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

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1. Executive Summary

The project

Northumbria University was commissioned by the North East Offender Health Commissioning Unit to undertake a two stage project: to identify the need for Mental Health First Aid (MHFA) training in prisons across the North East region; and 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 Two: An Assessment of the impact of 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.

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 enabled the evaluation to explore the need for, implementation and impact of MHFA training across different types of prison.

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.

Findings from stage one

Findings from stage one of this project indicated that care and treatment for prisoners with mental health conditions had 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, stage one of the project also identified that there was a need for MHFA training to help to address a number of issues facing the three prisons in relation to their treatment and care of prisoners with mental health issues, which included:

- Variable previous mental-health related training for prison staff, influenced by individual experience, staff perceptions of their role and available resources.
- Variable responses, from staff, to inmates with mental health issues based on staff perceptions of their role and individual staff-prisoner relationships.
- The use of informal diagnosis.

- A limited focus on prisoners with less severe mental health issues, which would benefit from being widened to include mental health problems other than suicide and self-harm.

MHFA was identified as having the potential to address these issues by:

- Assisting staff to more effectively deliver their existing responses to prisoners with mental health issues.
- Enabling the better identification of prisoners with mental health issues (particularly those whose conditions do not impact on the operation of the prison).
- Improving the capacity of staff to deal with a wider range of mental health issues other than suicide and self-harm.
- Developing 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.
- Helping to ensure that prisoners' mental health issues are seen as the responsibility of all staff, not just mental health specialists.
- Helping 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.

The stage one report, highlighted that realising the potential of MHFA would be dependent upon how effectively it was implemented and managed, with its success likely to be influenced by staff resources, the scope for staff to integrate MHFA into their working practices, and how well each prison would be able to balance the mental health and wellbeing of prisoners with other institutional priorities such as security, prison movements, recreation and work. The stage two-report considers these issues below.

It is important to note that MHFA is not designed to replace specialist provision, but to provide immediate interventions prior to professional help being obtained. All those interviewed, as part of the stage one evaluation, 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.

Findings from Stage Two

- MHFA training has the potential to improve the capacity of prisons in the region to better identify and care for prisoners with mental health issues. However, it cannot by itself address all the issues identified in this report. It is *one part of the solution, not the solution.*

- Each of the three prisons has attempted to roll-out MHFA, with some degree of success. A cohort of staff from all three prisons (HMP Acklington, HMP Durham and HMP Low Newton), have been MHFA-trained by specialists. Some of these staff have subsequently trained a selection of colleagues (and in one institution also a group of prisoners) at their respective prisons.
- The roll out of MHFA has been compromised by staffing levels at each of the prisons. When combined with the requirements of the prison regime, existing staffing levels make it difficult to release staff for the amount of time necessary to both undertake training and then deliver courses within their own establishments.
- As a result of the limited roll-out, there is a risk that:
    - The number of staff who can be MHFA-trained will be too small to significantly develop the capacity of each prison to better identify and care for prisoners with mental health issues.
    - Trained prison staff will not themselves be able to train the required number of people in the specified timeframe, to maintain their MHFA-instructor status.
- Staffing levels and the requirements of the prison regime are unlikely to change in the foreseeable future. Consequently, the future roll out of MHFA is likely to remain very challenging, even though staff are keen to roll out MHFA. However, the prospects for a successful roll-out can be supported by:
    - Ensuring the strategic management and prioritisation of the roll-out of MHFA training at both regional level (via NOMS/OHCU) and at individual prison level (via support from each prison's Senior Management Team).
    - Balancing the availability and take up of MHFA training, to ensure that both staff and prisoners receive it.
    - Ensuring that positive institutional messages are disseminated about MHFA and its importance to the prisons.
    - Ensuring that a single individual of appropriate seniority is given responsibility for managing the roll out of MHFA training where this is required. This individual should convene a meeting with MHFA-trained staff to discuss (and to consider how to address) the barriers to implementing the training and the skills and knowledge learned. This report could form the basis of the discussion.
    - Exploring the scope for instructors to deliver a shorter MHFA training course to their prison colleagues. The operational circumstances of prisons mean a shorter course is always likely to be more attractive and practical.
    - Exploring if the number of people instructors need to train (and the timeframe within which training must take place in order to maintain their instructor status) are flexible to enable instructors to maintain their status.

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.

Data Collection Methods

Data collection for stage two comprised semi-structured interviews with five members of staff, drawn from across the three prisons, who had undertaken the MHFA training course delivered by MHFA trainers. Staff interviewed included Senior Officers, those with responsibility for Health & Safety and Resources and a PhD student undertaking research and located in one of the prisons. The interviews covered a range of issues designed to explore participant's experiences of the MHFA training course and its impact on their practice and respective prisons.

The small number of interviewees reflects the fact that only a small group of prison staff (10 in total) participated in the initial MHFA training at the point at which stage two of the evaluation was undertaken. Despite the small sample, the findings generated highlight both the benefits of MHFA training, alongside a number of management and delivery issues to consider.

Data Analysis

Data analysis was structured around a number of themes that emerged during the interviews:

- Initial knowledge of MHFA training.
- Participation in MHFA training.
- Experiences of the MHFA training course.
- Delivery of MHFA training to prisoners.
- Delivery of MHFA training to Prison Service staff.
- Management of MHFA training.
- Access to MHFA trained-staff.
- Maintaining MHFA Status.
- MHFA: The Future.

3. Background & Context

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 comparatively high rates of self-harm and suicide also common (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 (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, 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), the Governments response *'Breaking the Cycle: Government Response* (Ministry of Justice, 2011), and the HM Government (2011) *'No health without mental health: a cross-government mental health outcomes strategy for people of all ages*' identified the importance of effective healthcare for offenders to help to reduce re-offending. In relation to mental health, these publications included proposals to improve services for offenders with severe personality disorders and further develop provision for prisoners experiencing mental illness. They also identified 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, and 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 from 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.

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, that results in differential local delivery which 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.
- 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.
- A need to re-orientate provision to focus on mood, anxiety and adjustment issues.

(Bradley Report, 2009; Durcan, 2008; 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 and 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.

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 institutional 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, stage one of this research found 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 or to be capable of replacing specialist mental health services within or linking into prisons. The findings contained in this report should be considered with this in mind.

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. 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.

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 train colleagues within their own organisations.

As part of their 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 others 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 via a 'training for trainers' model. Staff volunteers performing a range of different roles within prisons attend the MHFA course. Once accredited as MHFA instructors, they subsequently deliver sessions themselves to their colleagues, thus rolling out MHFA training across the prison estate.

6. The implementation of MHFA: Findings from North East prisons

Rationale

Members of staff from HMP Acklington, HMP Durham and HMP Low Newton participated in MHFA training in March 2011. Once trained and approved as MHFA instructors, it was anticipated that participants would subsequently deliver MHFA to their colleagues, and by doing so develop, over time, the capacity of each prison to better identify and care for inmates with mental health problems.

At the time of their training, the initial cohort of staff were directly involved in supporting the mental health and wellbeing of prisoners. Combined, the staff concerned had developed infrastructure (a sensory room and a trauma team) to support prisoners in distress or experiencing Post-Traumatic Stress Disorder, had responsibility for identifying mental health issues (especially in relation to self-harm and suicide risk) at inmate's reception into prison, or had a role as either Assessment, Care in Custody in Custody & Teamwork' (ACCT) trainers or assessors.

Initial knowledge of Mental Health First Aid training

Before their participation in MHFA training, interviewees had limited knowledge about the course and the requirements of participation. One interviewee did recall receiving information via email about the course and, more generally, participants understood that MHFA training would build on previous training, to better support the management and implementation of the ACCT procedure. However, interview findings suggest that participants were not aware of the breadth and depth of MHFA training, or details of tasks and independent study associated with participation in MHFA training.

Participation in Mental Health First Aid training

Findings indicate that participation in MHFA training was not managed strategically by one individual across all three prisons, who could then determine which staff, performing which roles, should participate in MHFA training. The evaluation has not been able to identify any formal criteria used to select original MHFA participants. In this context, participation was a result of a range of factors including; individual staff members proactively deciding to participate, individuals wishing to participate in an initiative that could boost the capacity of their prison to respond to those with mental health issues, being volunteered to participate by a line manager, and individual's desire to improve their knowledge of mental health issues and how to address these (particularly to assist in their ACCT-related roles). The comments below, made by interviewees, provide an indication of the reasons these reasons for their participation:

> *"I didn't feel very knowledgeable at all before I went on the course".*
>
> **Interviewee 4**

"I was interested…I thought it would be really educational, it would help me. The only insight I'd had into mental health was…through ACCT training and being and ACCT Assessor".

Interviewee 3

"We often deal with prisoners who we can see…there's an issue, but perhaps don't know what the issue might be…I thought it (MHFA) would be really helpful and it has been".

Interviewee 5

Experiences of the Mental Health First Aid Training course

Participant's experiences of the MHFA training course were generally positive. Delivery, (comprising presentations and group-based activities) was regarded as appropriate and very well structured. Interviewees praised the two MHFA trainers, who delivered the course, for their delivery style, openness and approachability. All participants felt that either all or some of the content was relevant to their job roles.

Benefits, for staff, of participating in MHFA training include:

- A greater awareness and understanding of the potential mental health problems that prisoners may have and how to identify these – particularly anxiety, depression, psychosis and stress.
- An improved understanding of how to respond to prisoners who may be experiencing mental health issues.
- A greater awareness of community-based mental services that inmates can be referred to upon their release.
- An awareness that the knowledge and skills provided by MHFA could be used to support colleagues as well as prisoners.

The comments made by participants, interviewed as a part of the evaluation, illustrate both how positive an experience participation in MHFA training was, and the benefits gained by participation:

"The guest speakers that came in were absolutely brilliant…a gentleman had had bipolar very, very badly and told us his life story".

Interviewee 1

"I found it very good… (name of tutors) who delivered it, really accessible…they kind of made it relevant, really open to discussion…it was really well pitched…suitable for people in the group who perhaps had less experience around mental health and those of us that had…more knowledge. I've picked up some ideas where I can signpost them to…and signs to look out for…depression and anxiety…that sometimes can be difficult to pick up on. There was new information…and it was very relevant…the focus on…anxiety, depression and psychosis are really relevant to the prison environment".

Interviewee 2

"The delivery of the course was brilliant, the teaching skills…it just makes you more confident…and to do the content that we did, it was just really good".

Interviewee 3

"I didn't know about all these things in detail. I knew that there was help available, but I know exactly where to send people now".

Interviewee 5

Trained Prison Staff Instructors: Delivering Mental Health First Aid Training to prisoners

MHFA training has been delivered to prisoners at HMP Low Newton by MHFA-trained prison staff. Prison Listeners and Prisoner Welfare representatives (whose primary role is to reduce bullying) were trained, and it is hoped that a group of 'Insiders' (prisoners who are designed to provide support to inmates as they enter prison) will be trained in the future. MHFA training for prisoners mirrored that provided to prison staff who attended the MHFA training course, and was delivered in group settings.

Staff, from HMP Acklington and HMP Durham, who participated in MHFA-training, have not trained any prisoners at their respective prisons because they argue a) they never envisaged doing so and b) current staffing resources preclude any such training. However, there is evidence of staff using the knowledge and skills learned, through their participation in MHFA training, with prisoners. During the course of their interview one interviewee discussed how as a result of their participation in MHFA training, they were better able to respond to a prisoner who had recently self-harmed, by discussing with the inmate if they were hearing voices and what these voices were saying, in a way they felt they lacked

confidence to do prior to their MHFA training. This example demonstrates how MHFA training can help staff to listen to prisoners and enable them to talk about how they feel, a service previously often lacking within in prisons (see p.13). More generally, participants discussed how they now feel more confident about how to both talk and listen to prisoners they are concerned may have mental health issues, so they can make a more informed decision about whether the prisoner concerned should be referred to a psychologist or a member of the In-Reach team.

Trained Prison Staff Instructors: Delivering Mental Health First Aid Training to Prison Service staff

MHFA training has been delivered to staff at HMP Acklington and HMP Low Newton, by staff who attended the original MHFA workshops.

At HMP Acklington, approximately 6-7 members of staff have been trained. Those trained include Prison Officers, Offender Supervisors and Psychologists. Training at HMP Acklington covered all the topics included in the original MHFA training sessions and was delivered in a group setting. Recruitment was organised by the staff development team, via liaison with the Detail Office to ensure staff availability. A further course was planned, but this had to be cancelled as the relevant staff were unavailable as no other staff were available to cover their duties whilst they participated in MHFA training. However, the Training Department at HMP Acklington currently plans to deliver a further two MHFA training sessions in the near future.

At HMP Low Newton, Prison Officers, and Psychology staff working in the Primrose Project have participated in MHFA training. The Primrose Project is designed to deliver more effective healthcare interventions for prisoners with severe personality disorders and complex needs to reduce the risk of their self-harming and harming others. A number of these staff were also involved in the Psychologically Informed Planned Environment Project (PIPE). PIPE is a coaching and mentoring scheme for prisoners to apply their learning from the offender behaviour programmes in which they have participated. MHFA training at Low Newton covered all of the topics delivered in the original MHFA training. Delivering training to these staff was straightforward as they were not part of the prison's central detail, meaning their roles didn't have to 'back-filled' whilst they participated. At present, there are no plans to roll out MHFA training to wing-based staff as this is deemed impractical due to difficulties 'back-filling' posts. Attempts were made to try and deliver MHFA training to staff working in the Care and Separation Unit. However, staff at the Unit chose to undertake a shorter mental-health awareness course instead because of the reduced time-commitment associated with this shorter course.

HMP Durham: To date, MHFA has not been rolled out at HMP Durham. However, there are plans to train those staff having the most regular contact with prisoners who have mental

health issues. The Governor at HMP Durham plans for staff working in Safer Custody and the Detox Wing, staff with specific responsibility for dealing with bullying and harassment, along with members of senior management teams, to receive MHFA training from staff at HMP Durham who are already MHFA-trained. The course will mirror the original training in terms of content and style of delivery. It is acknowledged that the roll-out of MHFA will take some time (possibly up to a year) and that staff delivering MHFA may themselves have to refresh their knowledge.

Interviewees, from all three prisons, expressed concerns about the roll out of MHFA training being compromised because wing-based staff are unable to take up training opportunities, as staffing levels mean roles cannot be covered to allow staff to deliver and participate in training. This problem is exacerbated by un-planned sick leave, which further reduces the pool of staff available to cover the roles of staff when they are undertaking training. MHFA-trained staff (instructors) are clearly frustrated that they cannot fulfil their MHFA role, by training colleagues, as fully as they wish. The instructors also have other responsibilities that limits the time they are available to train their colleagues.

To date, MHFA training has been officially optional. Therefore its roll out is felt to have been 'crowded out' by mandatory activities that have to be undertaken in the context of finite resources, staffing and time. The comments below, made during interviews, evidence the issues discussed above:

> *"I think if I was looking to train residential officers then that would be quite time consuming…involve organising the rotas…in terms of the care team…the feeling is it would be great…to do it, but people can't…not the ability to get staff released".*
>
> **Interviewee 2**

> *"Now in the Prison Service you do your control and restraint training and literally that's about it…there's cutbacks and unfortunately training is the one that's taken the biggest knock…main priority is running the core day…getting prisoners to work and education…they're not gonna curtail the regime so you can then train…unfortunately in the Prison Service at the minute, training is…quite low on the agenda…there's two of the Senior Officers on maternity leave, there's obviously people on nights, people on rest days…you only need a few out the equation…it's just a fact of life".*
>
> **Interviewee 3**

> ***"**I was approached to deliver (MHFA training) to our Segregation Unit staff, who deal with prisoners in crisis all of the time…the staff just weren't available".*
>
> **Interviewee 4**

"Because of capacity…you don't always get released to attend training courses… I'm quite disappointed…I know that other people on the course, from this prison, have said the same…they thoroughly enjoyed the course…just felt that perhaps it was a little bit of a waste because the whole point…was to do the teaching aspect and it's something we haven't been able to do".

Interviewee 3

Management of Mental Health First Aid Training

There is evidence that the roll-out of MHFA is, to some extent, being strategically managed at an institutional level. Clearly at HMP Durham, a senior member of staff is selecting staff to be MHFA-trained who are most likely to deal with prisoners with mental health issues, and overseeing their training. This strategic oversight is linked to a desire to use MHFA, at HMP Durham, with staff to help to address stress and depression-related work absence.

However, as highlighted above, it appears that no single senior manager has been given responsibility for managing the roll-out of MHFA training at HMP Acklington or HMP Low Newton. A number of interviewees raised their concerns that there is limited management-level commitment to the roll out of MHFA training. Those staff with responsibility for rolling out MHFA training, appear to have to combine this responsibility with their other duties. Consequently, there is a risk that the roll out of MHFA-training becoming secondary to the mandatory tasks that they have to perform.

In certain instances, those individuals who participated in the original MHFA training course have taken it upon themselves to roll out MHFA training to their colleagues and prisoners to the extent they are able to do so in their role. This had led to a situation where those subsequently trained are members of staff who are most easily available, rather than those who are necessarily the most appropriate staff to train (although those who are easily available and the most appropriate staff can be one in the same). This is linked to the fact that some trainers are not in a position, within their respective prisons, to easily negotiate the participation of those staff in MHFA training who may benefit from it.

"The first group I delivered to…I targeted them because they work with women with mental health difficulties, but also because it was easy to get them released because they're not part of the central detail…I think if I was looking to train residential officers then that would be quite time consuming…involve organising the rotas".

Interviewee 2

Access to Mental Health First Aid Trained-staff

There has been no formal communication, to wider prison staff or the general prison population, in any of the prisons informing them of staff (or prisoners) who have been MHFA-trained who could be a potential resource if they have concerns about the mental health of a prisoner. However, several interviewees stated that some of their colleagues had become aware, informally, that they had received MHFA training. Some of these colleagues have asked for advice about external agencies that they can refer prisoners to as they leave prison. Colleagues have also asked MHFA-trained staff for referral information for their family and friends.

> *"It hasn't been publicised as a potential source of support for colleagues".*
>
> **Interviewee 2**

Maintaining MHFA Status

All of those interviewed hoped to maintain their status (as instructors) by delivering the requisite number of MHFA training sessions within the relevant time period. However, none of the interviewees were certain that they would be able to so as a result difficulties in ensuring sufficient staff and prisoners could be released to participate in MHFA training sessions within the required timeframes. One interviewee suggested that they may have to deliver their training to non-prison staff. This is positive in that it will help to ensure that training status in maintained and will also result in more individuals benefitting from MHFA-training. However, the original MHFA training sessions were designed (and funded) to support the roll-out of MHFA within, and not outside of, the Prison Service.

> *"Its [maintaining MHFA status] not something I've get any control over…it's quite frustrating".*
>
> **Interviewee 5**

Mental Health First Aid Training: The Future

The future successful roll-out of MHFA training across all three prisons depends on the ability of each institution to properly manage its roll-out by identifying a sufficient number of relevant staff, in various job-roles, to train. It is also crucial to ensure trainers can maintain their status and that MHFA-trained staff are located throughout each prison. In the context of a range of other prison priorities (including security, prisoner movements, and ensuring prisoners can access healthcare, work, training and association) and finite time and resources, doing all of this will be extremely challenging for each of the prisons. This evaluation fully acknowledges the difficulties that are faced and that there are no simple solutions available, to any of the three prisons, to support the successful roll-out of MHFA.

However, it is also important to acknowledge that a failure to roll out MHFA training will result in a failure of MHFA to achieve its potential, a failure to increase institutional knowledge and capacity to respond to prisoners with mental health issues, and a failure to maximise the impact of the initial (and publicly funded) training. In order to support the future roll-out of MHFA, it may be useful for the three prisons to consider implementing the suggestions below:

Strategic management and prioritisation of MHFA training: A member of each prison's senior management team should (where this has not already happened) be given explicit responsibility for prioritising the roll-out of MHFA training in each prison. This individual should be someone in a position to select staff and prisoners to be trained and organise for rotas, venues and the backfilling of posts necessary for effective roll out. It would be useful for this individual to identify and to select those staff for training who have limited previous training around mental health, and those staff who are most likely, by virtue of their role, to have to offer an initial response to a prisoner with a mental health issue. Without prioritisation and leadership of this kind, the roll out of MHFA, the ability of instructors to maintain their status, and the ability of MHFA to develop the capacity of the prisons concerned to better identify and care for prisoner experiencing mental health problems is likely to be compromised.

A meeting between the senior manager responsible for rolling out MHFA and MHFA trained staff to discuss the specific barriers (including those identified in this report) that trainers in each prison face in their attempts to roll out MHFA training, and how these might be addressed. Such a meeting will enable the individual with responsibility for rolling out MHFA to understand specific barriers that they need to address.

Publicise the details of MHFA-trained staff and prisoners: The details of all MHFA trained staff and prisoners should be shared with the wider prison population and staff, to support staff and prisoners to access the knowledge and expertise of staff who are MHFA-trained.

Balanced MHFA Training: It is important to ensure that a mix of both staff and prisoners are MHFA-trained. Focusing MHFA training only on relevant prisoners (such as Prison Listeners) may result in them having to take on a disproportionate responsibility for prisoners with mental health issues, which is not the objective of MHFA training. Rather, MHFA is designed to support staff to more effectively deliver their duty of care to prisoners. Ensuring staff are trained is also important to avoid a situation where a MHFA-trained prisoner approaches an untrained members of staff with concerns about another prisoner, only for the staff member not to be in a position to help as they are not MHFA trained.

Positive Institutional Messages: As a part of effective strategic management, each prison should ensure it develops a strong institutional message that the training is a key part of wider attempts to raise awareness of, and to address mental health issues experienced by both staff and prisoners. Such a message will help to reduce any antipathy towards

engagement, and will also help to demonstrate that mental health and wellbeing is taken as seriously at an institutional level as it is by policymakers (see chapter 3).

Delivery of a shorter MHFA training course: The limited availability of MHFA-trained staff to deliver training to colleagues, and difficulties staff face in getting time off from their duties to attend MHFA are compromising the effective roll out of MHFA. A possible way forward would be to consider the delivery of a shorter, half-day long version of the MHFA that is available. Initial discussions about the delivery of a shorter course have taken place. We suggest that these continue as a matter of priority with a view to delivering shorter sessions as soon as practicable.

MHFA status flexibilities: We would also recommend investigation around flexibility in relation to the number of training courses that instructors have to deliver, and the timeframe within which these have to be delivered, so that trained staff are able to maintain their MHFA-trainer status more easily.

7. Conclusions

The implementation and roll out of MHFA in prisons has to some extent been successful. Staff have been trained, with the capacity and knowledge to support prisoners with mental health issues increased as a result. However, the roll out has been limited, compromised by difficulties freeing up both trainers and potential trainees to attend a three-day course because of the needs of wider prison regimes (which tend to 'crowd out' training). The future roll-out of MHFA training will be equally challenging as none of the difficulties identified above are easy to resolve. However, the recommendations made in the previous section of this report would assist MHFA to maximise its potential to help the prisons concerned identify and care for those prisoners experiencing mental health issues.

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