how these two processes integrate and how the integrity of the CPA is not undermined by OM, which is essentially coercive and is geared to reducing offending.

Primary care

Providing prison mental health care at the primary level has proved difficult. The All Party Parliamentary Group on Prison Health (2006) reported that primary mental health care is extremely weak. On their visit to Winchester prison they found nurses with a mental health nursing qualification who were employed to carry out a generic nursing function. They did attempt to carry mental health caseloads, but there was no additional resource and the expectation was that they should continue with all other duties. Unsurprisingly, only limited progress was reported.

SCMH study of five west Midlands prisons found primary mental health care in much the same state. This study involved semi-structured qualitative interviews with prisoners (n=98), interviews with other stakeholders (n=70), audits of prisons reception health screenings, general practitioner consultations in the prisons, in-reach and prison mental health nurse caseloads (including collecting profiling data on history, needs and severity of problem) and non-participant observation. Two of these prisons where attempts had been made to develop a specialist primary mental health care role, were frequently vulnerable to staff shortages in other health care areas. In two other prisons there was no meaningful primary mental health care at all and the fifth had a nominal service (a monthly session run by one nurse). Similar experiences were reported in London (Durcan & Knowles, 2006).

The gaps in primary mental health care in London and in the west Midlands had led initially to an overwhelming number of referrals to the new in-reach teams. Many of these referrals fell well below what the in-reach teams regarded as their referral threshold.

Primary mental health care in prisons clearly requires significant development. Most prisons are some considerable distance from being able to routinely employ evidence-based practice and programmes of care that are compliant with NICE guidelines, and prison health care departments are currently unlikely to have the level of skills among staff in place, even when mental health trained.

The roles and responsibility of the prison nurse

There is relatively little literature on prison nursing and very little in the way of research on its contribution. There are several discussion papers on the role of the prison nurse, but these tend to present somewhat idealised versions of what that is or should be (eg. Norman & Parrish, 2002; 1999). They set out an expectation that prison nurses will have expertise in a broad range of areas (ie. a generic function), rather than provide the specialised nursing provision that is provided outside prisons.

Nurses in prisons and secure mental health settings have been reported to have a tendency to rely on *'routines, rituals and regimes'* (p83, UKCC, 1999). SCMH have also observed that much activity seemed to be governed by 'custom and practice' and indeed was often seemingly non-clinical in nature, such as nurses spending considerable time in each shift faxing prescription sheets to a centralised pharmacy. GP clinics in prisons often have qualified nurses attending, but

with little more than a chaperoning role, escorting prisoners between their consultation and holding cell, passing medical records, but not having any significant clinical input. Such duties may have been carried out by discipline staff in the past (including HCOs) but some primary care trusts have chosen not to have non-nursing qualified HCOs or other discipline staff within the skill mix of prison health care departments.

Staff in the London review felt that mental health trained nurses who were operating in a generalist role with limited opportunity to employ their mental health skills would become de-skilled. De-skilled staff may be reluctant to abandon 'custom and practice' as they lack confidence to engage in evidence-based interventions. There is little to direct them to do otherwise. While mental health receives much lip service, in reality it is given little priority unless the mental health problems are severe and/or until the behaviour of a prisoner challenges the running and security of an establishment (reported to SCMH in the west Midlands study) and sometimes this may result in a placement in a prison's segregation unit rather than a transfer to more appropriate care (Rickford & Edgar, 2005).

Prison inpatient and day care provision

Some prison health care departments provide inpatient beds. It is consistently reported that the majority of prisoners using these inpatient beds will be admitted for reasons of poor mental health (Durcan & Knowles, 2006; Reed & Lyne, 2000). The care given to inpatients is minimal. Care may amount to little more than containment with increased opportunities for observation: inpatient wings have higher staff to prisoner ratios than ordinary locations. Although prison inpatient units are used essentially as psychiatric facilities, the Mental Health Act, 1983 has no application in prison. Compulsory treatment can only take place under exceptional circumstances and under common law. Therefore, admission to a prison inpatient unit cannot guarantee consistent treatment (medication) regimes.

Some prisons have introduced day centre type facilities, which some inpatients may be able to attend, but for most inpatients there will only be limited if any opportunities for meaningful activity and considerably less association time (time in the company of others outside one's cell) than that of the general prison population.

Assessment and screening

Prison health care nurses have a health screening function. Prisoners arrive at prison at a reception area where they are interviewed by prison health care nurses. Prisoners arriving from court for the first time are interviewed using a standardised questionnaire; those transferred between prisons will also be screened though there is no standardisation of this secondary screening between prisons. Screening procedures in prison receptions have been reported as being ineffective (Durcan & Knowles, 2006). As a result, prisoners with mental health problems have often not been identified (Parsons *et al*, 2001) and once on a prison wing this is even less likely to happen (Birmingham *et al*, 1998).

A new screening tool and process was piloted across 10 prisons and has now been adopted for use for all new prison receptions (Birmingham & Mullee, 2005; Carson *et al*, 2003). However, although it is intended that there be a second follow-up screening as part of this process, this often does not take place. A one-off screening at reception is always likely to have marked limitations and there is a need for a development of more exhaustive screening processes. SCMH found that some London prisons received as many as 80 prisoners in a single day, putting considerable pressure on screening staff and limiting the time spent with prisoners. It is important to note that prisoners may in any case be reluctant, at this stage, to reveal any mental health problems they experience. In addition to these limitations, there is a particular challenge for prisons with significant remand populations, where the stay in that prison may be of very short duration.

Training and supervision

There is no training specifically designed to help nurses work in prisons, bar some pilot programmes (eg. health leadership training open to health and other prison staff at HMP Pentonville). Major weaknesses have been reported in training and professional development for nurses in prisons (eg. UKCC, 1999; Department of Health, 1999b).

HMIP reports frequently comment on health care environments and staffing shortages but more recently some reports have commented on clinical supervision of nurses, or rather its absence (eg. HMIP 2006b, HMIP 2007). Freshwater *et al* (2001) described the provision of

clinical supervision as patchy. Walsh (2005) conducted research into clinical supervision in prisons and found barriers to its introduction such as sabotage by some staff.

While all prison doctors (ie. those working as GPs in prison health care departments) hold a qualification in general practice, many have had no training in the management of mental health problems (Pearce *et al*, 2004).

There is no training for working within in-reach teams. The practice of psychiatry in prisons is also seen as a gap in the training of general psychiatrists; only training for forensic psychiatrists includes this (Royal College of Psychiatrists, 2006; Reiss & Famoroti, 2004).

In addition to the development of in-reach teams, some considerable work has been done in designing an offender care pathway with good practice templates at different stages (Department of Health, 2005). These developments are commendable, but do not amount to the sort of comprehensive and overarching service model that has been designed for mental health services in the community. Not surprisingly, without this model there has been little done in the way of defining the roles of mental health practitioners in prisons.

As with community based mental health services there is a need to explore capabilities for the prison mental health practitioner, taking into account the different areas of practice in prisons – primary, secondary and inpatient, but also the different prison environments and populations, ie. women, children and young people, men, remanded prisoners, restricted and less restricted prisons.

The *10 Essential Shared Capabilities* (Department of Health, 2004a) provides a framework for establishing these capabilities and complements other key frameworks such as *The Knowledge and Skills Framework* (Department of Health 2004b) and the *Mental Health National Occupational Standards* (available at http://www.skillsforhealth.org.uk/mentalhealth/index.php). The Royal College of Psychiatrists also recommends a capability-based training for psychiatrists, seeing prisons as requiring a mixture of general and forensic psychiatry as well as psychotherapy. Access to expertise in substance misuse is also seen as crucial (Royal College of Psychiatrists, 2006). They see these capabilities as varying depending on the needs of different prison populations.

Any model of prison mental health care must consider the role of other prison staff, the 50,000 or so prison officer, technical, education and other staff, many of whom have day-to-day contact with prisoners with mental health problems.

The primary developmental need of these prison staff is a mental health awareness that includes an understanding of factors important to maintaining good mental health, recognising the signs of poor mental health and knowing how to respond (including referral routes). The introduction of Assessment, Care in Custody and Teamwork (ACCT), a new approach to management of self-harm and attempted suicide in prisoners, has involved some prison staff in formal mental health awareness training. Many of the staff SCMH interviewed in London and the west Midlands had, however, undergone no mental health awareness training.

Commissioning

The first steps in developing a mental health service for prisons have proven challenging. PCTs are commissioning services for a population that has been little engaged by the NHS previously and for whom there is no commissioning template. It is reasonable to expect commissioners to have only a limited understanding of the needs of this community. PCTs are not the only commissioners of services in prisons, particularly for prisoners with substance misuse and mental health problems for whom services are not well integrated (Podmore, 2006).

User involvement

While the development of service user involvement in the NHS has been slow, some progress has been made (Campbell, 2005). User engagement in prisons is likely to prove an even greater challenge, as these institutions are primarily concerned with the deprivation of liberty and public protection. Rickford and Edgar state that, *'The nature of the punitive environment can profoundly hinder the development of patient involvement'* (p59, 2005).

However, it is only through the engagement of service users in prison that their needs can be fully understood and a more comprehensive vision for prison mental health services can be formulated. In the west Midlands, SCMH interviewed approximately 100 prisoners about their experiences of service use and views on future provision. The results of this will be published in due course. However, several key findings have already emerged from the early analysis:

- prisoners perceived contact with in-reach teams as positive and felt that in-reach teams intervention had encouraged the prisons to proactively plan for their release
- prisoners with mental health problems not in contact with in-reach received little or no help in the prison and had greater concerns about their release and resettlement
- most reported a history of problematic substance use and felt that successful resettlement needed to involve help with this as well as their mental health problems.

Conclusion

The developments in prison mental health care to date have been positive, but it is important to realise that they are incomplete and that there is little pressure to improve the quality of care. Developing a more comprehensive model of mental health care will be a challenge. It will involve further investment and in the current climate this may encounter both public and political resistance. The commissioners of prison health care, primary care trusts, have considerable pressures upon them: many are in deficit and, *'it will be important to ensure that prison health care does not once again slip out of sight and down the list of priorities'* (p34, HMIP, 2007).

It is only in recent times that much attention has been given to tasks, capabilities and skills of the mental health workforce in the wider community. Performance tends to be measured in numbers, for example, the number of crisis resolution teams and the professionals within them. Therefore, it is not surprising that little if any attention has been paid to the specific workforce challenges for those mental health specialists working in prison or indeed of generalists who need to understand mental health issues.

Prisons are difficult places to provide good quality mental health care. They operate rigid regimes where primacy is given to security. Overcrowding means there is much movement of prisoners between establishments. The NSF and NHS Plan have not been applied to prisons and it is naïve to think that they could be, without some considerable thought being given to their prison application. This, though, is precisely what needs to be done if any significant progress is going to be made from here.

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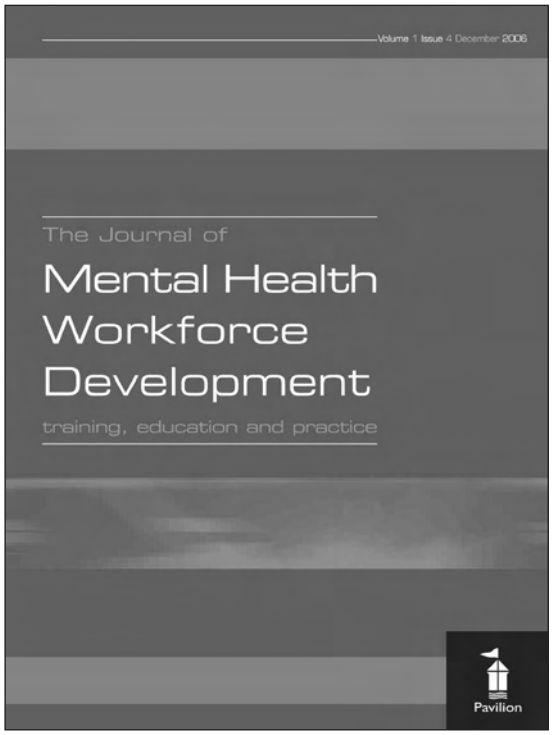

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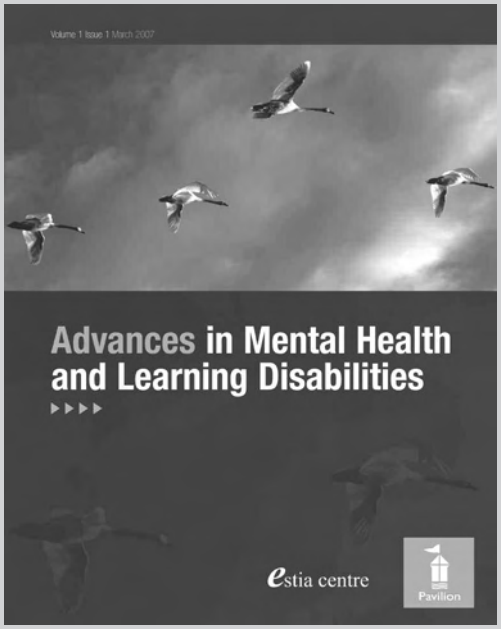

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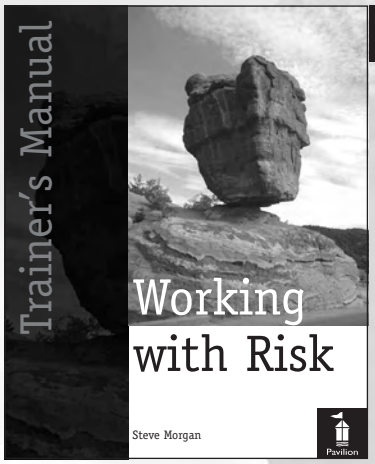
NEW for 2007

Working with Risk

Identifying and managing risk and constructive risk-taking require a sophisticated degree of collaborative working and analysis of information. Primarily, this requires greater connection to the perspectives and experiences of service users and carers than presently happens within a narrow and restrictive approach to risk assessment.

This new pack sets out a framework that places the engagement of service users' views and experiences as the foundation for collaborative risk assessment and management. The tools are developed as a flexible system for prompting and capturing good practice through a more expansive appreciation of risk in everyone's lives, as well as recognising the need to counter-balance the negative view of risk, with an appreciation of personal strengths and potentials.

The materials come in two parts:



The Trainer's Manual

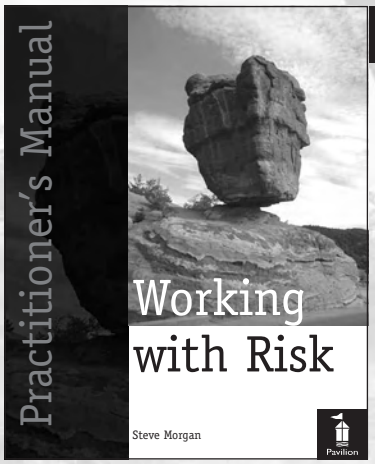
This contains all the materials needed to run the two-day workshop including full introduction and evaluation of the training. Day one focuses on exploring ideas and issues related to risk while day two focuses on putting risk into practice. The training can be delivered flexibly according to the needs of particular groups of participants/teams. The manual is divided into eight sessions:

Session 1 – Exploring the wider context of risk
Session 2 – Working with service users
Session 3 – Working with suicide and self-harm
Session 4 – Positive risk-taking
Session 5 – Risk decision-making and communication
Session 6 – Assessing and managing risk 1: practice
Session 7 – Assessing and managing risk 2: case study
Session 8 – Taking risks: case study

ISBN: 978 1 84196 212 2

Format: ringbound resource including OHP and handout masters.

Price: £195



The Practitioner's Manual

This sets out how good risk assessment, risk management and risk-taking practice should be followed for all users of health and social care services. It is designed to develop and extend personal reflection on an individual's knowledge and experiences.

Topics covered include:

- wider context of risk
- working with service users
- working with suicide and self-harm

ISBN: 978 1 84196 213 9

Format: ringbound resource

Price: £44.95

Of particular interest to: all those working within health and social care services, voluntary and independent sector services, and across all age groups and sectors, including mental health, learning and physical disabilities, and sensory impairments. It is also aimed at managers and practitioners of services wishing to implement the 'Working with Risk' approach within their organisations.

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