An Assessment of the need for Mental Health First Aid (MHFA) Training in Prisons in North East England

Dr Wendy Dyer
Paul Biddle

Centre for Public Policy

The Centre for Public Policy (CPP) at the University of Northumbria was the first research facility in the North East to specifically focus on public policy and governance issues. CPP provides research, evaluation and training in relation to the management and organisation of public services and has been specifically designed to provide a valuable resource for regional bodies, public sector agencies, partnerships and voluntary organisations in the North East region and elsewhere. Since its launch in 2002, CPP has developed a reputation for high quality work, helping policy makers and managers to plan, develop and evaluate their responses to the new ideas, initiatives and legislation which impact on the way they operate. Overall, CPP aims to contribute to the process of public and voluntary sector renewal by promoting discussion, debate and dissemination of best practice, regionally, nationally and internationally.

Centre for Public Policy
School of Arts and Social Sciences
Northumbria University
Newcastle upon Tyne
NE1 8ST

Tel: +44 (0) 191 243 7425

Fax: +44 (0) 191 243 7434

Email: cpp@northumbria.ac.uk

Website: www.northumbria.ac.uk/cpp

Contents

Acknowledgements

We would like to thank all those individuals who organised our access to HMP Acklington, HMP Durham and HMP Low Newton, and to all those individuals who took part in an interview.

Dr Wendy Dyer
Senior Lecturer in Criminology
Northumbria University

1. Executive Summary

The project

- Northumbria University has been commissioned by the North East Offender Health Commissioning Unit to undertake a two stage project which aims to evaluate the impact of Mental Health First Aid (MHFA) training in prisons across the North East region. This report outlines the findings from stage 1: An Assessment of the need for Mental Health First Aid (MHFA) Training in Prisons in North East England.

- MHFA is designed to give non-mental health specialists the skills to identify and respond effectively to those experiencing mental health problems prior to specialist interventions taking place.

- MHFA training is currently being delivered across prisons in north-east England. This training will be delivered to non-mental health prison staff. This initial cohort of staff will then be responsible for training their colleagues within their respective prison.

- This evaluation focuses on the roll out of MHFA training at HMP Acklington, HMP Durham and HMP Low Newton. These prisons have been selected as they enable the evaluation to explore the need for, implementation and impact of MHFA across different types of prison.

- In order to identify the need for MHFA training, stage one comprised an exploration of the existing approaches (pre-MHFA training) used by non-mental health staff to identify and manage prisoners with mental health problems, and their perceptions of the effectiveness of these approaches.

- Stage two of the evaluation will critically examine the implementation, outcomes and impacts of MHFA training.

Findings from phase one

- Findings are based on interviews with prison staff, Prison Chaplains and Prison Listeners (Prisoner Listeners are prisoners trained to listen to other prisoners who are in distress), and other documentary evidence including reports from Her Majesty's Inspectorate of Prisons.

The findings in context

- Reflecting the situation in the British prison system in general, managing prisoners with mental health issues is a key issue facing HMP Acklington, HMP Durham and HMP Low Newton. Prisoners are a very challenging group to treat and care for and the prison environment is a difficult one in which to deliver care and treatment. Each prison has finite resources and infrastructure available with which to respond to prisoners with mental health issues.

- The treatment and care for prisoners with mental health issues in all three prisons is felt to have improved in recent years. The existence of on-site mental health specialists at each prison is regarded as crucial to delivering this improved treatment and care. However, it was acknowledged that these services are stretched and there is scope to improve the identification of and responses to prisoners with mental health issues.

Mental health related training for staff appears to have been historically variable and limited. Further awareness-raising and training activities would be beneficial.

Identification of prisoners with mental health issues: There are several formal ways in which prisoners with mental health problems can be identified at reception. These approaches should enable most prisoners, with a serious mental health issue, to be identified. These formal processes are supplemented by informal approaches. In relation to these informal approaches, prison staff rely heavily on their knowledge and experience to identify a prisoner with a mental health issue who may not have been identified at reception. It was acknowledged that this creates scope for potential misdiagnosis, and that informal approaches may not identify those prisoners with mild to moderate mental health issues.

Responding to a prisoner with mental health issues

- Prison staff have a crucial role in the delivery of institutional responses to prisoners with mental health problems. Often they provide the initial response to prisoners experiencing a mental health crisis where their or others lives or safety are at risk. Staff may also have a valuable role to play in the ongoing support, treatment and monitoring of prisoners with mental health problems.

- Findings suggest that current prison staff interventions to address crisis situations involving suicide/self-harm threats or attempts are generally effective (in that they minimise suicide and incidents of severe self-harm, as evidenced by the falling numbers of self-inflicted deaths in custody (Ministry of Justice, 2011)). Non-mental health specialist staff feel at least reasonably confident to respond to suicide situations appropriately.

- Evidence suggests that the more general responses (those not focused on suicide/self-harm), to prisoners experiencing mental health problems, provided by prison staff are variable. Responses can be dependent on the experience and training of individual staff, individual staff-prisoner relationships, and individual staff understanding of their role in relation to mental health. Responses were also influenced by the time and staff resources available at any given time. As such, interventions received by prisoners can be variable, and may not always be appropriate.

- There are concerns that those prisoners whose mental health problems have no implications for the operation of the prison may not always receive an appropriate response, with such prisoners sometimes left to deal with their mental health issue without appropriate treatment and care.

- Staff working in segregation units generally felt more confident to respond appropriately to a prisoner with mental health issues as they tended to have received training, had experience of responding to prisoners with mental health problems, and because staff-prisoner ratios in segregation units usually provided time to undertake required responses. However, segregation units should be used primarily to deal with those breaking prison regulations. This raises questions about the use of these units to care for those with mental health issues. Some segregation units (e.g. HMP Durham) do also have an explicit 'care' function which. However, prison inspectors continue to argue that these units are not an appropriate location for prisoners with mental health issues.

- Prison Chaplains and Prison Listeners felt that they were able to provide support to prisoners with mental health issues by providing a listening service, advising on access to wider provision and by monitoring prisoners they know to be vulnerable. However, both were limited in the support that they felt that they could provide because of either a lack of time, resources or specialised knowledge.

The case for the introduction of MHFA across North-East Prisons

- There is scope to develop the role of prison staff in the identification, care and monitoring of prisoners with a mental health problem. In particular, there appears to be scope to broaden the information available to staff beyond suicide and self-harm, to help them respond appropriately to prisoners with mental health problems.

- Findings indicate that MHFA has the potential to address a number of issues identified in this report and help to further develop provision that is available to prisoners with mental health problems. In particular, MHFA training may:
    - Assist staff to more effectively deliver their existing responses to prisoners with mental health issues.
    - Enable the better identification of prisoners with mental health issues (particularly those who do not impact on the operation of the prison).
    - Improve the capacity of staff to deal with a wider range of mental health issues other than suicide and self-harm.
    - Develop staff knowledge, skills and capacity by disseminating good practice more widely across the north east's prisons, resulting in interventions which are more appropriate and less variable.
    - Help to ensure that prisoners' mental health issues are seen as the responsibility of all staff, not just mental health specialists.

- o Help to challenge the sometimes 'semi-normalisation' of problematic behaviour (such as less severe self-harm as a coping mechanism), and the approaches used to respond to prisoners with mental health problems (such as the use of segregation units) that may not always be appropriate.

- However, the extent to which this potential is realised will be dependent upon how effectively MHFA training and practice is implemented and managed. The impact of MHFA will also be influenced by staff resources, the scope staff have to integrate MHFA into their working practices, and how well the institutions are able to balance the mental health and wellbeing of prisoners with other institutional priorities such as security, prison movements, recreation and work.

The role of specialist mental health services

- All those interviewed emphasised the need for on-site mental health specialists to take primary responsibility for the effective identification, treatment and monitoring of prisoners with mental health problems. Staff stressed that the role of MHFA training and practice must be to support and not to replace specialist services.

2. The Research Project Methodology

Sample Selection

HMP Acklington, HMP Durham and HMP Low Newton participated in the research. These prisons were chosen to ensure that data could be drawn from different types of prison (including a category B prison, a category C prison and a women's prison) so that findings could be generalised. To ensure that as many perspectives as possible informed our findings, a wide range of staff were selected to take part in the project. Staff taking part in the project included Prison Officers working on 'normal location' wings, Prison Officers working with vulnerable prisoners, Prisoner Officers working on reception wings, education staff and Counselling, Assessment, Referral, Advice and Throughcare (CARATS, the universal prison drug treatment service) staff. Mental health specialists and healthcare staff also took part in the research as did Prison Chaplaincy staff and Prison Listeners (these are prisoners trained to listen to other prisoners who are in distress). In total, 32 individuals participated in the research.

Data Collection Methods

Data collection comprised:

- A literature review to contextualise the research and to identify existing mental health provision in each prison and its effectiveness.
- Semi-structured interviews (face to face and telephone) with a representative sample of 32 individuals who had a range of different roles across the three prisons (see 'sample selection' above).
- The interviews covered a range of issues designed to identify existing understanding, identification and responses to prisoners with mental health problems, including:
  - Interviewees' knowledge of mental health, including previous training/awareness raising, and perceived gaps in awareness, knowledge and training around identification and treatment.
  - How prisoners with mental health issues are currently identified.
  - Immediate and longer term interventions undertaken with prisoners suspected of having a mental health issue – and perceptions of their effectiveness.
  - Individual staff responses to prisoners experiencing mental health problems.
  - How competently interviewees feel that they are able to respond, immediately and in the longer term, to prisoners experiencing mental health problems.

Data collection was challenging. In order to comply with prison security policies, face to face interviews conducted in each prison could not be recorded. Notes of key points were made instead.

Data Analysis

The fieldwork generated a mixture of interview recordings and written notes. Written summaries of all recorded interviews were produced. Written notes were typed up shortly after each un-recorded interview. Data analysis was structured by a number of themes that emerged during the interviews:

- The identification of prisoners with mental health issues.
- Responses to prisoners with mental health issues.
- The ongoing care and support of prisoners with mental health issues.
- The knowledge, experience and capacity of staff to respond appropriately to prisoners with mental health issues, and the need for additional information, advice and guidance to improve the identification and treatment of prisoners with mental health issues.

Data was analysed using specially created analysis tables that enabled the research team to identify key issues.

Results in Brief

Data analysis identified number of common themes, patterns and concerns that are discussed in more detail in Chapters 6 and 7 of this report. In summary these are:

- The prison environment is a very challenging one in which to care for and treat those with mental health issues.
- Prison staff play a crucial role in dealing with prisons in a mental health crisis. They may also play an important role in the ongoing treatment and care of prisoners with mental health issues.
- There is limited and variable training for staff around mental health, outside of training related to the Assessment, Care in Custody in Custody & Teamwork' (ACCT) procedure for caring for people at risk in prison. Consequently, there is scope to improve information, advice and guidance available to staff, across a wider range of mental health problems.
- The potential for misdiagnosis of prisoners with mental health issues, and for variable and possibly inappropriate responses to these prisoners on some occasions.
- Identification and responses are influenced by the wider prison regime, staff expertise, time and experience, staff perceptions of their role, and the extent to which a prisoner's mental health issue impacts on the smooth running of the prison.
- MHFA training has the potential to develop the knowledge and capacity of those trained so they can better identify and respond to prisoners with mental health problems. However, the extent to which it can do so is dependent on a number of factors. These include how effectively the training is managed, the ability of

trained staff to roll out MHFA training to other staff across the prisons, and the scope for staff to integrate MHFA into their practice.

3. Background & Context

Introduction

This report identifies the case for introducing MHFA in north east prisons by exploring the general mental health needs of the prison population, analysing the specific mental health needs and issues in each of the three prisons, and by detailing the findings from interviews and focus groups with staff and prisoners from the three prisons. These interviews and focus groups explored the capacity of non-mental health prison staff and prison listeners to offer support to a prisoner experiencing a mental health crisis (where their lives or safety or the safety or lives of others were in danger) or a less severe mental health issue that required an intervention. This report assesses the case for introducing Mental Health First Aid (MHFA) training in three prisons in north-east England. These prisons include:

HMP Acklington, a category C prison for convicted male prisoners.

HMP Durham, a category B prison for adult male convicted and remand prisoners from Tyneside, Durham and Cumbria courts.

HMP/YOI Low Newton, a closed female prison and young offender institution.

Prisoner Mental Health

Prisons are not therapeutic environments. The imperatives of security and control will always create a challenging environment for the delivery of care to those who are mentally ill (HM Inspectorate of Prisons, 2007).

Evidence clearly indicates that prisoners are at greater risk of experiencing poor mental health and mental health problems than the overall UK population. *Patient or Prisoner: A new strategy for healthcare in prisons* (HM Chief Inspector of Prisons, 1996) highlighted the substantial proportion of the prison population with a mental illness. It also questioned whether enough was being done to ensure prisoners received adequate mental health treatment and care whilst they were in custody. More recently, the *Bradley Report (2009)* highlighted how custody can exacerbate mental ill health, vulnerability, the risk of self-harm and suicide. In more detail:

- The prison population has increased by approximately 60% since 1995. Consequently, there are now likely to be more people with mental health problems in prisons than ever before (Rutherford, 2010). Indeed, since the late 1980s, the proportion of the prison population showing signs of mental illness has increased sevenfold (HM Inspectorate of Prisons, 2007).
- A 1998 ONS report (Singleton et al, 1998) found that up to 90% of prisoners had one or more of the diagnosable mental health problems studied which included psychosis, neurosis, personality disorder, hazardous drinking and drug dependency, with over 70% having two or more diagnosable conditions.

- More recent research, by the Sainsbury Centre for Mental Health, indicates that multiple mental health problems are much more common in the prison population than the population at large. The prevalence of psychosis is 15-20 times higher in the prison population than the population at large. Furthermore, over 70% of prisoners have two or more mental health problems compared to 1 in 25 of the general population. Sixteen per cent of all prisoners have four or five co-existing mental health disorders, with high rates of self-harm and suicide (Sainsbury Centre for Mental Health, 2008).

- Male prisoners are five times more likely to attempt suicide than their counterparts in the general population (Durcan, 2008).

- Rates of neurotic disorder are much higher for female prisoners than male prisoners (The Bradley Report, 2009).

- Many prisoners have complex needs around substance misuse (HM Inspectorate of Prisons, 2007).

- In 2004, it was estimated that, at any one time, 3,700 prisoners had a mental health condition severe enough to require transfer to NHS mental health services (Edgar & Rickford, 2009).

- There are concerns that many prisoners remain undiagnosed and so receive no treatment (Rutherford, 2010).

- There is some evidence that imprisonment may improve mental health for young people in secure institutions. However, any benefits are lost following release (see Chitsabesan et al, 2006).

Evidence suggests that there are number of mutually reinforcing factors that explain the high incidence of mental illness among the UK prison population. Particularly important factors, explaining the high incidence of mental illness in prisons, include those with a mental illness being more likely to be arrested likely to be arrested, court assessments that result in those with mental illnesses receiving a prison sentence rather than a non-custodial punishment, and poor identification of mental health issues at initial reception into prison (Reed, 2003).

Policy and Practice Developments

The high levels of mental illness among prisoners, and historic weaknesses identified in service provision, have increasingly been recognised by policymakers and practitioners. In the last twenty years, a range of policies and interventions have been suggested and/or introduced to improve the identification, treatment and care available for prisoners with a mental health problem. The Reed Reports (1992-1994) called for better diversion of mentally ill offenders from prison, investment in mental health services, and improved working between the criminal justice system and health agencies. In 1999, the National Service Framework for Mental Health (Department of Health, 1999) was launched. This was a ten year strategy to address the mental health needs of working age adults, including prisoners. In 2001, the Department of Health and Her Majesty's Prison Service (2001)

launched the *Changing the Outlook: A strategy for developing and modernising mental health services in prisons.* This required all prisons and NHS partners to complete a detailed review of mental health needs based on existing health needs assessment work, to identify gaps in provision and develop action plans to fill any gaps in services.

A key development, in 2006, was to transfer responsibility for prison healthcare from the Prison Service to the NHS. This transfer was designed to improve care, treatment and outcomes for prisoners. Passing responsibility for healthcare to the NHS was particularly designed to ensure 'equivalence of care', so that prisoners receive broadly similar NHS services to those available in the community.

Further important developments include the creation of **Mental Health In-Reach Teams**. These teams are based on the community mental health team model and aim to provide specialist mental health services to prisoners, equivalent to those which are provided by community based mental health teams for the population at large. The **Care Programme Approach (CPA)** has been partially introduced in prisons. CPA requires social and health care services to work together to put in place key arrangements for the care and treatment of mentally ill people, including assessment, a care plan, a key worker, and regular reviews. **MAPPA** (Multi-agency public protection arrangements) have also been introduced. These are statutory arrangements for managing sexual and violent offenders as they leave prison and move back into the community, including those offenders who are violent due to a mental health issue (Rutherford, 2010).

The recent Green Paper '*Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders*' (Ministry of Justice, 2010) identified the importance of effective healthcare for offenders to help to reduce re-offending. In relation to mental health, the green paper includes proposals to improve services for offenders with severe personality disorders and further develop provision for prisoners experiencing mental illness. It also identifies a need to re-shape drug services in prisons to improve their effectiveness, and the importance of diverting less serious offenders, with mental health problems towards treatment, and away from a criminal justice system that can struggle to manage and care for them appropriately.

Developments in policy and practice, particularly since the NHS took over responsibility for the provision of prison health care, have begun to improve provision for prisoners with mental health issues. Evidence suggests that mental health services have been expanded and that improvements have been made to provision with recent reports, by the Prison Reform Trust, the Centre for Social Justice, the Policy Exchange and Nacro, all recognising developments to improve treatment had taken place (Brooker & Ullman, 2008; Centre for Social Justice, 2009; Edgar & Rickford, 2009; Royal College of Nursing, Nacro and the Centre for Mental Health, 2010). Furthermore, funding has increased considerably with around £20 million per year spent on prison mental health in-reach services between 2006-2010.

Remaining Challenges

In spite of policy and practice developments, and improvements to mental health services in prisons since the NHS took over responsibility for the provision of prison healthcare, evidence indicates that challenges remain in the delivery of services to treat, care for and monitor prisoners with mental health problems. It has been argued that there are too few psychiatric NHS in-patient beds left since the large scale closure of hospitals which began in the 1960s, and that there is a relationship between the reduction in capacity of mental health institutions and the increase in the prison population, which means prisons are now increasingly filled with more vulnerable prisoners with mental health problems (Reed, 2003; Rutherford, 2010). Key remaining challenges to address include:

Service Delivery: Evidence suggests that mental health services in prisons are often understaffed, subject to changing remits and that they are delivered in the context of a lack of a blueprint for the delivery of mental health services in prisons based on assessed need (HM Inspectorate of Prisons, 2007). This can make treatment less effective than should be the case. Consequently, prisoners either do not recover or have their conditions effectively managed. Additional issues identified as impacting on services for prisoners with mental health issues include:

- Custom and practice that prevent flexible working and the appropriate use of skills within prisons.
- Inflexible appointment systems.
- A lack of understanding between different services.
- A lack of services providing someone for prisoners to talk to about feelings.
- A lack of services to help prisoners in a crisis.
- Difficulties that prisoners can have getting access to information, advice and guidance about available therapies and medications.

(Durcan, 2008).

Equivalence of care: *The Future Organisation of Prison Health Care* (HMPS, NHS, 1999) endorsed the concept of equivalence of care, with prisoners having access to a range of healthcare services of a broadly similar standard to those who access community-based NHS provision. Research suggests that resources committed to mental health services in prison remain insufficient to deliver equivalence of care. The average In Reach team comprises the equivalent of four full-time staff. For equivalence to be achieved in a typical male prison it would require an In Reach team comprising the equivalent of eleven full time staff. Indeed, research has identified that many In Reach team leaders feel that they are insufficiently staffed. Furthermore, provision that simply mirrors that available in the community is not sufficient to deal with the different needs that prisoners have. Rather, services need to be nuanced to reflect prisoners' needs, rather than replicate community provision, if real equivalence is to be achieved (Bradley Report, 2009; Durcan, 2008).

Mental Health In Reach Teams have been identified as experiencing a number of other difficulties, in addition to the staffing issues discussed above. The growth in referrals and caseloads has been considerable since In Reach teams were established, making it more difficult for them to meet the demands placed on them (Sainsbury Centre for Mental Health, 2008). In addition to evidence suggesting teams are too small to ensure equivalence of care, there are further concerns that teams may lack important links to governance structures and externally-based colleagues, both of which can support good practice (HM Inspectorate of Prisons, 2007). Furthermore, there is evidence to suggest that many In Reach teams are not fulfilling their original remit of treating prisoners with severe mental illnesses, but are instead fulfilling a generalist role. Other research does suggest that some teams are focusing their activities on those with severe mental health issues. This difference reflects the aforementioned concern that a blueprint is lacking for the delivery of mental health services in prisons based on assessed needs, which results in differential local delivery that impacts on care (The Bradley Report, 2009; HM Inspectorate of Prisons, 2007).

Staff capacity and training: Evidence suggests staff capacity and training need to be improved so that all those coming into contact with mentally ill prisoners can intervene, as appropriate to their role, to support prisoners experiencing a mental health problem. Studies have found that less than 25% of wing staff have received training around mental health, and that this training was usually delivered as a part of initial, suicide or self-harm training. Training was felt to be good, but not sufficiently widespread. Whilst Prison Officers awareness of mental health problems has increased, they generally lacked confidence that they were correctly managing prisoners with mental health problems (HM Inspectorate of Prisons, 2007). Furthermore, work pressures mean that wing-based staff have little time to spend with prisoners and are unlikely to seek help for a mentally ill prisoner, unless a prisoner poses a threat to their own safety (suicide or self-harm) or to the effective running of the wing (Durcan, 2008).

Further difficulties with mental health service provision in prisons have been identified as:

- Silo working with a lack of integration and limited joint commissioning with other relevant services, with an associated need for more integrated care and treatment.
- Tensions between care and security that impact on levels of care that can be given to prisoners with mental health issues.
- Prisoners with needs just below those required to trigger a response not receiving provision, despite still being in need of some form of intervention.
- There remains too much unrecognised and unmet need.
- The inability of services to reduce levels of mental illness in prisons which remains high.
- A need to re-orientate provision to focus on mood, anxiety and adjustment issues.
  (Bradley Report, 2009; HM Inspectorate of Prisons, 2007; Rutherford, 2010).

Clearly, despite new approaches and extra resources, mental health problems among the prison population remain significant, and prison-based mental health services would benefit from improvement. In principle, the roll out of the MHFA training course may potentially help to improve the capacity of prisons to identify, support and care for those prisoners experiencing mental health problems. MHFA training could so this by:

- Raising the profile of mental health issues, and helping all staff to realise that identifying and responding to prisoners with mental health problems is everyone's responsibility

- Giving all staff working in prison environments greater knowledge and skills to identify and give immediate support to prisoners experiencing a mental health crisis.

- Providing staff with the knowledge and skills to identify and respond appropriately to a wider range of mental health issues.

- Increasing the capacity of prisons to respond to moderate and mild mental health issues

- Enabling prison staff to better support the work of mental health specialists working in prisons.

4. Mental health services and issues at HMP Acklington, HMP Durham and HMP Low Newton

Overall, findings suggest that the issues facing HMP Acklington, HMP Durham and HMP Low Newton in relation to mental health are broadly similar to issues identified across prisons generally. As such, key issues include: limited resources and variable knowledge of mental health issues, increasing numbers of prisoners with mental health issues entering the prisons, and a physical environment not conducive to the mental health and wellbeing of prisoners.

The Prisons

HMP/YOI Low Newton

Like similar prisons HMP/YOI Low Newton, a closed female prison and young offender institution, holds a large proportion of women who are vulnerable, self-harming and mentally ill, with a much smaller number having severe personality disorders. Mental health services available at Low Newton include a dedicated mental health team to manage diagnosis, treatment, care and review, with one to one counselling and group support available provided by MIND. At any one time, 10% of prisoners are being supported by suicide and self-harm prevention procedures.

A 2009 inspection found that mental health services were mostly satisfactory. In this context, the inspection report recommended a programme of mental health awareness training be provided for all prison staff. The report also called for increased availability of support and counselling for those with mental health problems as these were currently lacking (HM Inspector of Prisons, 2009).

HMP Acklington

An inspection undertaken by HM Chief Inspector of Prisons (2009) identified that around one third of prisoners in HMP Acklington, a Category C prison for convicted adult male prisoners, had mental health problems. Primary and secondary mental health services are provided at the prison. Mental health services include a small mental health team, mental health trained nurses, segregation staff who have received mental health training and forensic psychiatry psychologist provision. Some patients are subject to CPA. Overall, the inspection found mental health provision was insufficient and that the mental health team was both small and stretched, with a waiting time of six weeks for routine/non-urgent assessments (HM Chief Inspector of Prisons, 2009). There was no psycho-social support for those on the Integrated Drug Treatment System (IDTS) programme.

HMP Durham

A 2009 HM Chief Inspector of Prisons inspection found mental health services at HMP Durham, a Category B local for adult male prisoners, to be good and able to meet the complex needs that prisoners often had. Provision included in patient and out-patient provision and registered mental health nurses. The mental health team was found to have strong links with community-based providers and secure units. A substantial majority of staff had received mental health training. Overall, the inspection identified that 35% of prisoners had a mental health issue.

Mental health issues at HMP Acklington, HMP Durham and HMP Low Newton

Interview findings indicate that an increasing number of prisoners entering all three prisons do so with a mental health issues. Across the three prisons, interviewees (including prison staff, prisoners and healthcare staff) identified prisoners as experiencing a wide range of mental health problems, ranging from severe personality disorders to mild anxiety. However, more common mental health issues were self-harm (particularly in HMP Low Newton, which is a female prison), mood swings with accompanying violence, depression and anxiety. The prisons also had to respond to prisoners who found it particularly difficult to adjust to prison life (who were often referred to, in interviews, as 'poor copers'). There was a sense that depression and anxiety were linked to imprisonment. Therefore, there was a concern that interventions may not be effective as they could not fundamentally change the environment that was the cause of the mental health issues experienced by prisoners.

The prison environment

Staff working in prisons work in extremely difficult environments, with a very challenging group of people, who often experience complex, mutually reinforcing problems including substance misuse, mental health problems and various forms of social exclusion. Furthermore, all of the three prisons studied have finite time and resources (both general and specialist) with which to respond to an increasing number of prisoners with mental health issues. Responding to the mental health needs of prisoners also has to be balanced with other priorities including security, work, education, training and association. These factors may influence the appropriateness of the care, treatment and monitoring that can be provided to prisoners with mental health problems.

In the two male prisons studied in particular, there are signs of a culture of prisoners being reluctant to engage with staff for fear of the reaction of other prisoners. This is linked in part to issues around masculinity and identity (where the Western cultural ideal of masculinity includes qualities such as physical fitness, stoicism, determination, sexual dominance, control, and the suppression of emotions) and the importance that male prisoners associate with being able to cope un-supported. This reduces interaction and communication between staff and prisoners, making it more difficult for staff to identify prisoners with

potential mental health problems. This culture (and its implications) appears to be less of an issue in the female prison, where it is felt by staff that many prisoners are more open about their mental health issues.

The role of MHFA

As a result of the wider context identified above, there are no 'quick fixes' available to solve the problems associated with the management and treatment of prisoners with mental health problems. It is unrealistic to expect MHFA to address the challenging context, identified above, in isolation. However, the findings of this study (described below) do suggest that MHFA may have some role to play in improving the identification, treatment and management of prisoners with mental health issues.

5. Mental Health First Aid training

Mental Health First Aid (MHFA) has been introduced in Hong Kong, Finland, Singapore, Canada and Scotland. There are plans to introduce it across Wales and Ireland. In England, MHFA training is delivered by MHFA England, part of Wealden, Eastbourne and Lewes (WEL) Mind's training portfolio (**www.mhfaengland.org.uk**). MHFA is a training course for those who would like to recognise mental health problems and give initial help to those who need emotional or mental health support. The course is aimed at those who have little or no knowledge of how to help when someone is suffering from a mental health problem.

The course provides details to participants about how to deliver MHFA to individuals experiencing Depression, Suicidal behavior, Anxiety Disorders (PTSD, GAD, Phobias), Self-harm and Psychotic Disorders (Bipolar, Schizophrenia). MHFA is designed to enable individuals to help someone who is experiencing one or more of these mental health problems, prior to professional help being obtained. Overall, training is primarily concerned with raising awareness of the importance of mental health and to promote recovery among those who might be experiencing mental health problem.

Mental Health First Aid (MHFA) is a 12-hour intensive course, usually delivered over 2 days. The course provides an overview of common mental health problems, causes, symptoms and treatments, and teaches people how to:

- Recognise distress.
- Recognise the difference between Therapy and First Aid.
- Be confident in administering help in a First Aid situation.
- Provide initial help and guide a person towards appropriate support.

The aims of Mental Health First Aid are to:

- Preserve life where a person may be a danger to themselves or others.
- Provide help to prevent the mental health problems developing into a more serious state.
- Promote the recovery of good mental health.
- Provide comfort to a person experiencing a mental health problem.
- Reduce stigma and discrimination through education.

MHFA is developed and regulated by the National Institute for Mental Health in England (NIMHE) and England's Care Services Improvement Partnerships (CSIP).

As well as training people to deliver MHFA, the course also trains instructors who will obtain the skills necessary to themselves train colleagues within their own organisations. During the training participants complete various written tasks to demonstrate they understand what it means to be a MHFA instructor. Participants are also expected to deliver facilitated sessions (a 'facilitation task') in his or her Activity Groups during Development and Assessment Days. Following completion of the course, participants should deliver two

courses themselves as soon as possible and send all relevant material, relating to these course, to their mentor who, based on this information decides whether or not to approve participants as MHFA instructors. Those who are approved are then required to deliver a minimum of 4 courses the 12 months following their approval to remain on the MHFA instructors register. In the second and subsequent years approved instructors need to deliver two courses a year. Approved instructors are also required to attend continual professional training events.

MHFA training in prisons in the North East is being delivered using a 'training for trainers' model. Staff volunteers performing a range of different roles within prisons attend the MHFA course. They subsequently deliver sessions themselves to their colleagues, thus rolling out MHFA training across the prison estate.

6. Findings from North East prisons

The following section details the findings from this study which assessed the case for the introduction of MHFA training into prisons across the North East. Findings are based on semi-structured interviews with prison staff including Wing-based staff, those working with vulnerable prisoners and mental health specialists. For more detail of the methodology used refer to section 2: The Research Project Methodology.

Analysis of the data generated by the interviews uncovered a number of patterns, common themes, issues, concerns. Findings are presented under headings which reflect these common themes, issues and concerns.

Previous training

All of the prison staff interviewed had received some form of training/awareness-raising relating to some aspects of mental health, although the quality, amount and time elapsed appears to vary greatly. The training most commonly undertaken by prison staff was training designed to enable them to deliver the 'Assessment, Care in Custody in Custody & Teamwork' (ACCT) procedure. The ACCT procedure is designed to reduce the risk of prisoners committing suicide or self-harming, by delivering individualised, regularly reviewed care planning, delivered by various individuals/disciplines within a prison. All of those staff interviewed had received training about how to open and complete ACCT documentation, and how to ensure that they undertook activities (such as observation and updating ACCT documents) so that they remain compliant with ACCT requirements, designed to prevent prisoner suicides.

Several staff had received ACCT Assessor Training. This had provided the staff concerned with information about suicide, how to identify prisoners at risk of suicide and interventions that can reduce risk. As such, these members of staff were able to assess prisoners' suicide and self-harm risk, co-ordinate care plans and review the impact of ACCT.

Interview findings suggest that in staff working in Segregation Units (where some prisoners with mental health issues are at least temporarily located) had generally received mental health awareness training which they had found useful. However, some staff did feel this training was basic.

Interview findings suggest that non-ACCT specific training around mental health is variable. In more detail:

- There is a perception among staff that the delivery of training, in general, to Prison Service staff is challenging because of its cost implications and because of difficulties around freeing staff for training and arranging cover for those staff attending training sessions. As such, training opportunities relating to mental health are regarded as sometimes limited in availability and narrow in scope.

- As a group, interviewees had been on awareness raising/training covering a range of issues including personality disorders, self-harm, the impact of substance misuse on mental health, and how to respond to a prisoner suspected of experiencing a mental health issue. However, it appears that very few staff had experienced strategically planned, structured and comprehensive mental health awareness raising and training that covered all of these issues.

- Excluding ACCT training, whilst some interviewees have attended information/training sessions around mental health as outlined above, it appears many have not or had not attended sessions recently. As a consequence, some (but not all) staff felt that they have limited knowledge of mental health issues, beyond suicide/self-harm.

- A number of those who had received information/training about mental health felt that they would still benefit from further activities in order to refresh and improve their knowledge and working practices.

Overall, it appears that awareness raising/training around mental health for prison staff has historically been variable, with some staff having received awareness raising/training and others not. Furthermore, a number of those who had received awareness raising/training felt this was limited, often some time ago and that they (and prison staff generally) would benefit from a comprehensive training package on mental health.

Identification of prisoners with mental health issues

Formal identification

There are a number of ways in which a prisoner can be formally identified as having a mental health issue. Upon arrival, relevant prisoners can be identified at reception and/or during their initial healthcare screening. Subsequently, prisoners with mental health issues can be formally identified from their being subject to the ACCT procedure, a review of wing observation records or through analysis of computer-based records. Most interviewees felt that these approaches should identify most prisoners with a mental health issue- particularly those with more serious mental health problems. However, it was acknowledged that it was possible for prisoners, with mental health issues, to be potentially missed by these formal procedures – particularly in cases where individual prisoners were determined not to discuss or admit to experiencing mental health problems.

Patient Confidentiality

The identification of prisoners with a mental health problem by wing staff is made problematic by the requirements of patient confidentiality. In order for these requirements to be satisfied, healthcare staff and mental health practitioners cannot pass on details of their patients mental health problems to wing staff. So whilst staff may be aware that prisoners on their wing have a mental health issue of some kind, they may not necessarily know exactly what the issue is.

Personal Officer Scheme

An effective Personal Officer scheme was identified as essential to support the effective initial identification of prisoners with mental health issues. This is because an effective personal officer scheme embeds communication, observation and positive relationships, between individual staff and prisoners, which help prisoners with mental health issues to be identified, supported and monitored.

Informal identification

As a result of the potential weaknesses of the formal approaches designed to identify prisoners with mental health issues, non-mental health prison staff, Chaplains and Prison Listeners also rely on informal approaches to identify problems, including:

- Ensuring that prisoners know that there is a member of wing staff that they can discuss any concerns that they may have about their mental health and wellbeing.
- Observation of prisoners' behaviour, to identify changes to individual prisoner's behaviours and routines (for example, changes to communication and/or temperament, anxiety, poor coping, eating and sleeping patterns).
- Having an informal conversation with a prisoner to explore their concerns, issues and anxieties, with a view to making the prisoner comfortable to disclose that they may have a mental health issue and be a suicide/self-harm risk.
- Responding to concerns raised by other prisoners about individual prisoners. Responses include observation, conversation, with relevant prisoners', and in some cases a discussion of a prisoner's risk of suicide or self-harm.

It was acknowledged that these **informal approaches also had potential limitations** – particularly in a context where some prisoners may seek to manipulate prison staff and procedures. In more detail, these potential limitations include:

- These approaches rely on the knowledge, expertise and experience of individual staff members, which appear variable. As such, interviewees spoke of a risk of misdiagnosis which may lead to inappropriate responses, which may potentially lead to a further deterioration in a prisoner's condition. For example:
  - Prisoners with possible mental illness having this labelled as a learning difficulty.
  - Prisoners with substance misuse and/or mental health issues being identified as 'troublesome/having an attitude problem', 'attention-seeking', and being a 'discipline problem'.
  - Prisoners regarded as faking a mental health problem to avoid prison activities such as work or education.
- A key issue that emerged from the interviews is the difficulty that staff can face separating what were often referred to, by interviewees, as the 'mad' from the 'bad'.

That is, staff can sometimes find it difficult to identify those have a mental health problem from those who do not, but who display problematic behaviour (such as aggression, violence, manipulation and non-compliance with prison rules and requirements).

- Linked to the previous two points, several interviewees discussed dealing with prisoners they had been defined as presenting a discipline issue, only to reflect subsequently that the prisoners concerned may have had a mental health problem.

- Although informal approaches may generally identify those prisoners with more severe mental health problems, there is a concern that they may not necessarily identify those with moderate or mild mental health problems, who require interventions.

- Whilst these informal approaches enable staff to identify a problem, they do not (as staff may lack information and experience) enable the precise identification of a problem. This is made by mental health specialists/healthcare staff.

- The effectiveness of informal approaches is reliant on the members of staff using them. Some of those interviewed argued that not all staff regard identifying mental health problems as part of their role and so may not always effectively use informal approaches that can help to identify prisoners with a mental health problem.

- The staff to prisoner ratios on 'normal location' wings are regarded as making informal identification of all prisoners with mental health issues potentially difficult. Staff numbers can be insufficient to enable regular observations and conversations that can be crucial to identifying prisoners who may be experiencing a mental health problem. However, staff-prisoners ratios in Segregation Units were felt to be at a level sufficient to enable regular observation and discussion between staff and prisoners, required to manage prisoners with a mental health issue.

- Prison Listeners were concerned that current approaches failed to identify prisoners with mental health problems until these prisoners reached crisis point, mainly because of staffing levels made earlier intervention difficult, but also because they felt that some staff chose not to intervene in pre-crisis situations.

Responding to a prisoner with mental health issues

Overall, interviewees across all three prisons felt that responses to prisoners with mental health issues had improved in recent years. Both healthcare staff and mental health specialists are regarded as responsive, helpful and as able to intervene quickly to stabilise, support and plan the care of many prisoners with mental health conditions. The location of specialist mental health practitioners, on site, was regarded as being crucial to the improved responses it was felt were being delivered to those with mental illness in all three prisons.

The introduction of ACCT was generally regarded as helping to more effectively manage and support prisoners at risk of suicide or self-harm, by enabling better risk management through care planning and by requiring prisoners to talk about their conditions.

Reliance on off-site hospital provision was associated with treatment delays. In addition, concerns were raised that hospitals sometimes discharged prisoners back to prison too soon or inappropriately as they were too violent to be treated in a hospital setting.

Responding to a prisoner experiencing a mental health crisis

Interview findings suggest that most prison staff know how to respond to prisoners experiencing a mental health crisis (that is, a situation where the prisoner, other prisoners or prison staff are in immediate and serious danger due to a prisoner's mental health problems).

Reflecting previous ACCT-related training received and strong links with specialist staff working in each prison, most prison staff felt confident about how to handle certain aspects of incidents where a prisoner was at risk of self-harm and suicide, or where a prisoner posed an immediate risk to others. For example, staff felt confident in their ability to initiate the ACCT procedure, open an ACCT document and engage healthcare and/or mental health staff to take forward management and treatment.

However, the research identified a number of responses and issues relating to prisoners experiencing a mental health crisis:

Responses

- In general staff felt that they were able to respond effectively to prisoners experiencing a mental health crisis – even if they sometimes found doing so challenging because the dynamics of each situation varied, so that it was not always possible to anticipate the exact nature of the problem or the response required. For example, some prisoners respond well to being given options, but others respond better to instructions.
- All prisoners who were identified as having or being at risk of suicide or self-harm were automatically subject to the ACCT process, which was initiated by the member of staff responding to the initial crisis.
- Initial responses by staff focused on bringing the immediate situation under control, calming down the prisoner, gaining information about the incident, identifying any factors that triggered it, and beginning to organise on-care. As such, staff would:
    o Remove any items that presented a suicide or self-harm risk (for example, razor blades).
    o Discuss the incident with a prisoner to find out exactly what happened and why.
    o Distract the prisoner so that they did not commit further harm.
    o Organise a referral to healthcare/mental health staff.
    o Undertake subsequent regular observation.
- Non-healthcare/mental health staff always engaged either healthcare staff and/or mental health practitioners for assistance when dealing with a prisoner who was

potentially experiencing a mental health crisis, to get a diagnosis, organise treatment and to gain advice about the management and care of the prisoner concerned. Prisoners were always informed that healthcare staff/mental health practitioners were being contacted and why.

- Many of those interviewed stated that they always passed any information and concerns that they had to their senior colleagues for their assistance and views, so that they did not have to deal with a crisis individually – and so that other staff could assist with monitoring and observation.

- Abusive, violent and unhygienic prisoners were (subject to approval from healthcare staff) generally moved to a segregation unit. Those cases involving suicide or self-harm risks were also sometimes (but not always) moved to prison segregation units. The segregation unit was often used for a short period of time. Use of the Segregation Unit was designed to enable a prisoner to calm down/stabilise, and to enable the prisoner to be located where more frequent observation and interaction with staff was possible.

- Wherever possible, staff dealing with the immediate crisis would provide prisoners with information about the choices that are available and consequences flowing from the decisions that they make. The objective of this approach was to give a prisoner options. If this approach does not work, staff take control, using physical restraint as an absolute last resort in situations where the prisoner or others are in immediate and severe danger.

- Findings suggest that responses were typically (although not always) reactive, rather than preventative. Prison staff primarily responded to crisis situations (self, harm, suicide and violence), rather than engaging in proactive, preventative activities. This reactive focus appears to be linked to the limited capacity of staff to monitor and engage with prisoners, due to staff-prisoner ratios, which means initial responses necessarily focus on responding to more severe situations.

Issues influencing responses

- Individual staff-prisoner relationships, alongside staff perceptions of their role in relation to the identification and care of prisoners with mental health problems, influenced prison staff responses, to prisoners with suspected mental health issues. Some staff clearly believed that they needed to play a proactive role in the identification and amelioration of prisoners mental health problems, by talking to prisoners, referring them to specialist provision, monitoring their engagement with provision, visiting them regularly and helping prisoners to help themselves by providing information about provision that could support their mental health and wellbeing (such as the gym, work and the library). Other staff appear to interpret their role more narrowly, as one that should focus on dealing with the immediate consequences of a mental health crisis and engaging specialist provision.

- Patient confidentiality meant that, in some cases, staff were not aware of prisoners' mental health conditions –and so could not take this into account when responding to a prisoner with a mental health issue. For example, education staff discussed that they are not always aware that an individual has a mental health problem and felt that this precluded them being able to respond to the relevant prisoners appropriately (for example, by observing them more closely or providing encouragement).

- There is some evidence from the interviews to suggest that self-harm among prisoners happens regularly enough to have sometimes become 'semi-normalised' and partially accepted (when it is not severe) as an activity that is used, by prisoners, as a coping mechanism. This raises questions about the extent to which responses to self-harm may need to be re-assessed, including the need to review current approaches to awareness raising and training.

- Findings suggest that the need to ensure the smooth operation of residential wings may influence the way in which staff respond to a prisoner with a mental health issue. This is understandable as the effective operation of the prison has to be a key priority for all prison staff. Consequently, responses tend to focus on those prisoners with mental health issues which disrupt the smooth running of a prison. This may lead to a situation where prisoners with mental health problems who do not disrupt the operation of the prison 'suffer in silence', and are not identified or treated appropriately. Furthermore (and discussed below), some staff are concerned that activities designed to support the effective operation of a prison (such as cell searches) risk exacerbating the mental health problems of a prisoner with an existing mental health condition.

On-going care, treatment and observation of prisoners with mental health problems

Interview findings indicate that prison staff perceive that they have (and that they should have) a secondary role in the on-going care, treatment and observation of prisoners who have mental health problems. Healthcare staff and/or mental health practitioners working in each prison take the lead in diagnosing, planning, caring and reviewing prisoners with a mental health problem. Interviewees also feel that these roles are appropriate, in the context of the skills and experiences that they and healthcare/mental health professionals have.

However, it is clear that prison staff do have a role in the on-going care, treatment and observation of prisoners with a mental health problem. For example:

Prisoners in the ACCT procedure

- Wing-based staff have an important role in the care, treatment and observation of prisoners who are subject to the ACCT procedure. They can undertake a range of activities to ensure that the ACCT care plan is delivered. These interventions typically include:
  - The observation/suicide watch of prisons to meet ACCT requirements.
  - Checking that those prisoners on ACCT are taking any medication for their mental health condition.
  - Liaising with healthcare staff and others if they have any concerns about a prisoner to arrange appointments or wing visits with staff.
  - Communicating with prisoners to identify their mood.
- Several wing-based staff also discussed how they encourage prisoners to engage with the ACCT process and to have input into its content.
- Chaplaincy staff check on the welfare of ACCT prisoners to ensure that their treatment is humane and not causing a deterioration in their condition. Chaplains can also provide a listening service to prisoners on ACCT.

Non-ACCT prisoners with mental health issues

- Although healthcare staff do not give wing staff details of patients' mental health problems, they do sometimes ask for wing staff to observe relevant prisoners. As such, wing staff can be engaged in the ongoing care and support of non-ACCT prisoners.
- Wing staff felt that they could additionally support the care, treatment and monitoring of prisoners with mild to moderate mental health issues in a number of ways including:
  - By providing information about support and activities that are available within the prison (mental health services, Prison Listeners, gym, education and work), encouraging prisoners to access provision and supporting them to do so.
  - Encouraging relevant prisoners to participate in association.
  - Organising for prisoners to send additional letters, make additional phone calls and/or receive additional visits from their families to support their mental health and wellbeing.
  - Talking and listening to prisoners to help them to cope with anxiety and bereavement when they felt they had the experience/skills to do so.
  - Prioritising workloads so as to be able to check on and visit prisoners regularly, that are known or perceived to be vulnerable and/or not coping well so that they feel less isolated –and to identify any deterioration in the condition of these prisoners speedily.

- o Checking that prisoners attend their appointments and ensuring progress is being made.
- Education staff discussed how they could help prisoners with moderate mental health issues by providing activities to help to keep these prisoners occupied.
- Chaplaincy staff are able to support prisoners with milder mental health problems by offering a listening service, providing information about services that are available in prison that may help prisoners with mental health issues (for example, In-Reach services, prison listeners, CARATS provision) and by making referrals to healthcare/mental health services if they are concerned about an prisoners' mental health status.
- CARATS staff identified their work to help prisoners deal with their substance misuse, to develop prisoners' self-confidence and to improve prisoners' self-esteem as their main contribution to assisting mentally ill prisoners. They also felt that CARATs interventions could help prisoners to control depression and paranoia related to substance misuse.

Furthermore, in both ACCT and non-ACCT cases, wing staff helped prisoners organise time off work to attend healthcare appointments.

Responding appropriately to prisoners with mental health problems

The extent to which non mental health staff felt able to respond appropriately to prisoners experiencing a mental health problem varied, depending on the specific situation and staff experience, expertise and perceptions of their role in relation to responding to prisoners with mental health problems.

Prison Chaplaincy

Prison Chaplains felt that their ability to respond appropriately was limited by the time that they had to spend with individual prisoners, because of the range of additional activities they are required to undertake on a daily basis. Whilst Chaplain's felt that they had skills around listening, referring prisoners to specialist services, and reducing the isolation of vulnerable prisons who were struggling to cope, they also felt that they lacked the knowledge and expertise required to provide specialised interventions to prisoners experiencing mental health problems.

Wing-Staff

Wing staff acknowledged that their ability to respond appropriately to prisoners with mental health problems was limited by the number of prisoners with mental health problems, staff-prisoners ratios and the many other tasks that they had to undertake. Consequently, they tended to focus their available time on those prisoners they believed had the most serious mental health issues (generally those prisoners identified as suicide or self-harm risks).

In this context:

- The ability to call in healthcare staff and mental health specialists immediately was crucial in enabling wing staff to feel that they could respond appropriately to a prisoner experiencing mental health problems. Indeed, interview findings suggest some wing staff felt comfortable only to remove a prisoner from their immediate environment and refer them to specialist provision.

- Most wing staff felt that they responded as well as they could to incidents of self-harm and suicide by reducing immediate danger by removing items required for self-harm and suicide, administering first aid, talking to the prisoner, calming a prisoner down, engaging healthcare staff, by initiating the process of on-going care and monitoring (by opening an ACCT document), and by undertaking regular observation and monitoring.

- A number of wing staff stressed that demonstrating to an prisoner that a plan of action was being developed (such as referral to healthcare and/or the opening of an ACCT document) was something they made a point of doing – and that this generally helped to calm a prisoner and prevent a deterioration in their condition in the short term.

- Wing staff felt that appropriate responses were based on their experience and advice from colleagues, rather than as a result of training. As such, those staff who had worked in prisons longer, who had received ACCT Assessor Training, and/or who had a background in counselling or had previously worked with people experiencing mental health issues, generally felt more confident that their interventions with prisoners were appropriate.

- A number of wing staff commented that lack of knowledge and training about what were relevant interventions, made them concerned as to whether or not their responses (such as listening and providing information about services and activities) and the way that they delivered these responses, were appropriate. Whilst staff felt confident to intervene, some were less confident that these interventions were always appropriate. For example, one interviewee gave an example of prisoner with a severe mental health issue, whose cell was searched by a group of officers and dogs, suggesting that this may have exacerbated this prisoners' mental health issues.

- It is felt there are certain situations where it is very difficult to respond effectively. For example, there were concerns that there is very little that can be done to help prisoners with personality disorders because of the nature of this illness.

Other prison staff

Other prison staff (for example education staff and CARATs staff) were concerned that although they knew how to refer to specialist provision in a crisis situation, their ability to respond to some situations was limited by their lack of clarity about where to signpost those with less severe problems.

Prison Listeners

Whilst wing staff generally felt that they informed prisoners of mental health services and encouraged relevant prisoners to access these, Prison Listeners questioned the extent to which this was the case. The listeners argued that staff can be reluctant to become involved in the care of prisoners with mental health problems. However, listeners were generally positive about the ways in which staff dealt with crisis situations –and acknowledged that dealing with these situations was often difficult for staff. Listeners had concerns about how crisis situations were followed up due to limits on staff time and resources. Listeners also had concerns about prisoners, with mental health issues, being placed in segregation units and/or on basic regime.

Prison Listeners were confident that they themselves were able to respond appropriately to prisoners with mental health problems, based on the training they had received to become listeners and due to their knowledge of provision and how to signpost and encourage prisoners to use it, where this was necessary. This confidence was underpinned by their knowledge of how to refer to specialist provision.

The role of Segregation Units

Prisoners experiencing a mental health crisis or more severe mental health problems can be sent to segregation units, at least temporarily, in an attempt to stabilise their condition. It is felt by staff that Segregation Units are sometimes the most appropriate location, available within the prison, for these prisoners. These units were felt to provide a calmer environment than ordinary wings, and to enable staff to monitor and interact with these prisoners more effectively.

However, Segregation Units are primarily designed to punish prisoners who break prison regulations. They are not designed primarily to be therapeutic environments. This raises questions about the appropriateness of using Segregation Units to care for and treat prisoners with mental health issues. However, some units (for example the unit as HMP Durham) do have an explicit 'care' function, which potentially makes their use less inappropriate. However, a HM Inspector of Prisons Report (2009) found that the unit at HMP Durham had a poor regime and that it was not an appropriate location for prisoners with mental health issues.

7. The case for the introduction of Mental Health First Aid across North East prisons

Evidence suggests that there are staff, chaplains and prisoner listeners who are able to respond to prisoners experiencing a mental health crisis, and that they are also able to contribute to the on-going care, treatment and observation of prisoners experiencing mental health problems. This is achieved through a combination of experience, training and judgement.

However, responses to prisoners with mental health issues can be variable for a range of reasons identified above. Furthermore, staff are also concerned as to whether their responses are always appropriate, and that they sometimes rely heavily on instinct and experience, which may impact on quality of the responses received by prisoners. This situation suggests that comprehensive training would be useful in the context of large numbers of prisoners with mental health problems. To provide more uniform responses, evidence suggests that awareness raising and training are needed:

- Which cover a wider range of issues than ACCT-related training (which focuses specifically on self-harm and suicide) to include issues such as anxiety, depression, substance misuse-related mental problems, personality disorders and bereavement.
- To provide information about how to identify these conditions and possible interventions to support prisoners with these conditions, prior to the commencement of (and subsequently alongside) any specialist treatment including:
  - How to effectively identify when a prisoner has a mental health condition and when they may be 'faking' a condition, in order to better address the 'mad' from the 'bad' problem identified above.
  - How to respond appropriately to different situations including crisis situations (where a prisoner is at immediate risk of harming themselves, other prisoners or staff) and less critical situations, so that staff know they are intervening appropriately. This would include guidance about how to effectively communicate and empathise.
- Regularly, so that information and good practice can be reinforced.
- That includes role play and practical scenarios so that staff are able to practice interventions in situations that have some similarity to real life.
- To ensure that non-wing staff (e.g. education staff) are clear about how to signpost and refer prisoners who they have concerns about (particularly for prisoners with less severe mental health problems).

Findings suggest that meeting the training needs of non-mental health specialist staff is also to some extent about providing staff with reassurance that they can identify, respond and refer those prisoners with mental health problems.

The role of MHFA

Alongside the introduction of MHFA training, reassurance is needed to allay the concerns expressed by those interviewed that the delivery of MHFA training may be a strategy to develop the capacity of prison staff, in order to replace expensive mental health specialists currently delivering services at HMP Acklington, HMP Durham and HMP Low Newton. Interviewees expressed the view that the role of MHFA-trained staff should be to support, not replace, specialist mental health practitioners who work in prisons. If prison staff are to be positively engaged with MHFA training, it is essential that a clear message is given concerning the role of MHFA and MHFA-trained staff, in relation to specialist practitioners, in the care and management of prisoners with mental health issues.

The potential of MHFA

In theory, MHFA can help to improve mental health care and support in prisons by providing those trained with the ability to identify and respond to prisoners experiencing a mental health issue. As such, MHFA has the potential to improve the provision of mental health services for prisoners. Specifically, MHFA can potentially address a number of the issues identified in this report as follows:

- It is designed to assist staff who have a limited knowledge of mental health.
- MHFA may help staff to undertake their current activities more effectively.
- Subject to its effective roll-out, MHFA has the potential to substantially increase the knowledge, skills and capacity within each prison to identify and respond to prisoners with a wide range mental health issues. In particular, MHFA may potentially increase the scope for enhanced preventative activities, by giving trained staff the capacity to deliver these.
- MHFA may reduce the variability in responses, by non-mental health specialists, to prisoners with mental health issues – and so improve overall institutional responses.
- MHFA can assist staff to meet Prison Service requirements by proactively identifying and engaging with prisoners who are experiencing mental health problems.
- By supporting a cultural change within each prison so that the identification of and support for all mental health issues (not just self-harm and suicide) are accepted as the responsibility of all staff, not just mental health specialists.

However there are also a number of issues that may challenge the potential impact of MHFA. These issues (which will be explored further in phase 2 of the project) include:

- Constraints on staff time and organisational capacity identified above, which may undermine the comprehensive roll out (and so the impact) of MHFA. Success will rely in part on the importance and priority given to this initiative by senior Prison Management.

- How effectively the MHFA programme is communicated, managed, promoted and administered.
- The impact of staff-prisoner ratios on ability of staff to put into practice the knowledge and skills they gain from MHFA training.
- The effectiveness of the personal officer system and the extent to which this system is able to support staff to put their MHFA training into practice.
- Existing wider prison cultures and practices which result in staff and prisoners having varying degrees of suspicion and antipathy towards each other, which 'semi normalise' less severe self-harm as a coping mechanism, and which result in the use of Segregation Units to manage the challenging behaviour of some prisoners experiencing a mental health crisis. Addressing these issues successfully is a vital prerequisite to enable MHFA to maximise its potential impact.
- MHFA training along with wider institutional messages needs to convince staff that addressing the mental health needs of prisoners is everyone's responsibility - and not just the responsibility of mental health specialists.

8. Phase Two

MHFA training is currently being rolled out across all prisons in the North East. Phase 2 of this evaluation, which will examine the impact of the roll out of MHFA, will begin in October 2011, allowing 2-3 months for the training to be implemented and practice to become embedded within the prisons. This second stage will:

- Explore the management and administration of MHFA.
- Include interviews with the original cohort of MHFA trained staff to:
  - Identify its impact on their practice.
  - Explore how effectively they have been able to deliver MHFA to colleagues within their prison.
  - Examine their views on the impact of MHFA in improving the identification, treatment and care of patients with mental health issues
- Include interviews with staff that have been provided with MHFA training by their prison colleagues in order to identify the impact of this training on their identification of and support for prisoners with mental health issues.
- Pay specific attention to identifying the extent to which MHFA enables each prison to address the challenges, identified in this report, that they face in identifying and managing prisoners with mental health problems.

Bibliography

The Bradley Report (2009) *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.*

Brooker C & Ullmann B (edited by Lockhart, G) (2008) *Out of Sight, Out of Mind. The State of Mental Healthcare in Prison,* Policy Exchange.

Chitsabesan, P, Kroll, L., Bailey, S, Kenning, C., Sneider, S, Macdonald, W. & Theodosiou, L. (2006) Mental health needs of young offenders in custody and in the community. *British Journal of Psychiatry,***188**, 534–540

Department of Health (1999*) National Service Framework for Mental Health.*

Department of Health and Her Majesty's Prison Service (2001) *Changing the Outlook: A strategy for developing and modernising mental health services in prisons.*

Durcan, G (2008) From the inside. *Experiences of prison mental health care, Sainsbury Centre for Mental Health.*

Edgar, K & Rickford, D (2009*) Too Little Too Late. An independent review of unmet mental health need in prison*, Prison Reform Trust.

HM Chief Inspector of Prisons (1996) *Patient or Prisoner. A new strategy for health care in prisons.*

HM Inspectorate of Prisons (2007) *The mental health of prisoners. A thematic review of the care and support of prisoners with mental health needs.*

HM Chief Inspector of Prisons (2009) *Report on an un-announced full follow up inspection of HMP Acklington.*

HM Inspector of Prisons (2009) *Report on an un-announced short follow up inspection of HMP and YOI Low Newton.*

HM Chief Inspectorate of Prisons (2009) *Report on an un-announced full follow up inspection of HMP Durham*.

Ministry of Justice (2011) Safety in Custody 2010 England and Wales. Ministry of Justice Statistics Bulletin, July.

Ministry of Justice (2010) *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders.*

Reed, J (2003) 'Mental health care in prisons', *The British Journal of Psychiatry 182: 287-288*

Royal College of Nursing, Nacro and the Centre for Mental Health (2010) *Prison Mental Health: Vision and Reality.*

Rutherford, M (2010) Blurring the Boundaries. T*he convergence of mental health and criminal justice policy, legislation, systems and practice*, Sainsbury Centre for Mental Health.

Sainsbury Centre for Mental Health (2008) *Short Changed. Spending on Prison Mental Healthcare,*

Singleton N et al (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London.

The Centre for Social Justice (2009) *Locked Up Potential. A Strategy for reforming prisons and rehabilitating prisoners.*