AWARE Study Manual

Contents

Introduction

Background of the AWARE project

Mental health issues and disorders in prisoners and former prisoners are a serious problem in the criminal justice system, on the one hand for the prisoners themselves, on the other hand for the people who work with them.

The WHO defines mental health as '(...) a state of well-being in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively and contribute to the community.' (WHO, 2001). Following this definition, it is imaginable how being locked up in detention might exacerbate or cause mental health issues, but it is also a chance to provide access to support for people with mental health needs. Compared to the general population, (former) prisoners are more likely to be affected by mental disorders such as psychosis, depression, personality disorders and substance abuse (Fazel & Seewald, 2017). A mental disorder seldomly stands for itself, most prisoners suffer from two or more mental health disease or disorder. Most prisoners suffering from a mental illness also have issues with substance abuse (Brooker & Glyn, 2012).

Mental health in detention and upon release requires greater attention. Mental health is a key factor in achieving the goal of reintegrating prisoners into society. For example, people with mental disorders are 40% more likely to reoffend than people who do not have a mental disorder (Fazel & Seewald, 2012).

Still there is little or no training for non-specialised staff like prison officers on how to deal with prisoners having mental health issues. They do not know when to refer a prisoner to mental health services or do not feel qualified to help them with their personal emotional problems (Prison Reform Trust, n.d.). To respond to these training needs, we will look at mental health in detention and training needs from a European perspective.

The AWARE project brings forward as solution a training programme for prison staff, probation services, civil society organizations and volunteers who work with former prisoners. We are taking a holistic approach to reducing stigmata about mental health problems, raise awareness of mental health in the criminal justice system and thus contribute to the social integration of prisoners on release. This includes facilitating exchange of knowledge by establishing a network through staff training and online communities of practice.

To provide impulses for the development of further training, we have reviewed existing scientific and practical findings on mental health in the criminal justice system and gathered them in a state-of-the-art report. Also, to capture the service user voice and analyse needs we asked prisoners and staff in 5 EU-

countries about mental health in prison. Both the state of the art analysis and research report are available on the project website http://www.aware-project.org/ The AWARE training methodology combines both the perspective of correctional justice staff and that of prisoners, aiming thus to ensure that proposed training meets the needs of staff in order to provide them with the most effective support in their work.

The AWARE Training programme

This manual has been written with the intention of providing a tool for anyone working in the correctional justice system and who might come in contact, at any level, with prisoners who are experiencing mental health issues. It is intended to be an easy read both for non-specialised staff who have an interest in deepening their knowledge on the mental health issues in prison, but also to provide facilitators of prison staff programmes an efficient instrument for delivering training on mental health awareness.

Irrespective of the mental health care pathway that might exist in different prisons, training and support on mental health awareness is needed for all prison staff, particularly wing-based officers, to help them:

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

According to Paton (2004), as cited in (Musselwhite et. Al, 2004), recognition of mental health problems and of suicide risk represents the first level of care in mental health care pathways in prisons. The scheme described by Paton encompasses the following:

Level	Task	Personnel
Level 1: Recognition of mental health problems and of suicide risk	• Recognise when someone has symptoms of mental distress/disorder and/or is at risk of suicide • Reach out and engage in a supportive relationship • Identify the presence of suicidal thoughts • *Facilitate links with people who do first line helping interventions, i.e. with Level 2)*	All staff in contact with prisoners
Level 2: First line helping intervention	• Estimate level of risk	*Some* staff: ACCT[1] assessor teams, mental health liaison

[1] Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm. (www.gov.uk)

(assessment and crisis management)	• Attend to the person's pain and distress • Work with the person to promote their immediate safety • Address and contain those aspects of the current situation affecting health and safety • Facilitate links with family (if supportive), friends, peer supporters, professional help. • *Help plan care on the wing/unit (jointly with those at Levels 3 and 1 and individuals themselves)*	officers, senior officers/wing managers, probation, psychologists, chaplains, teachers, workshop managers, general nurses
Level 3: On-going care (less challenging/ complex cases)	• Provide counselling, treatment or therapy • *Consult with and be a resource for people at Level 2 (and 1?)* • *Obtain information from and pass it to health care providers outside prison*	Primary care RMNs[2], GP[3]s, primary care mental health workers (e.g. health psychologists), some chaplains, psychologists (who may be offering interventions for selfharm). Some staff will work across the boundary of Levels 2 and 3
Level 4: On-going care (more challenging/ complex cases)	• Provide counselling, treatment or therapy • Care programme approach • *Consult with and be a resource for people at Level 3 (and 2?)* • *Obtain information from and pass it to health care providers outside prison*	Mental health in-reach staff, in establishments with no in-reach, community mental health services

The AWARE training methodology is intended to provide an overview of the whole map of services and intervention levels for prisoners with mental health issues, without bearing the ambitious purpose of providing any subject specific information or content on specialised care for prisoners with mental health

[2] Registered Medical Nurse

[3] General Practitioner

issues. The practical activities developed in this manual are meant to support all staff in contact with prisoners to recognise mental health issues and provide prisoners with the adequate care and support.

The AWARE training is structured in four modules that provide a short theoretical background of main themes and concepts on mental health issues, as well as an overview on how to transfer these concepts in training for prison staff.

- Module 1. Mental Health Awareness in Prison
  - Definition of mental health/illness and mental health concepts for non-specialised staff
  - Understanding of the factors that influence mental health
  - Awareness of the difficulties associated with mental health illness labelling
- Module 2. What could / should I (or my colleagues) do as a non-experienced professional/ volunteer?
  - Support system of the prison for mental health issues and the role of different staff groups
  - Inmates perception on the prison support system for mental health issues
  - Inmates' perceptions on the determinants of satisfaction with prison settings
- Module 3. What resources do I have?
  - Capitalising on prison resources to support mental health issues
  - Case management of mental health issues in prison
- Module 4. Mental Health as a primary key to (re)integration
  - Resources and support system for inmates after release
  - Multiagency cooperation to support the (re) integration of inmates

The themes addressed by the four modules are further explored in separate units within each module. Each training unit showcases a short theoretical background for the subject addressed in that specific unit, and it also provides guidance on the implications for training staff from the correctional justice system. This part of the manual is intended to a useful read for any correctional staff, specialised or non-specialised, whether their role involves direct contact with prisoners who experience mental health issues or they are staff involved in delivering training on mental health awareness.

The second part of the manual is intended to be useful guidance for facilitators delivering training on mental health issues. It provides information and guidelines on how to engage participants into training, what are the learning outcomes, how to organise learning and what are the competences that participants should develop as a result of the training.

References

Brooker, C., Glyn, J. (2012). *Briefing 45: Probation Services and Mental Health.* London: Centre for Mental Health

Fazel, S., Seewald, K. (2012). *Severe mental illness in 33 588 prisoners worldwide: systematic review and regression analysis*, The British Journal of Psychiatry, DOI: 10.1192/bjp.bp.111.096370

Musselwhite, C., Freshwater, D., Jack, E., & Maclean, L. (2004, September). *Mental Health Awareness for Prison Staff*. Institute of Health and Community Studies, Bournemouth University. https://core.ac.uk/download/pdf/75079.pdf

Prison Reform Trust (n.d.). *Mental Health Care in Prison.* London: Prison Reform Trust. Retrieved from http://www.prisonreformtrust.org.uk/WhatWeDo/ProjectsResearch/Mentalhealth

World Health Organisation, (2001). *Strengthening mental health promotion*, Fact sheet no.220

AWARE Training – the modules

Mental Health Awareness in Prison

Definition of mental health/illness and mental health concepts for non-specialised staff

Can prisoners, their families and friends, prison staff and their families be happy? Prisons are not about happiness, they are about tragedy, suffering, blame and shame – is how a lot of people from inside and outside prison would respond. Yet, we are ready to accept that any prison-connected distress both inside, and outside the walls is be somehow managed, subdued, controlled, put away or deflected. Or medicated, at best. Yes, we know, that prisons can harm human autonomy, can degrade dignity, and can impair or destroy self-reliance. We know that prisons can embrace authoritarian values that harbour violence and abuse, that imprisonment can worsen beneficial interaction with one's peers, fractures family ties, destroys the family's economic stability. We know how prejudices about prison and prisoners limit the prisoner's future prospects for any improvement in his/her economic and social status (American Friends Service Committee., 1971).

Insecurity is a part of the human condition of prisoners. It can imposed by the uncertainties of the prison environment, and rules' enforcement. Prisons represent an environment in which self-esteem is undermined, and often - personal safety put at risk. Under such conditions, power thrives and weakness is targeted for victimisation. This may make the prisoner more likely to feel that violence is justified. This insecurity and threat of increased violence, combined with the deprivation of personal responsibility, leads to vulnerability, chronic stress, reclusion, feelings of loss and to a reduced ability or willingness to communicate. For people on remand or those serving indeterminate sentences, these feelings are aggravated by the uncertain length of custody.

Continuous stress affects people mentally, physically and cognitively, with results ranging from physical and mental exhaustion to burnout – a condition shared by both staff and prisoners. Traumas and post-traumatic stress disorder may accelerate this development, especially when the prison climate is characterized by disturbed communication, depreciation of work by superiors, low social team spirit among working groups, lack of positive corporate identity and organizational parameters, such as overtime accumulating as a result of a poorly organized work process. Prisoners face social Isolation, losing with their families since coming to prison, extended periods of inactivity, of enforced idleness. This can lead to frustration, anxiety and a temptation to use drugs – a very serious mental health risk for prisoners. There is nothing worse for the mental well-being of those who find it difficult to cope with life in prison than being idle. Engaging in activities that are genuinely productive and experienced as meaningful can help prisoners to feel that their time inside has purpose.

How are you feeling today? What are you thinking about most? How fulfilling was your last meal? What about your sleep and physical exercises? Have you had the chance to do something today that made you feel good? What are looking forward to in the next few days? What can we do together these days? What are you grateful for right now? Those are amongst the questions that can orient us in mental health state of the prisoners and the staff. Yes, mental health, when available, is a positive sense of wellbeing, which enables us to survive pain, disappointment and sadness. Mental health requires resilience, an underlying belief in our own and in others' dignity and worth.

Thinking about mental health in prison implies that we expect from prison as an institution to provide an opportunity for prisoners' personal development, without harming themselves or others. In order for this to happen, prisoners must feel safe and connected. If they do not feel safe they cannot be assisted towards insight into their own offending behaviour, and this insight cannot be achieved without prisoners and staff be treated equally with positive expectations and respect (WHO, 1998). Safety and dignity are amongst the core factors that influence mental health in prisons. Many people in prison have hurt other people, and respectful attitude towards them is not intended to excuse that behaviour in any way, but to restore the common belief in a world of mutual respect, safety and therefore - humanity.

Much of the evidence about the poor mental health in prisons is focused on offenders, and not on their families or on prison staff. Yet, **prison staff** are also affected by many of the same problems, including stigma, risk to personal safety, and poor working conditions. We know that the vast majority of staff are dedicated professionals, who struggle, sometimes lacking the training and resources, to help prisoners turn their lives around.

Similarly, **families and partners of prisoners** are a key part of the mental health and wellbeing picture. In AWARE's research, we found that – even in prisons where access to psychiatric resources were available – prisoners overwhelmingly stated that the first person they would speak to about their feelings would be their partner or their families. Supporting these relationships and the families themselves then, is to support a front line resource for mental wellbeing.

To be AWARE then means to be able to feel, to think, to ask and to respond, (through human relations, medicine, psychology, pedagogy, social work, culture, economic and living support and so on) and to be open to sharing experiences. In order to be reliable the positive mental health process should involve all the individuals affected by imprisonment in all of the roles we may assume, when experiencing prisons, crime and punishment.

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.

Mental health promotion involves actions that improve psychological well-being. This may involve creating an environment that supports mental health. National mental health policies should be concerned both with mental disorders and, with broader issues that promote mental health. Mental health promotion should be mainstreamed into governmental and nongovernmental policies and

programmes. In addition to the health sector, it is essential to involve the education, labour, justice, transport, environment, housing, and welfare sectors.

Mental health care planning overall goal is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

Mental health management: In addition to support from health-care services, people with mental illness require social support and care. They often need help in accessing educational programmes which fit their needs, and in finding employment and housing which enable them to live and be active in their local communities.

WHO Definitions taken from the WHO Mental Health page

Depression

Depression is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. People with depression may also have multiple physical complaints with no apparent physical cause. Depression can be long-lasting or recurrent, substantially impairing people's ability to function at work or school and to cope with daily life. At its most severe, depression can lead to suicide.

Management of depression should include psychosocial aspects, including identifying stress factors, such as financial problems, difficulties at work or physical or mental abuse, and sources of support, such as family members and friends. The maintenance or reactivation of social networks and social activities is important. ((*Depression*, n.d.)

Bipolar disorder

A bipolar diagnosis means manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated or irritable mood, over-activity, rapid speech, inflated self-esteem and a decreased need for sleep. People who have manic attacks but do not experience depressive episodes are also classified as having bipolar disorder.

Effective treatments are available for the treatment of the acute phase of bipolar disorder and the prevention of relapse. These are medicines that stabilize mood. Psychosocial support is an important component of treatment." ((*WHO | Psychosis and Bipolar Disorders*, n.d.)

Dementia

"Dementia is usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.

Dementia is caused by a variety of diseases and injuries that affect the brain, such as Alzheimer's disease or stroke.

Though there is no treatment currently available to cure dementia or to alter its progressive course, many treatments are in various stages of clinical trials. Much can be done, however, to support and improve the lives of people with dementia and their carers and families."((*Dementia*, n.d.)

Self-harm/ Suicide

"Suicide is the act of intentionally ending one's own life. Nonfatal suicidal thoughts and behaviors (hereafter called "suicidal behaviors") are classified more specifically into three categories: *suicide ideation*, which refers to thoughts of engaging in behavior intended to end one's life; *suicide plan*, which refers to the formulation of a specific method through which one intends to die; and *suicide attempt*, which refers to engagement in potentially self-injurious behavior in which there is at least some intent to die. Most researchers and clinicians distinguish suicidal behavior from non-suicidal self-injury (e.g., self-cutting), which refers to self-injury in which a person has no intent to die. ((Nock et al., 2008)

Suicide is often the single most common cause of death in correctional settings. The WHO Guide to Preventing Suicide in Jails and Prisons states that "In some situations, inmates who make suicidal gestures or attempts will be viewed as manipulative. These inmates are thought to use their suicidal behaviours to gain some control over the environment, such as being transferred to a hospital or moved to a less restrictive setting. The possibility of a staged suicide attempt to instigate an escape, or for some other nefarious motive, must also be an ever-present worry for all officers, particularly those working in maximum and super maximum-security areas. Incarcerated men with antisocial or sociopathic personalities may be more prone to manipulative attempts as they are likely to have difficulty adapting to the over-controlled, collective conditions of prison life. Moreover, for some prisoners, self-harming behaviour may be a possibility of reducing tension." (*Prevention Suicide in Jails and Prisons.*, 2007)

It may be difficult to find a difference between self-harm and suicide attempts, even for the inmate. The WHO guide states that "There is indication that many incidents involve both a high degree of suicidal intent and so-called manipulative motives such as wanting to draw attention to one's emotional distress or wanting to influence one's management, such as avoiding a transfer to another facility where family visits will be less frequent."((*Prevention Suicide in Jails and Prisons.*, 2007)

Traumatic brain injury (TBI)

Traumatic Brain Injury in Prisons and Jails:An Unrecognized Problem states that many people in prison are living with a traumatic brain injury. This may cause symptons such as "Attention deficits may make it difficult for the prisoner with TBI to focus on a required task or respond to directions given by a correctional officer. Either situation may be misinterpreted, thus leading to an impression of deliberate defiance on the part of the prisoner. Memory deficits can make it difficult to understand or remember rules or directions, which can lead to disciplinary actions by jail or prison staff. Irritability or anger might

be difficult to control and can lead to an incident with another prisoner or correctional officer and to further injury for the person and others. Slowed verbal and physical responses may be interpreted by correctional officers as uncooperative behaviour. Uninhibited or impulsive behavior, including problems controlling anger6 and unacceptable sexual behavior, may provoke other prisoners or result in disciplinary action by jail or prison staff." ((*Traumatic Brain Injury in Prisons and Jails*, n.d.) ((*WHO | Neurology and Public Health*, n.d.)

Schizophrenia and other Psychoses

Psychoses, including schizophrenia, are characterized by distortions in thinking, perception, emotions, language, sense of self and behaviour. Common psychotic experiences include hallucinations (hearing, seeing or feeling things that are not there) and delusions (fixed false beliefs or suspicions that are firmly held even when there is evidence to the contrary). The disorder can make it difficult for people affected to work or study normally. Treatment with medicines and psychosocial support is effective. Facilitation of assisted living, supported housing and supported employment can act as a base from which people with severe mental disorders, including schizophrenia. (*Schizophrenia*, n.d.)

Developmental disorders, including autism

Developmental disorder is an umbrella term covering intellectual disability and pervasive developmental disorders including autism. Symptoms of pervasive developmental disorders, such as autism, include impaired social behaviour, communication and language, and a narrow range of interests and activities that are both unique to the individual and are carried out repetitively. Developmental disorders often originate in infancy or early childhood. People with these disorders occasionally display some degree of intellectual disability. Structure to daily routines helps prevent unnecessary stress, with regular times for eating, exercise, learning, being with others, and sleeping. Regular follow up by health services for adults with developmental disorders, and their carers, needs to be in place. ((*Autism Spectrum Disorders*, n.d.)

References

American Friends Service Committee. (1971). *Struggle for justice : a report on crime and punishment in America, prepared for the American Friends Service Committee*. New York : Hill & Wang.

WHO Regional Office for Europe. (1998). *MENTAL HEALTH PROMOTION IN PRISONS*. https://www.euro.who.int/__data/assets/pdf_file/0007/99016/E64328.pdf

Autism spectrum disorders. (n.d.). Retrieved 30 September 2020, from https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders

Dementia. (n.d.). Retrieved 30 September 2020, from https://www.who.int/news-room/fact-sheets/detail/dementia

Depression. (n.d.). Retrieved 30 September 2020, from https://www.who.int/westernpacific/health-topics/depression

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and Suicidal Behavior. *Epidemiologic Reviews*, *30*(1), 133–154. https://doi.org/10.1093/epirev/mxn002

Prevention suicide in jails and prisons. (2007). World Health Organization, International Association for Suicide Prevention (IASP).

Schizophrenia. (n.d.). Retrieved 30 September 2020, from https://www.who.int/news-room/fact-sheets/detail/schizophrenia

Traumatic Brain Injury in Prisons and Jails. (n.d.). 5.

WHO | Neurology and public health. (n.d.). WHO; World Health Organization. Retrieved 30 September 2020, from http://www.who.int/mental_health/neurology/en/

WHO | Psychosis and bipolar disorders. (n.d.). WHO; World Health Organization. Retrieved 30 September 2020, from http://www.who.int/mental_health/mhgap/evidence/psychosis/en/

Understanding of the factors that influence mental health

The results of a focus group study (Nurse, 2003) on influence of environmental factors on mental health within prisons, revealed that prisoners reported that long periods of isolation with little mental stimulus contributed to poor mental health and led to intense feelings of anger, frustration, and anxiety. Prisoners said they misused drugs to relieve the long hours of tedium. Most focus groups identified negative relationships between staff and prisoners as an important issue affecting stress levels of staff and prisoners. Staff groups described a "circle of stress," whereby the prison culture, organisation, and staff shortages caused high staff stress levels, resulting in staff sickness, which in turn caused greater stress for remaining staff. Staff shortages also affected prisoners, who would be locked up for longer periods of time, the ensuing frustration would then be released on staff, aggravating the situation still further. Insufficient staff also affected control and monitoring of bullying and reduced the amount of time in which prisoners were able to maintain contact with their families.

Key factors of the prison environment that influenced prisoners' mental health included isolation and lack of mental stimulation, drug misuse, negative relationships with prison staff, bullying, and lack of family contact. Key issues that influenced the mental health of staff included perceived lack of management support, the negative work culture, staff safety, and high stress levels increasing staff sickness, which in turn created higher stress levels.

Isolation and lack of mental stimulation

Remand and sentenced prisoners and uniformed staff emphasised the negative effect on prisoners' mental health of being locked up for as long as 23 hours a day. Remand prisoners do not normally work or have access to education, while many sentenced prisoners had limited access to both. Prisoners discussed how lack of activity and mental stimulation led to extreme stress, anger, and frustration.

The focus groups thought that any activity, whether it was exercise, work, or education, was beneficial. The focus group of non-uniformed staff thought that education was particularly important for prisoners, especially as many prisoners have limited literacy skills.

Negative relationship with prison staff

All the prisoner focus groups described a cycle of negative attitudes, whereby if an officer treated a prisoner badly, prisoners would make the officer's life hard, which caused more stress for officers. This was captured by a series of comments from the female focus group.

All prisoner focus groups (except sentenced prisoners) suggested that staff should have more training and be better valued and that more staff would reduce stress levels for prisoners. Remand prisoners described how fewer staff increased the amount of time spent in cells, which made prisoners more difficult to deal with, thereby increasing stress levels of staff and prisoners.

Bullying Rule

45 prisoners (convicted for sex offences, child abuse, or vulnerable to abuse from other prisoners) emphasised bullying by other prisoners as an issue, although other prisoner focus groups did not discuss this but described bullying of prisoners by staff members (see above). One participant from the rule 45 group described how bullying from other prisoners affected their mental health.

Some focus group members were resigned to bullying, saying you can't stop it, while others said that it still affects mental health and was the main reason for people on their wing becoming ill. Suggestions for reducing bullying involved having sufficient supervision by senior prison officers, especially at meal times.

Working environment and culture

The reduction in staffing levels and concurrent rises in numbers of prisoner over the past few years was frequently expressed as a cause of stress in staff. Inmates have less time out of cells now as there are fewer members of staff to supervise them, which increases tensions between staff and prisoners. This also leads to less job satisfaction for staff. Poor management style, lack of communication, insufficient information, and lack of continuity of care with prisoners were identified as factors that increased levels of stress in staff. Staff acknowledged their own contribution to stress in their jobs, describing how the macho culture in prisons made it difficult for prison officers to open up and talk about their problems.

The healthcare group had concerns about safety as some staff had to interview prisoners on their own in inadequate facilities. The whole group thought this was important, and it reflected the general sense of isolation. The non-uniformed staff placed less emphasis on their own stress levels at work but described how other staff members would offload their stress on them. The uniformed staff considered that stress was the most important thing affecting their health at work; an important aspect of this was the fear of violence.

Circle of stress

Various causes of stress—including reduced staffing levels, prison culture, prison management, and fear of safety—were frequently described as interacting with each other and increasing overall stress levels. This was best described by a member of the healthcare group who described a “circle of stress,” whereby low morale and staff shortages increased stress levels, which in turn increased staff sickness rates, reduced staffing levels, further lowered the morale of remaining staff and led to more stress and staff sickness.

The results of this focus group show that how wider environmental and organisational factors affect mental health within a prison setting. long periods of being locked up with little activity or mental stimulation have a negative impact on the mental health of prisoners, whether or not they had a formal mental illness.

These factors could be dealt with by reduced numbers of prisoners or by increased staff levels—for example, by the provision of occupational health to address high staff sickness levels and by improving staff communication, training, supervision, support, and teamworking. This would reduce the length of

time prisoners are locked up and begin to alter the cultural environment within the prison, which in turn could have a significantly positive impact on prisoner mental health.

References

Nurse, J. (2003b). Influence of environmental factors on mental health within prisons: focus group study. *BMJ*, *327*(7413), 480–0. https://doi.org/10.1136/bmj.327.7413.480

Awareness of the difficulties associated with mental health illness labelling

There are more than 10 million individuals in prison at any given time with more than 30 million circulating through each year. Research has consistently shown that prisoners have high rates of psychiatric disorders, and in some countries there are more people with severe mental illness in prisons than psychiatric hospitals. Despite the high level of need, these disorders are frequently underdiagnosed and poorly treated (Fazel et al., 2016).

The impact of illness labels on the stigma experiences of individuals with mental health problems is a matter of ongoing debate. Some argue that labels have a negative influence on judgments and should be avoided in favour of information emphasising the existence of a continuum of mental health/illness. Others believe that behavioral symptoms are more powerful influencers of stigma than labels (Dolphin & Hennessy, 2017).

Labels can exacerbate symptoms and labels such as personality disorder, may even exacerbate depression and anxiety as well as giving others the license to behave badly (Robinson, 2009). Also, labels for mental health illnesses have the potential to both stigmatise and alienate individuals. We can quickly fall into the trap of dichotomous thinking. You have a mental health problem, or you don't and are healthy. Labels create an artificial divide between 'normal' and 'abnormal'. We are then inclined to treat apparent abnormalities as discrete, treatable entities, such as anxiety, depression and various psychological disorders. Once this kind of thinking becomes embedded, it can become institutionalised in healthcare to the point it reinforces, rather than alleviates, the presenting symptoms (Langer, 2016).

In view of its characteristics and basic focus, labeling theory is difficult to apply to the diagnosis and treatment of the mentally ill among prisoners. Labeling theory applies to general societal processes, whereas the prison is a comprehensive institutional setting where social interactions occur within a unique micro enviroment. Prisoners have already gone through some if not all of the processes of being labeled criminals and thus, according to labeling theorists, have already acquired a deviant master status which will make it difficult for them to function later as normal adults. Thus, the issue of diagnosing and treating (i.e., labeling) certain inmates in jail as mentally ill is not a process that fits well into the paradigm developed by labeling theory. The processes do have a number of things in common, and some of them may prove problematic. Psychologists working in prisons can expect to encounter points of tension in their interactions with correctional staff as well as with prisoners, notably those feigning mental illness for advantages in the criminal justice process (Dunn & Steadman, 1982).

In case of prisoners, mental illness labelling can often lead to stigmatization by prison staff, media and the general public. As a result of the stigma attached to mental illness, affected individuals will often go to great lengths to conceal their conditions and to avoid seeking necessary treatment, which may worsen their illnesses. Further, resources for those in need of community and inpatient care are drastically overstretched. The combined result of these factors is that people who are more properly in need of

mental health care — preventative and restorative — are at considerable risk of finding themselves within the criminal justice arena (Andrewartha, 2010).

Education as a means of challenging mental illness stigma, may be achieved in many ways, but is in principle the act of informing the public about the realities of mental illness and addressing the present fallacies. Unlike protest, which essentially does no more than advise the public what it should not be doing or thinking, education operates by offering factual information and contrasting prevailing myths with legitimate truths in respect of mental illness to replace inaccurate information with facts. Education in this context does not seek to make the public at large experts on mental illness. Rather, it is intended to provide sufficient factual data from which the public can draw to challenge existing misconceptions about mental illness.

Education and training programmes are the most popular means of fighting mental illness stigma as they are easy to utilise and disseminate. They have also had fairly reasonable rates of success. While there is a positive correlation between being informed about mental illness and a disinclination to support mental illness stigma, it is uncertain whether targeted education campaigns actually transform people from ignorant to knowledgeable in respect of mental illness.

References

Andrewartha, D. (2010), "Words will never hurt? Media stigmatisation of people with mental illnesses in the criminal justice context", Alternative Law Journal, Vol. 35 No. 1, pp. 4-7.

Dolphin, L., & Hennessy, E. (2017). Labelling effects and adolescent responses to peers with depression: an experimental investigation. *BMC Psychiatry*, *17*(1). https://doi.org/10.1186/s12888-017-1389-9

Dunn, C., & Steadman, H. (1982). *Mental Health Services in local jails: Report of a Special National Workshop*. US Departament of Health and Human Services. https://www.ncjrs.gov/pdffiles1/Digitization/85919-85928NCJRS.pdf

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry*, *3*(9), 871–881. https://doi.org/10.1016/S2215-0366(16)30142-0

Langer, C. (2016). *Be Wary Of Mental Health Labels*. National Health Executive. https://www.nationalhealthexecutive.com/Comment/be-wary-of-mental-health-labels

Robinson, A. (2009). Dangers of diagnostic labels in patients with mental health issues. *Prog. Neurol. Psychiatry*, *13*(5), 6–7. https://doi.org/10.1002/pnp.134

What could / should I (or my colleagues) do as a non-experienced professional/ volunteer?

Support system of the prison for mental health issues and the role of different staff groups

Since there is more than one reason that people with mental illness become entangled in the criminal justice system, it is unlikely that any one approach will consistently reduce recidivism and prevent criminal activity for this group. At this point, most prevention and intervention programs for offenders with mental illness focus on providing access to mental health treatment or psychiatric medications.

Offenders with mental illness demonstrate many of the same risk factors for criminal activity as offenders without mental illness, it is likely that programs addressing indirect routes to crime such as poverty, employment, housing, social support, and substance abuse will be helpful.

Successful programs for offenders with mental illnesses that effectively prevent or break the cycle of criminal justice involvement are possible, but these programs need to be comprehensive—addressing the holistic needs of this high-risk population, rather than a sole focus on mental health symptoms and treatment. Early programming may also be critical for intervention. Emerging adulthood is the key point at which both symptoms develop and criminal justice involvement usually begins (Peterson & Heinz, 2016)

In supporting prisoners with mental health issues, the care pathway available at prison level might include the involvement of various staff groups with dedicated responsibilities. The scheme proposed by Paton (2004), as cited in (Musselwhite et. Al, 2004), as presented in the introduction *The AWARE Training Programme,* describes four levels of intervention in mental health care:

Level 1 Recognition of mental health problems and of suicide risk	All staff in contact with prisoners
Level 2: First line helping intervention (assessment and crisis management)	*Some* staff: ACCT assessor teams, mental health liaison officers, senior officers/wing managers, probation, psychologists, chaplains, teachers, workshop managers, general nurses
Level 3: On-going care (less challenging/ complex cases)	Primary care RMNs, GPs, primary care mental health workers (e.g. health psychologists), some chaplains, psychologists (who may be offering interventions for selfharm). Some staff will work across the boundary of Levels 2 and 3
Level 4: On-going care (more challenging/ complex cases)	Mental health in-reach staff, in establishments with no in-reach, community mental health services

Within the training package on Mental Health Awareness for prison staff (Musselwhite et. al, 2004), an outline of two new roles addressing mental health issues in prison was developed, these being the mental health liaison officer role and the assessor role.

The role of a prison mental health assessor

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

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

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

The role of a mental health liaison officer

In addition to their normal duties, the mental health liaison officer should also be able to:

- Create an awareness of prisoners with the potential risk of developing, and those who may already be experiencing, mental health problems;
- Take a lead on being the first point of contact for issues surrounding prisoners' mental health;
- Offer evidence-based guidance, support, information and knowledge on prisoners' mental health issues to other colleagues on the wings;

- Establish good working relationships, communicate and assist formally and informally with other colleagues such as other discipline officers, health care staff, psychologists and ACCT assessors on mental health issues;
- Respond appropriately, within their sphere of competence, to the mental health needs of prisoners.

References

Peterson, J., Heinz, K. (2016) "Understanding Offenders with Serious Mental Illness in the Criminal Justice System," Mitchell Hamline Law Review: Vol. 42: Iss. 2, Article 3. Available at: http://open.mitchellhamline.edu/mhlr/vol42/iss2/3

Musselwhite, C., Freshwater, D., Jack, E., & Maclean, L. (2004, September). *Mental Health Awareness for Prison Staff*. Institute of Health and Community Studies, Bournemouth University. https://core.ac.uk/download/pdf/75079.pdf

Inmates perception on the prison support system for mental health issues

It is well accepted and documented, that prison settings play a role in the manifestation and exacerbation of mental health issues. Indeed, there have been multiple studies that have shown significantly higher prevalence rates amongst prison inmates, when compared to the general population (Bradley, 2009; Fazel & Danesh, 2002). Consequently, the task of delivering mental health care within prisons is hindered by the context itself, as well as the multitude of variables and needs that one needs to consider when treating inmates.

A lot of studies have indeed been carried out, regarding the needs and best practices when it comes to diagnosing and treating mental health patients in prison settings, but unfortunately most of them have been focusing on the issue from the side of the therapists and health care professionals themselves rather than that of the inmates, who, at the end of the day are the receivers of the provisions themselves (Morgan, Rozycski & Wilson, 2004). In one of the few studies that has focused on the perceptions of inmates regarding mental health support inside prisons, conducted by Morgan et al in 2004, a clearer image regarding the views of prisoners became available. What was interesting about this study was the fact that none of the stereotypical beliefs about how inmates would see therapy held true (or at least were significantly prevalent). Few inmates seemed to think that treatment was for “weak” people or that it might be used against them in trial. The same was true regarding being a snitch or confusing mental health professionals with undercover policemen trying to elicit a confession out of them. Contrary, the most important aspects that affected the decisions of inmates seemed to be the lack of proper guidance as to where and how to seek help and the fact that they preferred to talk about their personal issues with family and friends (perhaps a remnant of the stereotypical belief that the two act as equivalent forms of help). Furthermore, problems with lack of proper training and understaffing of prisons in the face of an ever-increasing inmate population, also seemed to produce these effects (Offender Health Research Network, 2010).

In general, it seems that the main concerns of prisoners do not lie so much in their perceived views or fear of mental health therapy, but rather on the unavailability and lack of efficiency and proper diagnosis and treatment when it comes to getting what they need. Moreover, and due to the above, there seems to be a focus on the behaviorally “clear” cases of mental illness in prison, due to the perceived threat to the general environment, leaving more subtle or less aggression-related disorders largely undiagnosed or untreated. Indeed, cases that do not respond to sedative medication, seem to be largely ignored to limited resource allocation and provision (Gonzalez & Connell, 2014).

Results from the study

The results of our study seem to corroborate with the scarce, previous research. Indeed, out of the 530 participants, only 50% said that they had received any kind of mental health support inside prison and only 39,9% have found it helpful. Furthermore, a worrying 20% claims that they have not received help that they asked for. Moreover, inmates seem to generally believe that the prison staff is after their best

interests, but the percentage is barely above 50%, making it ambiguous and problematic at best. Alarmingly, almost 40% report that they are not taken seriously when reporting negative feelings and that they cannot make an appointment with a mental health professional in reasonable time on their own request. This does indeed support previous research that seems to report that due to understaffing and insufficient training of prison staff, while the fact that most inmates (80%) prefer to talk about their problems with friends and family also concurs with Morgan et al (2004) and the study by the National Institute of Health (offender health research network) in the UK (2010).

Implications on prison staff training

Considering all the above, we can draw some conclusions regarding the areas on which prison staff and/or the state can improve and focus their attempts to become better providers of mental health care for inmates. Firstly, regarding the state, it is imperative for further provision of qualifications to prison workers, as well as greater funding of positions that cover mental health issues of prisoners, not only on a behavioral basis (through the use of drugs) as it is customary until now, but on a psychological basis as well, providing people that have the time and resources to listen to the true mental health needs of inmates, even if they are not always accompanied by such behaviors. The state should also set better control and evaluation standards, update archaic methods of diagnosis that are not well suited and adjusted for prison environments in today's age.

On the side of prison workers, it is imperative for new paradigms to be created, based on the real needs and voices of inmates. It is not a good sign that this part of the project found next to nonacademic sources and research that were based on the experiences and beliefs of inmates and not professionals. The voices of inmates need to be heard and considered when planning the points on which such interventions, treatments and diagnostic tools are to be developed and widely used. In addition, prison staff should be able to get specialized training regarding the needs of prisoners and the specifics of the prison context (its effect on mental and physical health, etc.). Finally, and probably most importantly, it would be extremely helpful if mental health professionals could build interpersonal skills specific for the context, in order to gain the trust of the inmates, seeing that there is tendency for them to always refer to their family and friends and disregard psychologists/psychiatrists, maybe in correspondence with an awareness campaign about the differences and advantages that a mental health worker can provide in comparison with a friend, spouse or family member, in order to foster inmates' voluntary participation in such programs.

References

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

Fazel S & Danesh J. (2002). Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet* 359: 545-50.

Gonzalez, J. M., & Connell, N. M. (2014). Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity. *American Journal of Public Health, 104*(12), 2328-2333. doi:10.2105/ajph.2014.302043

Morgan, R. D., Rozycki, A. T., & Wilson, S. (2004). Inmate Perceptions of Mental Health Services. *Professional Psychology: Research and Practice, 35*(4), 389-396. doi:10.1037/0735-7028.35.4.389

The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners (Rep.). (2010). UK: The Offender Health Research Network.

Inmates' perceptions on the determinants of satisfaction with prison settings

Not much research has taken place on prisoners' satisfaction with prison. However, prisoners' satisfaction with the institution appears to be a good proxy of prisoners' perception regarding the quality of prison (Molleman & van Ginneken, 2015). This is important because we would expect that a better service would accomplish its goals more efficiently, therefore addressing prisoners' needs, promoting their rehabilitation and ultimately helping prisoners turn away from crime. Several factors can be associated with reduced/increased perception of prison quality, such as social support, contact with the outside environment, prisoners' mental health and availability of services and support structure. In a context where mental health issues can play an important role, considering the high prevalence of mental disorders (cf. Fazel & Danesh, 2002), the AWARE project argues that barriers to mental health usage and help-seeking will have an impact on prisoners' satisfaction with the institution. The decision to seek mental health services can be influenced by prisoners' beliefs and attitudes, such as thinking that mental health services are only for crazy people, or being afraid of being seen as weak, or the lack of confidentiality (Morgan, Rozycki, & Wilson, 2004).

Sources of support to prisoners' play an important role in prisoners' well-being. Results from a systematic review show that visits have a positive effect on prisoners' well-being, reducing recidivism and violent behavior (De Claire & Dixon, 2015). Prisoners' contact with the outside world (i.e., possibility to keep in contact with family, friends, lawyer) is also expected to reduce the pains of imprisonment (Molleman & Leeuw, 2012) and therefore contribute to prisoners' perception of prison quality. Other sources of support include the formal sources available in prison such as security staff, technical staff, and volunteers. These sources can be important to help prisoners deal with different problems. As mentioned by Mitchell and Latchford (2010), prisoners struggling with depression or other mental health issues will look for technical staff (e.g., physicians), while prisoners facing bullying or discrimination will look for prison officers' support. Therefore, we argue that the availability of these support sources will contribute to increase prisoners' perception regarding prison quality.

AWARE – results from a study with prisoners in 5 EU countries.

Introduction

Considering the goals of the AWARE project, the partnership aimed at understanding how prisoners perceive the mental health system within the criminal justice system, and about their experience of mental health support structures.

Method and Design

Data was collected in 5 different EU countries that are part of the AWARE partnership. A total of 497 answers to the AWARE needs assessment questionnaire were used to understand the determinants of prisoners' satisfaction with the institution. Distribution of cases among countries can be found in Table 1.

Table 1 - Number of participants per partners country

	Number of participants	Percentage
Portugal	135	27,2
Germany	100	20,1
Romania	94	18,9
Greece	95	19,1
Bulgaria	73	14,7
Total	497	100,0

Results

Results were calculated with the overall sample and for each country. Composite indicators were build summing the different items after ensuring good internal consistency. Using the data from the 5 countries, results show that contact with the outside environment and prisoners' perception that staff cares about their well-being are the significant determinants of satisfaction with the institution. Namely, data shows that for each additional point in the indicator of contact with the outside world, there is a 28% increase in the probability that prisoners' will say they are satisfied with the institution. On other hand, prisoners' perception that staff cares about their well-being is the strongest predictor of prison quality. In fact, an increase in 1 unit in this indicator, increases the probability that prisoners' will say they are satisfied with the institution by a factor of 1.61 (61%).

Results vary per country, with different determinants of prison quality showing up as follows:

- In Portugal, contact with the outside world and prisoners' perception that staff cares about their well being were positive determinants of prison satisfaction, while barriers to the use of mental health services was a negative predictor of prison satisfaction. Namely, for each additional barrier flagged by the respondents, the probability that the prisoner considers that he is satisfied with the institution decreases 32%;
- In Germany, the perception that staff cares about their wellbeing was the only positive significant predictor of satisfaction with prison. Prisoners that think staff care about their well being are 82% more likely to be satisfied with the institution. The other significant predictor in the German sample was the prisoners' mental health indicator. The results show prisoners with lower daily concerns are more likely to be satisfied with the prison institution. In fact, seeing the other side of the coin, each additional daily concern reduces the likelihood that the prisoner is satisfied by 42%;
- With the Romanian data, only one predictor appears to be statistically significant. The number of daily concerns shows a negative relation with prisoners' satisfaction with the institution. This means that for each additional daily concern mentioned by the respondents, satisfaction with the institution increases by a ratio of .54. That is, for each additional daily concern, it is 46% less likely that the prisoner is satisfied with prison;

- In Greece, the only significant predictor of prisoners' satisfaction with prison was the perception that staff cares about their well-being. This predictor was very strong, showing that an increase in one unit in the composite scale increases the by 126% the probability that the prisoner is satisfied with the institution;
- Working with the data collected in Bulgaria, no single predictor showed a statistically significant relation with prisoners' satisfaction. This result can potentially be explained by the large amount of missing values that resulted from the data collection.

Discussion and practical implications for prison staff training.

The results from the study with a sample of prisoners from five EU member countries shows that different variables predict prisoners' perception about prison quality / satisfaction with prison.

In their responses to the AWARE survey, prisoners consistently said they were satisfied with their prison when also they thought that staff care about their well-being (significant for the Portuguese, German and Greek samples). On other hand, more daily worries from prisoners responding in Germany or Romania meant that they were significantly less likely to be satisfied with their prison. Also important to AWARE prisoner respondents – although only significantly so for Portuguese respondents – was contact with the outside world. There is a very strong tendency that the higher the contact with the outside world, the more likely prisoners are to be satisfied, and this is particularly true in the German and Romanian samples.

These results provide evidence that is valuable for intervention/training: prison staff should be aware of the importance of this variable in what concerns prisoners' satisfaction and therefore encourage contact with family and friends as well as with the lawyer. The opportunity to make phone calls and ensuring privacy during these calls as well as during visits are also key aspects of this variable that correlate with perceptions of prison quality. High costs of prison phone calls were mentioned as a barrier for some prisoners to stay in touch with family and friends.

Prison staff also need to know that how happy a prisoner is with prison life is related to the perception that staff care about prisoners' well-being. It is important for staff to know that their availability to support prisoners is valuable for prisoners' satisfaction. Prisoners' perception that staff cares about their well-being, take them seriously if they have physical issues or negative feelings as well as their perception that a physician, mental health professional and social assistant is available is key to understand prisoners' satisfaction with the institution. To increase this availability of staff, a rehabilitation orientation should be favoured in staff training, and staff preconceptions and prejudices against prisoners or certain groups of offenders should be addressed.

References

De Claire, K., & Dixon, L. (2015). The Effects of Prison Visits From Family Members on Prisoners' Well-Being, Prison Rule Breaking, and Recidivism: A Review of Research Since 1991. *Trauma, Violence & Abuse*, 1524838015603209-. https://doi.org/10.1177/1524838015603209

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys. *The Lancet*, *359*, 545–550. https://doi.org/10.1016/S0140-6736(02)07740-1

Mitchell, J., & Latchford, G. (2010). Prisoner perspectives on mental health problems and help-seeking. *Journal of Forensic Psychiatry and Psychology*, *21*(5), 773–788. https://doi.org/10.1080/14789949.2010.488697

Molleman, T., & Leeuw, F. L. (2012). The Influence of Prison Staff on Prisoner Conditions: A Multilevel Approach to Staff and Prisoner Surveys. *European Journal on Criminal Policy and Research*, *18*, 217–233. https://doi.org/10.1007/s10610-011-9158-7

Molleman, T., & van Ginneken, E. F. J. C. (2015). A Multilevel Analysis of the Relationship Between Cell Sharing, Staff-Prisoner Relationships, and Prisoners' Perceptions of Prison Quality. *International Journal of Offender Therapy and Comparative Criminology*, *59*(10), 1029–1046. https://doi.org/10.1177/0306624X14525912

Morgan, R. D., Rozycki, A. T., & Wilson, S. (2004). Prisoner perceptions of mental health services. *Professional Psychology-Research and Practice*, *35*(4), 389–396. https://doi.org/10.1037/0735-7028.35.4.389

What resources do I have?

Capitalising on prison resources to support mental health issues

What resources do I have?

How can we really identify and treat depression, anxiety and mental ill health effectively in criminal justice settings? From the 364 AWARE respondents who work with prisoners and/or ex-offenders, an alarming 85% reported that they are aware of prisoners facing some form of mental health problem inside their secure facility. This was true of every staff role, from medical doctor to prison officer, from psychologist to probation workers. Over one third said that this problematic behavior occurred at their workplace on a daily basis.

AWARE's respondents echo previous research and experience that there is a high prevalence of mental health problems in prisoners and insufficient provision for these problems. Asked to identify the most common manifestations of mental health illness among prisoner populations, AWARE respondents talked about substance abuse-related issues (22%), depression (21%), self-harm behaviors (22%) and personality disorders (18%), though these may be characterized as symptoms and not disorders in themselves. In fact, the majority of the staff who responded were not qualified to diagnose elusive constructs such as personality disorders, which are hard to identify even by trained professionals (Hopwood, 2018).

Provision is lacking to train staff and volunteers in prison and probation to identify first signs of mental ill health, it is lacking in custody-setting mental health resources (compared to those available on the outside), and it is lacking in training and strategy to preempt or identify a serious clinical need in prison and probation. And, if a condition does become more serious, there is a general lack of referral possibilities for expert support. In turn, prison and probation staff stress related to the prison organisation and environment increases, and can negatively affect the mental health of prisoners, developing into cycles of stress.

In the face of this lack of resources, where did AWARE prisoners identify they most need support?

Listen to prisoners: Insecurity, isolation, frustration and constant stress are hallmarks of prison life, and it takes time and support to build the resilience speak out about your feelings. Slightly more than half of prisoners felt that they were taken seriously asking staff for psychological help, but still 42% did not. Similarly, 40% of prisoners said that they were afraid their request for psychological help would not be treated confidentially and nearly half (49%) said they would be afraid this request would somehow be used against them. From peer support schemes (Foster & Magee, 2011) to focus groups for environmental stress factors(Nurse, 2003), this manual gives practical advice on ways to help prisoners feel listened to, even when prison staff may be busy and professional clinical staff unavailable.

Train staff and provide regularly updated information: Prisoners often described how helpful it is to talk, listen and be understood helped them with their own problems, simply to be treated like a human being. To do this, staff must be effectively trained in psychological first aid, to listen out for the many different

potential warning signs of mental distress.

- *Information for prison and probation staff:* all correctional staff need information on how to recognize a need for psychological support, whether in their fellow colleagues or an inmate. The World Health Organisation Psychological First Aid: Guide for Field Workers is available in 30 languages and covers psychological first aid which involves humane, supportive and practical help to fellow human beings in crisis situations. It is written for people in a position to help others, and shows clear steps to support people in distress and to care for yourself and your colleagues. The WHO guide gives a framework for supporting people in ways that respect their dignity, culture and abilities.

- *Information for prisoners on what good mental health* is, what they can expect to experience in prison and how, how to request psychological help if they think they need it and what that process would look like.

This AWARE manual provides examples of posters and infographics to print out for the prison environment, or to circulate in staff digital information groups. The four sections in this manual are designed to be delivered by non-specialists in mental health, over short periods. We provide infographics and visual material as a first conversation starting point, a way to ask colleagues and prisoners alike 'how are you feeling today?'

Support links with families and local community groups, specializing in either mental health, drug or wellbeing issues, or providing a wider support network for families, children and partners of prisoners. This community is a key part of the mental health and wellbeing picture. In AWARE's research, we found that – even in prisons where access to psychiatric resources were available – prisoners overwhelmingly said that the first person they would speak to about their feelings would be their partner or their families. Build a bridge from the prison to organisations which support families with someone in prison, with substance abuse issues or who provide practical support with issues around money, housing and schooling.

Build links with local sports and wellbeing organisations, numerous pilot initiatives in the past few years build a strong case for exercise supporting enhanced psychological well-being in prison (Battaglia et al., 2015), some going as far as to prove positive effects on recidivism. Individuals otherwise reluctant to engage in mental health programs may find sport and well-being activities an accessible way in. As well as being a way to bring together groups within the prison, develop communication skills and learn life lessons, sport can be a shared passion to break down stigma and community acceptance outside the prison walls. Strong links between prison, probation and sports club can be a vital reintegration tool on release.

Make the process for requests more transparent: 41% or AWARE prisoner-respondents do not know who to turn to if they are feeling sad or depressed, and one in five respondents had asked for professional help but had not received it. Perhaps they did not make the request in the correct way, or to the correct staff member. What matters is that every prisoner knows how requests for psychological help are made, how,

to whom, how long these take to process, how confidentiality is ensured and how they will receive a response. It is important to prisoners that every request is answered, even if only to notify of long delays or to say on what grounds the request has been declined.

To have an AWARE prison then means to be able to listen, to inform, to ask and to respond and to build bridges with organisations on the outside which can support activities we know prisoners need for their wellbeing (meaningful contact with family and partners, sustained contact with outside organisations). At its best, staff will have the training to identify and respond to a call for psychological help, and a prisoner or ex-offender will be thrown a mental health lifeline whenever he needs it the most.

References

Battaglia, C., di Cagno, A., Fiorilli, G., Giombini, A., Borrione, P., Baralla, F., Marchetti, M., & Pigozzi, F. (2015). Participation in a 9-month selected physical exercise programme enhances psychological well-being in a prison population. *Crim Behav Ment Health*, *25*(5), 343–354. https://doi.org/10.1002/cbm.1922

Foster, J., & Magee, H. (2011). *Peer support in prison health care: an investigation into the Listening Scheme in one adult male prison*. School of Health & Social Care, University of Greenwhich. https://gala.gre.ac.uk/id/eprint/7767/1/helenDraft_Listener_report_27_091_doc-finalversion2.pdf

Hopwood, C. J. (2018). A framework for treating DSM-5 alternative model for personality disorder features. *Personality and Mental Health*, *12*(2), 107–125. https://doi.org/10.1002/pmh.1414

Nurse, J., Woodcock, P., & Ormsby, J. (2003). Influence of environmental factors on mental health within prisons: focus group study. *BMJ (Clinical research ed.)*, *327*(7413), 480. https://doi.org/10.1136/bmj.327.7413.480

Case management of mental health issues in prison

What is case management? - While strategies and practice vary from one setting to another, traditional case management consists of a social or mental health worker who secures and coordinates continued social, mental health, medical, and other services for a client. The roots of the case management approach can be found in early 20th century social work, but most researchers attribute its development as a distinct service delivery method to the social reform movement of the late 1960s and early 1970s.1 In particular, the deinstitutionalization of the mentally ill during that period required mental health social workers to develop new ways to connect clients to community social service agencies and to monitor clients' use of services (Healey, 1999).

Case management models - Most current literature on mental health or social work case management has distilled the fundamental functions of the case manager into five sequential activities: (1) assessing the client's needs; (2) developing a service plan; (3) linking the client to appropriate services; (4) monitoring client progress; and (5) advocating for the client as needed.4 The original social work case management model cast the case manager exclusively as a broker of services and precluded his or her involvement with the client as a counselor or treatment provider.

In correctional settings, case managers may be assigned to inmates who have mental health disorders, alcohol or drug abuse disorders, or both (co-occurring disorders). In a prison, the community comprises the general, or open, population housing units and the various departments and programs that deliver services to the offenders. The case manager may need to broker between both correctional administrative systems (e.g., security, classification, housing) and treatment-oriented services and programs (e.g., education, vocation, health/medical, mental health, and alcohol and drug abuse services).

Case managers employed by state prisons may come from a variety of backgrounds and disciplines. Some facilities use trained mental health staff as case managers, while others rely on classification staff to fulfill the function. The use of case managers who also are trained mental health professionals provides services that meet or exceed most of the legal, correctional, and professional standards established for the provision of mental health services (Hills et al., 2004).

Prison-based case managers who work with offenders with mental illness perform the following activities:

- Create and monitor an individualized service plan or treatment plan that provides a detailed account of the inmate's multiple intervention needs.
- Assess the inmate's programming needs and refer the inmate to programs as appropriate.
- Meet regularly with the inmate to monitor and assess his or her psychiatric functioning and evaluate for decompensation.
- Provide counseling and psychotherapy.
- Refer the inmate to other mental health and medical staff as needed.
- Act as a liaison between classification, security, and health services.

- Provide information to security and classification staff to help them in their decisions regarding such issues as an inmate's housing and responsibilities.
- Communicate with various institutional staff who have contact with the inmate to help monitor his or her level of functioning.
- Plan for aftercare upon discharge from the prison and release back to the community.
- Communicate with the probation or parole agency.

Case managers are responsible for the following aspects of discharge and aftercare planning:

- Arranging appointments at mental health agencies in the community for inmates who require mental health treatment upon release.
- Arranging for the continuation of psychotropic medications.
- Making other types of referrals, such as vocational rehabilitation, substance abuse services, self-help groups, and financial assistance.
- Helping inmates apply for public assistance and other benefits in preparation for release.
- Notifying staff at other facilities about the mental health needs of transferring inmates.

Staff training - Prison-based case managers working with inmates with mental illness should possess, at a minimum, the skills needed by any successful prison staff member, including correctional officers (Rice & Harris, 1993). Line correctional staff assigned to work with inmates with mental illness are best prepared for this role if they receive the same training as direct care workers in psychiatric hospitals (Hafemeister, 1998).

Correctional officers can be highly effective when they are trained to—

- Understand that simply listening and talking to mentally ill inmates may resolve crises.
- Understand that frequent contact by staff, even brief contacts, can help calm confused and anxious inmates.
- Provide accurate information about the institution and how to access mental health services to inmates. • Observe and record inmate behavior.
- Receive and relay inmate requests for assistance from mental health staff.
- Consult with mental health staff about mental issues.
- Monitor inmates who take psychotropic medications for compliance and side effects.
- Identify the early signs and symptoms of mental illness and implement suicide prevention (Hafemeister, 1998).

Basic training for all correctional staff should therefore include the following information:

- How to recognize the early signs and symptoms of serious mental illness and suicide.
- The nature and effects of psychotropic medications.
- The mental health services available in the prison.
- How and when to make referrals to mental health services (Cohen & Dvoskin, 1992).

Case managers should demonstrate the ability to—

- Establish rapport with inmates.
- Educate inmates about the institution and its mental health services.
- Link inmates to other services and departments.
- Link inmates to community services on release.
- Prepare treatment plans.

References

Cohen, F., and Dvoskin, J.A. (1992). Inmates with Mental Disorders:A Guide to Law and Practice. *Mental and Physical Disability Law Reporter*, 16 (4), 462–470.

Hafemeister,T.L. (1998). Legal Aspects of the Treatment of Offenders with Mental Disorders. In Wettstein, R.M. (Ed.), *Treatment of Offenders with Mental Disorders* (pp. 44–125). New York:The Guilford Press.

Healey, K. (1999). *Case Management in the Criminal Justice System*. U.S Department of Justice. https://www.ncjrs.gov/pdffiles1/173409.pdf

Hills, H., Siegfried, C., & Ickowitz, A. (2004). *Effective Prison Mental Health Services: Guidelines To Expand and Improve Treatment*. US Department of Justice: National Institute of Corrections. https://info.nicic.gov/nicrp/system/files/018604.pdf

Mental Health as a primary key to (re)integration

Resources and support system for inmates after release

Although it is difficult to estimate the prevalence of mental illness among incarcerated populations, recent estimates suggest that about one in every two prisoners in the state and federal system have mental health problems. For example, more than two-fifths of state prisoners (43 percent) reported symptoms that met the criteria for mania compared to less than 2 percent of the general public, and three times as many state inmates (24 19 percent) suffered from major depression as the general population (8 percent) (James & Glaze 2006). Incarcerated women are even more likely to experience mental health problems than their male counterparts (James & Glaze 2006).

Released prisoners suffering from mental health problems require immediate and ongoing medical services in order to successfully reenter the community (Gaynes 2005). These services not only refer to the obvious needs for medication, medical equipment, prescriptions and referrals, but also to assistance in accessing these key supports. Many individuals facing mental health challenges will require intensive support in order to navigate life outside of prison. This support is particularly critical given that mentally ill releasees tend to receive less support from family members relative to other former prisoners and rarely have private insurance or Medicaid benefits to fund medical treatment (Mallik-Kane & Visher 2008). If mentally ill individuals experience delays in medications and medical care, they can pose a risk to themselves and the communities in which they live. Indeed, a released prisoner's unmet need for mental health services and treatment often directly precipitates arrest (Bazelon Center for Mental Health Law 2001).

Individuals with mental illnesses are likely to also have other illnesses, including histories of substance use; in fact, two in five men and three in five women released from prison reported a combination of physical, mental, and substance abuse problems (Mallik-Kane and Visher 2008). Substance abuse often co-occurs with mental illness, with estimates suggesting that three in four state inmates with a mental illness also have a substance abuse or dependence problem, compared to a little over half (56 percent) of state inmates without a mental problem (James and Glaze 2006).

Individuals with triple diagnoses (often mental illness, substance abuse, and HIV/AIDS) will also require particular attention, as the complexity of drug interactions becomes even more severe in triply diagnosed than in dually diagnosed patients (McKinnon, Carey, and Cournos 1997 as cited in Hammett et al. 2001).

Even among those who are otherwise in good health, substance abuse problems can derail a successful transition from prison to the community. Drug use and intoxication are common in the months following release (Visher, La Vigne and Travis 2004), and without sustained advocacy and follow-up, 20 those with substance abuse problems are likely to relapse and engage in other negative behaviors (Gaynes 2005). Compared to others released from prison, substance users were more likely to engage in criminal behavior and to be reincarcerated in the year following their release (Mallik-Kane and Visher 2008).

When an inmate returns to the community, they will need a positive support system in place that encourages a healthy lifestyle, positive behaviors, and self-sufficiency. Whether an individual has a family member, friend, or mentor to aid them at the moment of release, no one should leave prison without someone immediately available to support them (National Academies 2007). This support is usually best when it comes from family members, as the strength of family support directly predicts an individual's success upon release in areas such as employment, housing, and abstinence from illegal activities (Nelson, Deess, and Allen 1999) and many prisoner report that family support is the most important thing in keeping them out of prison (Visher and Courtney 2006).

Even fragile families, though not ideal, can provide crucial resources upon release, such as housing, medication management, crisis intervention, and feedback to probation and parole (Family Justice 2006). A supportive family may also steer former prisoners away from both illegal activities and the people who engage in them (La Vigne et al., 2008).

One of the most important and also underrated parts of the issue at hand is the care for inmates suffering from mental problems, not only during their imprisonment but also after it. This part of an inmate's life is one of the most important, since the correct re-introduction to civil society is crucial for the reduction in the probability of re-offense from the side of the inmate. Although this is a two-way street, in which not only the inmate but also society itself need to make steps in order to meet the other half-way, the way that one is stigmatized after a prison sentence, reinforces criminal behavior. This, combined with the vulnerability that comes with mental disease, makes things even harder and creates the exact double stigma that this project sailed out to combat in the first place. Moreover, correctional facilities play a vital role in communicating and continuing mental health care for inmates. Especially in the cases where the prison environment triggered or fostered the development of mental health problems, it is extremely important for prisons to act as providers of mental medical history to outside organizations and institutions that will take on the mental health needs of inmates. Thus, the last section of the questionnaire is focused on existing practices regarding this aspect of after prison life, the provision and knowledge of such institutions and their structure and function.

When asked to respond on whether there is an assessment procedure after release, only 30% of the participants to the AWARE research answered positively, while 35% answered that there isn't any and another 30% that they do not know. This uncertainty and confusion is also evident in the next question, regarding the existence of a plan to return to communities created for ex-inmates after release. In this case, 30% prison workers answered that this was the case sometimes, 22% never and 17% always. These answers showcase a lack of informed opinions or a confusion regarding the existence and definition of such organizations. However, when inquired on whether they know where to send inmates after their release in regard to their mental health issues, more than half (60%) of participants answered positively. Finally, in relation to the nature of those organizations, participants pointed to NGOs as the go to entities to refer ex-inmates. This contrasts the lack of knowledge or existence of state-run structures with a similar function, thus necessitating the need for NGOs to feel that gap.

References

Bazelon Center for Mental Health Law 2001. “Finding the key to successful transition from jail to the community: An Explanation of Federal Medicaid and Disability Program Rules.” Washington, DC: Bazelon Center for Mental Health Law.

Gaynes, Elizabeth. 2005. “Reentry: Helping former prisoners return to communities.” Baltimore, MD: Technical Assistance Resource Center, Annie E. Casey Foundation.

Hammett, Theodore M., Cheryl Roberts, and Sofia Kennedy. 2001. "Health-Related Issues in Prisoner Reentry." *Crime & Delinquency* 47(3): 390 - 409.

James, Doris J., Lauren E. Glaze. 2006. “Mental Health Problems of Prison and Jail Inmates.” Bureau of Justice Statistics Special Report. Washington, DC: U.S. Department of Justice.

La Vigne, N., Davies, E., Palmer, T., & Halberstadt, R. (2008). *Release Planning for Successful Reentry: A Guide for Corrections, Service Providers, and Community Groups*. Urban Institute: Justice Policy Center. https://www.urban.org/sites/default/files/publication/32056/411767-Release-Planning-for-Successful-Reentry.PDF

Mallik-Kane, Kamala, and Christy Visher. 2008. “Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration.” Washington, DC: The Urban Institute.

Nelson, Marta, Perry Deess, and Charlotte Allen. 1999, September. “The First Month Out: PostIncarceration Experience in New York City.” New York, NY: Vera Institute of Justice.

Visher, Christy, and Shannon Courtney. 2006. “Cleveland Prisoners' Experiences Returning Home.” Washington, DC: The Urban Institute.

Visher, Christy, Nancy G. La Vigne, and Jeremy Travis. 2004. “Returning Home: Understanding the Challenges of Prisoner Reentry.” Washington, DC: The Urban Institute.

Multiagency cooperation to support the (re) integration of inmates

Coordinated multi-agency strategies are widely viewed as the most successful method to facilitate mental wellbeing, even within the correctional system (Penal Reform International [PRI] & Prison Reform Trust [PRT], 2020). An inclusive approach will increase information sharing processes and decision-making actions. Prison staff can play a decisive and critical role in anticipation of mental illnesses and so improve the wellbeing and welfare of prisoners (United Nations Office on Drugs and Crime [UNODC], 2009). It is also crucial for all organisations dealing with prisoners to interact effectively and efficiently with each other (PRI & PRT, 2020).

However, access to specialised mental health staff in prison is often limited by lack of resources and few links to community-based mental health facilities. Most participants in the AWARE survey of staff working with prisoners reported negatively when asked about gaining procedural instructions to deal with mental health cases. They identified a lack of proper training on a formal level from the side of the prisons/organizations and the lack of implementation of it on earlier academic training curricula related to prison work. Interestingly, when asked about who a prisoner is more likely to turn to in times of need, most prison workers said the prison psychologists or other medical/ social support staff. When we asked prisoners the same question, a significant majority unequivocally referenced family and friends as their primary contacts for mental health concerns.

> Which group do prisoners themselves say they are most likely to turn to?
>
> 82% said family or their partner
>
> Which group do people who work with prisoners think prisoners are most likely to turn to?
>
> 92% said psychologists/ social support staff in prison

Prison staff are not trained to adequately address prisoners' mental health needs, yet rates of co-existing mental health and substance misuse problems are known to be high among prisoners, and drug use is among one of the primary issues faced by prison systems (Stöver & Kastelic, 2014). Prisoners with comorbidity of mental and physical health disorders have diverse requirements needing a thorough, organised, integrated, multi-agency approach (NHS England Health & Justice Commissioning, 2018). Prisons, community services, mental health organisations, and the voluntary sector must work effectively together to comply with such requirements (Clinks, 2019).

> "Multi-agency cooperative service arrangements with general hospitals, emergency services, psychiatric facilities, community mental health programmes, and substance-use programmes]should be established]" (Konrad et al., 2007, p. 118)

Prisoners might already have been in contact with mental health services prior to sentencing: in one Prison Reform Trust study, this was the case with around a quarter of female prisoners and around one sixth of male prisoners. Yet, only 30% of prison staff in our AWARE survey said they would have a return to community plan in which mental health was routinely considered. 60% of respondents, however, knew

where to send inmates after their release in regard to their mental health issues, most frequently identifying community organisations and NGOs as the go-to entities to refer ex-inmates.

UNODC recognises that prison staff should work collaboratively with community agencies who are experts in the needs of certain groups, in order to tailor programmes to their specific needs, making them more productive and easing continuity of care upon release (UNODC, 2009). Subsequently, probation staff will be engaged in further progression of treatment by certifying prisoners' involvement in therapeutic communities, counselling, or community health services (Møller, Stöver, Jürgens, Gatherer, & Nikogosian, 2007). These ties to partner organisations will help guarantee that the mentally ill continue to receive the care they need upon their release (PRI & PRT, 2020).

Activity

Family support groups help families with a member in prison to face the numerous challenges including financial hardship, relationship breakdowns, anxiety and mental health issues. This also ensures that the family will be able to visit their relative in prison, to support them during their sentence and to still be there for them on release. This activity aims to show one approach to supporting families outside also supports prisoners inside, and has been shown to reduce the negative consequences and reduce the likelihood of committing crime again.

Families Outside https://www.familiesoutside.org.uk/ provide extensive support for family members to feel comfortable as possible visiting prison and to anticipate the mental health issues associated with a prison sentence. They provide practical support with housing, income support, parnting, schooling and education. The support is both face-to-face support and via a 24 hour helpline. They also provide tools, resources, and training to individuals and groups who come into contact with families affected by imprisonment: prison staff and social workers, health care professionals and teachers can all attend training sessions to increase the awareness of the issues and challenges faced by families and ensure that they continue receive the support they need.

Listen to family members of three prisoners tell their story about how they became involved with Families Outside, and what help they were: https://www.familiesoutside.org.uk/families/family-stories/playing-our-part/

- Do you have a family support network either in prison or in the community near your prison?
- Do you think prisoners and staff would benefit from this network? How/ Why not?
- If you wanted to set up a network of this kind, what challenges and opportunities can you already see? How could you overcome the challenges and make the most of the opportunities?

Multi-agency approaches in criminal justice in Europe

Multi-agency cooperation provides an array of valuable information from prior to conviction, during sentencing and afterwards, that can be crucial for the rehabilitation process to keep them away from criminal behaviour (RAN P&P, 2016). AWARE respondents too highlighted the important fact that some offenders do not stay much time in prison, and this is where multi-agency cooperation is vital, they work

to ensure that the work that started in the Prison or/and Probation Services is continued 'through the gate' by other agencies and society. The Prison and Probation services are often considered to be primarily responsible for minimising the prisoners' chance of recidivism and maximising their chances for a well-succeeded reintegration. However, this responsibility also belongs to different organisations in society (e.g., judiciary organisations, police, intelligence services, municipalities, housing associations, social work, etc.) (RAN P&P, 2016).

Sweden has examples of effective cooperation (e.g., Dynamic Security and Prison Intelligence, Local work on probation in Halland Västra Gätaland) between prison and probations services and with municipalities and community organisations. However, this is not common across Sweden nor in all EU Member States. Many Member States admit that there is a gap between prison and probation services that do not allow this multi-agency cooperation in the first place, and therefore, hinders the cooperation with community/external organisations (RAN P&P, 2016).

Therefore, and as a solution to this issue, some guiding principles and good practices were developed to establish a multi-agency cooperation approach (RAN P&P, 2016):

1. Trust and personal relationships: identified as key for an effective multi-agency approach. Trust is built when people try to know each other, know their interests, and understand their needs.
2. The need for information sharing agreements/framework: it is essential to make a distinction between classified information that cannot be shared and sensitive information that can be prudently shared. This information sharing can be vital for the development of prison and probation professionals daily work, but also to community organisations' professionals to continue the work "outside the gates".
3. Diversity in shaping the multi-agency cooperation: when we talk about multi-agency collaboration, we cannot have a "one size fits all" approach. Each Member State should develop its strategy, based on the criminal justice infrastructure.

Data and best practice

Title of the programme	Project Link (Lamberti, 1999)
Introduction	The Project Link was developed by the Department of Psychiatry of the University of Rochester (U.S.A.) along with a partnership of five community organisations that served the inner-city population. This project was committed to the prevention of recidivism and hospitalisation of people with serious mental illness, as well as the promotion of their reintegration into society. The project has established crucial links between health care, social service, and criminal justice

	systems. This coordinated effort of several agencies was necessary to tackle the numerous issues of this high-risk target group.
Aim of the programme	The key purpose of Project Link was to help individuals with mental illness following their release from prison or hospitalisation, through institutional-based and community-based programmes.
Method and Design	Project Link employs a multidisciplinary collaboration, which they characterised as the mobile treatment team, that consisted of a forensic psychiatrist, a dual diagnosis treatment residence, and multicultural staff. The inclusion criteria for the participants were the presence of severe and persistent mental illness, and a history of involvement with the criminal justice system. For clients with chemical dependence, a treatment residence was developed. Multi-agency cooperation between judges, public defenders, prison staff, probation staff, social service staff and healthcare staff helped in the engagement of the target group. After treatment, participants filled in a satisfaction assessment survey for the improvement of the project's performance.
Results	The main results of this project were the decreasing number of individuals with mental health problems in prisons, as well as the number of people transferred to psychiatric hospitals from prisons. Additionally, participants stated that this project helped them reduce their use of drugs and alcohol.
Discussion	Project Link has made a substantial contribution to decreasing imprisonment among this highly vulnerable group of persons with severe mental illness. Consequently, this project has been applied by the Monroe County Office of Mental Health as a standard for other programmes that serve similar target groups in danger of being arrested or detained. One of the innovations of this project was the creation of links between several organisations that worked together to achieve better results.

Acknowledgements and references	Lamberti, J. S. (1999). Prevention of jail and hospital recidivism among persons with severe mental illness. *Psychiatric Services*, *50*(11), 1477–1480. https://doi.org/10.1176/ps.50.11.1477

References

Clinks (2019). *Whole prison, whole person. How a holistic approach can support good mental health in prison.* London: Author.

Konrad, N., Daigle, M., Daniel, A., Dear, G., Frottier, P., Hayes, L., & Sarchiapone, M. (2007). Preventing suicide in prisons, Part I: Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons. Crisis: *The Journal of Crisis Intervention and Suicide Prevention*, 28(3), 113-121.

Møller, L., Stöver, H., Jürgens, R., Gatherer, A., & Nikogosian, H. (2007). *Health in prisons. A WHO guide to the essentials in prison health*. Copenhagen: WHO Regional Office for Europe.

NHS England Health & Justice Commissioning (2018). *Integrated mental health service for prisons in England service specification*. London: Author.

Penal Reform International (2018). *Mental health in prison: a short guide for prison staff*. London: Author.

Penal Reform International and Prison Reform Trust (2020). *Women in prison: mental health and wellbeing A guide for prison staff*. London: Author.

RAN P&P (2016). *Working group meeting – Multi-agency cooperation*. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-p-and-p/docs/ran_p-p_multiagency_cooperation_around_radicalised_offenders_stockholm_24-25022016_en.pdf

Stöver, H., & Kastelic, A. (2014). Drug treatment and harm reduction in prisons. In L. Møller, G. Galea, & C. Udesen (Eds.), *Prisons and health* (pp. 113–133). Copenhagen: World Health Organization.

United Nations Office on Drugs and Crime (2009). *Handbook on prisoners with special needs*. New York: United Nations.

AWARE Training – the implementation

Participants profiling

Participants enrolled in an AWARE training programme or activity should present an interest in gaining new knowledge and/or develop skills on how to recognise mental health issues of prisoners and how to better provide support and mental health care as part of their role in the prison context. Prior to the implementation of the training, a need analysis should be conducted in order to identify expectations in terms of training delivery and ensure that participants start the training from a similar starting point, regardless of their previous knowledge on the topic and their role in assisting prisoners with mental health issues.

In terms of learning outcomes, it is expected that participants who attend the AWARE training will gain better knowledge and understanding on why mental health issues are important and how to:

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

The participants involved in the AWARE training should have the following pre-requisites

- to work in the Correctional Justice System or in cooperation, having a role in supporting (ex) prisoners with mental health issues
- to have the ability of working in a team
- to have the motivation necessary to learning new things
- to actively engage in learning activities about mental health

The AWARE training is addressed to all staff from the correctional justice system and who are in contact with prisoners or ex-prisoners. According to Paton's scheme (2004), explained in the Introduction of this manual, the first level of intervention in mental health issues refers to recognising mental health problems and suicide risk. The job roles and positions might differ from country to country or type of institution, but essentially the following are amongst the most common job roles:

- prison guards/officers
- educators
- social workers
- teachers
- chaplains
- medical doctors
- medical nurses
- psychologists

- probation workers

While extremely meaningful, prison staff might be reluctant in engaging with training on mental health issues. This can be as a result of lack of awareness on the subject, lack of interest or simply practical barriers to accessing training. There are almost as many barriers to learner engagement as there are benefits, but they can be eliminated with a few smart learner engagement strategies. Trainers who deliver the AWARE training can follow some general tips to increase the engagement and motivation of their trainees:

1. Set clear learning goals
2. Make learning convenient
3. Get creative with course content
4. Use on-the-job training and relatable simulations
5. Reward trainees for engagement

Training course plan

The AWARE training is designed to be delivered over the course of a six weeks' time. It can be adapted both as a face to face training, online or blended learning approach. In the context of COVID-19 restrictions, and depending on the national prison situations, any form of digital training is encouraged to engage as many participants as possible and ensure safety of prison staff involved. However, irrespective of the means and form of delivery, one group activity every week should take place, either it is organised under the form of an online webinar or classroom activity. The rest of the training activities can be implemented on e-learning platforms or systems which are most at hand for the training organizers. The weekly activities might include discussions, exchange of materials and information, self-study and support from training facilitators.

The **learning objectives** of the AWARE training are to:

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

The **competences** developed by participants during the AWARE training include the following:

- **Mental illness knowledge & Suicide risk assessment:** recognise when someone has symptoms of mental distress/disorder and/or is at risk of suicide
- **Interpersonal skills:** reach out and engage in a supportive relationship
- **Suicide awareness:** estimate level of risk
- **Management of distress and appropriate attitude:** Attend to the person's pain and distress

- **Management of mental health issues:** work with the person to promote their immediate safety; address and contain those aspects of the current situation affecting health and safety
- **On-going management and support:** facilitate links with family (if supportive), friends, peer supporters, professional help

When planning the delivery of the AWARE training, facilitators could make use of the **guidelines** below:

Training related area	**Requirements**
Overall level for all prison staff	Training should be at an appropriate level. They often have appropriate attitudes, skills and ability but do not realise it – need to contextualise this Content needs to allow individuals to develop an awareness and allow prison staff to gain confidence in their knowledge, skills and attitudes
Overall context of training for all prison staff	Training must embed learning in the prison context by using appropriate language and examples Content should have specific prison examples and use prison language
Overall delivery of training for all prison staff	Clear presentation of material - Aided by handouts and accompanied by interactive training instruments Different methods of delivery used, including role-plays, case discussions and vignettes.

The schedule of the AWARE training can be structured as follows:

- Week 1 – Introducing participants to the topic of mental health awareness
  - Including understanding mental health, mental health promotion, challenging attitudes;
- Week 2 – Module 1. Mental health awareness in prison
  - Mental Health Awareness – including mental illness knowledge, mental and physical health awareness, management of mental health issues, referral processes, interpersonal skills, management of distress, care planning. Main mental health issues addressed included those most frequently encountered in prisons: anxiety, depression, bi-polar disorder, psychosis and schizophrenia, comorbidity and dual diagnosis and personality disorders
  - Suicide and Self-Harm – including interpersonal skills, suicide risk assessment, suicide awareness, management of distress, care planning, practice assessment tool.
- Week 3 – Module 2. What could / should I (or my colleagues) do as a non-experienced professional/ volunteer?

  - Using AWARE data to show how identifying, assessing and ongoing treatment of non-clinical mental health issues is a part of what we already do, and how inmates see the support of different staff groups. Case studies illustrate best practice.
- Week 4 – Module 3. What resources do I have?
  - Go heavily into data and best practice which supports a) that small changes can make huge differences b) that the prison is a team, with many resources, and is more effective when it pulls together.
- Week 5 – Module 4. Mental Health as a primary key to (re)integration
  - Highlight AWARE data and case studies which show which resources inmates rely on release, why and how a joined up approach to multiagency support in identifying the right care, making the right referrals and integrating the family/ outside groups in mental health care will help him/her to stay out of the criminal justice system.
- Week 6 – Feedback and evaluation
  - Questionnaires, discussions and practical activities developed to perform an in-depth evaluation of the training. These are meant to assess trainee's attitudes towards the following:
    - Methods of delivery
    - Previous knowledge and experience of mental health
    - Satisfaction with each module and area covered in the package
    - Overall length and logistics of the training days
    - Confidence in being an assessor or mental health liaison officer and how much the training prepared them for that role
    - Confidence in putting the training into practice
    - Overall issues and concerns with the training package

The lesson plans below are examples on how to deliver practical sessions within the AWARE training. These lessons can be used implemented as such or adapted according to the needs of the trainees and context of training.

Title of activity 1	Suicide prevention
Suggested timing	1 hour
Materials and resources needed	Blackboard or flipchart
Learning outcomes	
• List three characteristics of potentially suicidal inmates. • List the four steps, in order, which staff must take in responding to a suicidal inmate. • List two steps used in monitoring potentially suicidal inmates.	

Methodology

Begin the session by informing participants that you will be talking about inmate suicide prevention in prisons. Each of us shares three responsibilities with respect to suicide prevention:

- We must be able to recognize warning signs that tell us inmates may be considering suicide
- We must be able to respond correctly to suicidal behavior.
- We must follow-up on and monitor inmates who have been identified as potentially suicidal.

Before giving you some basic information about suicide prevention, I would like you to answer some questions about suicide. You will not have to turn your answers in. (use the pre-test) in the handout section.

If you haven't completed the pre-test, continue working on it. During the rest of this session, we will talk about the correct answer to each of the questions.

I. IDENTIFYING SUICIDAL INMATES.

Do you remember the three responsibilities we all share concerning suicide prevention?

DISCUSSION GUIDE:

Ask interactive questions and encourage discussion.

They were:

- recognize
- respond
- monitor, follow-up

What information can help us recognize a suicidal inmate?

DISCUSSION GUIDE:

Write student answers down on the flip chart. Probe for responses that loosely fit the next overhead. After two or three minutes, or when student responses begin to drop off, continue with the lesson plan.

All of the areas you mentioned can be useful in helping us recognize suicidal inmates. To help organize our discussion, we will talk about the following areas as they relate to suicide:

- Incidence
- Frequency
- At-Risk Groups
- Method
- Inmate History
- Inmate Behavior

Adolescents are an at-risk group. Adolescents may not have well developed support networks or coping skills to handle the crises they face. Middle aged or older single males may experience the erosion of relationships, reduced support from others and unfulfilled expectations. The elderly may fear becoming dependent upon others. All of these stresses, coupled with reduced support and coping skills may lead to a higher incidence of suicide for these groups.

Traditionally in corrections, newly arrested inmates have been identified as a high risk group. Inmates who are serving longer than average sentences, and who lose important outside relationships are at an at-risk group. Knowing an inmate falls into one of these at-risk groups help us pay closer attention or ask the right questions. We also may benefit from knowing how and when suicide occurs.

INSTRUCTOR'S NOTES:

Information on the method, where in the institution they occur and time they occur should be gathered from the statistical office and presented here. Point out that this also is the answer to questions 1 and 2 on their pre-test.

- Where (segregation, housing units, hospital)
- When (time of day or night -- in the U.S. prisons, for example, 48% occur from midnight to 5 a.m.)

All of these kinds of information help us generally to take suicide seriously, to focus our attention on special groups who have higher risk of committing suicide, and to try to control inmate behavior through increased watchfulness. While this information is useful in recognizing potentially suicidal inmates, not every suicidal inmate will fit the typical pattern. For this reason, two other kinds of information can be of help to us.

- Inmate History
  - Previous Suicide Attempts
  - Loss of an Important Person
  - Stress
  - Mental Disorder
  - Medical Status

The answer to question 3 is a.

Each of these factors increases the risk that an inmate may be suicidal.Previous history of sui cide attempt, recent loss of a significant other, or other major stressful event make sense as contributing to suicide risk. The existence of a mental disorder or medical impairment such as HIV+ or AIDS may contribute suicide risk since the inmate's ability to make clear judgements and use effective coping skills may be reduced. Knowing about an inmate's history helps us pay closer attention to changes in mood, changes in behavior or veiled statements which may indicate the potential for suicidal behavior. Observing his or her behavior can help us further identify suicidal inmates.

- Inmate Behavior

- Symptoms of Depression
- Changes in Behavior
- Suicidal Thoughts
- Plan
- Resources

The answer to question 4 is f, all of the above. We will go into some detail on the first two areas: symptoms of depression, and changes in behavior.

- Symptoms of depression may include:
  - sleep problems
  - loss of appetite
- Behavior:
  - moodiness
  - Fatigue
  - expression of helplessness
  - loss of hope
  - withdrawal
  - suspiciousness
  - expressions of guilt
- Changes in behavior that may occur prior to a suicide are:
  - withdrawal from friends
  - suspiciousness
  - "saying goodbye"
  - giving away property
  - hoarding medication

Plan and Resources refer to whether an inmate has identified a specific way that he or she may attempt suicide, and whether he/she has access to the gun, medication, knife, bed sheet that is intended to be used in the suicide.

Knowing common symptoms or behaviors of suicidal inmates helps us recognize a potentially suicidal inmate.

To summarize, each of us is responsible for helping to identify potentially suicidal inmates. Our ability to recognize these inmates is increased if we know the basic information we just covered.

RESPONDING TO SUICIDAL INMATES

Let's assume that an inmate fits the pattern we have just described, and that his or her behavior tells us that the potential for suicide exists. How should we respond?

DISCUSSION GUIDE:

Write student answers down on the flip chart.

General Staff Responses

Basic Responses --

- Listen and Hear
- Take though and feelings seriously
- Be affirmative and supportive
- Refer to: Shift Supervisor, Unit Manager, Psychologist or Medical Professional

The first three responses are good communication skills. As an inmate talks about suicidal feelings, it is important to give our undivided attention, and not to dispute or ignore his or her claim that they are feeling suicidal. The answer to question 5 is b. We should not try to minimize the inmate's statements about thinking of to worry so much, or that many people think of suicide. When you think that an inmate is potentially suicidal, who would you inform? Or, to whom would you refer the inmate.
DISCUSSION GUIDE:

Write student answers down on the flip chart. As students respond, point out that sometimes it may be appropriate to talk to your supervisor before making the referral (e.g. Segregation), and at other times, a direct call to the Psychologist or Medical department should be made immediately. After two or three minutes, or when responses begin to drop off, continue the lesson plan.

Let me emphasize something here:

Don't fail to respond. Notify your supervisor as appropriate and then, make the referral. Let the Psychologist or Medical Professional evaluate the risk of suicide and make the decision about whether a suicide watch or other intervention is needed.

Advanced Responses --

- Ask directly about thoughts of suicide.
- Make a contract where appropriate.

In your role as a correctional worker, you may get to know some inmates on your work detail or in your unit pretty well. In cases where you know an inmate, it may be appropriate to ask an inmate to clarify why they are feeling down, or if they are thinking about suicide. The answer to question 6 is b. Sometimes inmates will talk openly about their feelings and thoughts with their work supervisor, unit staff or correctional officer when they would not be as open with other inmates. Asking about suicidal thoughts or talking with an inmate about suicidal feelings will not prompt an inmate to commit suicide.

Making a contract with an inmate may also be helpful. Let me use two examples to illustrate what I mean by a contract. First, you may ask for the inmate's word that he or she will come to talk to you before acting out a suicidal feeling. Another example might be to get the inmate to agree to wait for a certain number of hours or days before taking any action on a suicidal feeling. Obviously, contracts require trust, and we can't rely on them completely to reduce the risk of acute suicide. Contracts can

reassure an inmate that we are here to help. At times, a suicidal inmate may feel relief when they agree to put off acting on a suicidal impulse for specific period of time.

Both of these advanced skills are just that, advanced. If you do not feel comfortable trying them, don't. Just be sure that you have made the appropriate referral and that you are using the basic skills we described earlier.

MONITORING -- FOLLOWING-UP ON SUICIDAL INMATES.

Monitoring and Follow-up

- Evaluation
- Suicide Watch
- Inmate Companions
- Return to population
- Continued observation

After you have referred the inmate a Psychologist or Medical Professional will evaluate his or her suicide risk using many of the concepts we have just discussed. If the inmate is viewed as an acute suicide risk, a Suicide Watch will be started. A watch can last several hours to several days, depending on the inmate's intent to harm himself.

The answer to question 7 is a, true. Inmate Companions may be used to help watch a potentially suicidal inmate. These inmates would rotate in shifts and would be required to observe the potentially suicidal inmate until the watch is over. They are not placed in the cell with the suicidal inmate. In our institution, we do (do not) use inmate companions.

Following a Suicide Watch, an inmate is typically returned to general population or other pre-watch status. Often, other inmates may have heard that the inmate was suicidal. As an inmate returns to the general inmate population, it is our responsibility to be supportive and to help the inmate retain as much dignity as possible. Staff should not share information about an inmate's emotional issues with other inmates. We should not respond to prying questions which other inmates may raise.

The risk of suicide is not over when the Suicide Watch ends and the inmate returns to population. The answer to question 8 is e, days, weeks or months. Inmates who have been acutely suicidal may continue to have thoughts of suicide for quite some time. For this reason, continued monitoring must occur. Usually a Psychologist or Medical Professional will meet with the inmate regularly. There are some things that all of us can do that will help the monitoring and follow-up process.

How should staff continue to monitor an inmate who has been identified as previously suicidal?

DISCUSSION GUIDE:

Write student answers down on the flip chart. End after two or three minutes, or when student responses begin to drop off.

All of your suggestions are helpful. If I could offer you some guidance, I would recommend that you go back to the model we already have seen:

- Basic responses
- Advanced responses
- Referral (as needed)

CONCLUSION

In conclusion, let me remind you that each of us has three responsibilities where suicidal inmates are concerned. Those responsibilities are:

- We must be able to recognize warning signs that tell us inmates may be considering suicide.
- We must be able to respond correctly to suicidal behavior.
- We must follow-up on and monitor inmates who have been identified as potentially suicidal

Guidelines for assessment

Have trainees complete the test at the end of the lesson. Check the answers together.

Reference material / handouts

Preventing Inmate Suicides test

Please answer the following questions about inmate suicide. You will not be asked to turn your answers in. Answers to these questions will be covered during this training session.

1. In prison, most suicides occur in:

a) Segregation
b) Regular housing units
c) Mental health units

2. In the prison, most suicides occur:
    a. Just after 4 p.m.
    b. Between midnight and 5 a.m.
    c. No specific time
3. Looking at an inmate's history, which of the following increase the risk of attempting suicide?
    a. Previous suicide attempts
    b. Recent loss of an important relationship
    c. Major stress
    d. Mental disorder
    e. Medical disorder
    f. All except e
    g. All of the above
4. Which of the following behaviors indicate that an inmate may be suicidal?
    a. Statements about suicide

b. Symptoms of depression
c. Giving away commissary & other possessions
d. Withdrawal from friends
e. Hoarding medication
f. All of the above
g. All except d

5. One of the best things to do if an inmate tells you he is thinking of suicide is to tell him not to worry so much, many people think about suicide.
   a. True
   b. False
6. You should never ask about suicidal thoughts or talk directly about suicide with an inmate since this may prompt the inmate to commit suicide.
   a. True
   b. False
7. According to BOP policy, inmates may be used to "watch" a suicidal inmate.
   a. True
   b. False
8. After being released from the hospital for a suicide attempt, how long may an inmate's thoughts of suicide continue?
   a) Inmates are not released until all thoughts of suicide are over.
   b) Days
   c) Weeks
   d) Months
   e) b, c, or d

Title of activity 2	Be aware of Ethnic Minority Stereotypes!
Suggested timing	1 hour
Materials and resources needed	Mobile device with internet connection to display the interview
Learning outcomes	
Become aware of the fact that we all deal differently with negative feelings and emotions, that each of us has different ways we would seek help and that we might not recognize one another's mental health warning signs.	
Methodology	
How we deal with our own mental health is deeply linked to how we have been brought up to think about mental health at home, at school and in our wider society. What mental health is and how it is	

treated is understood differently in different cultural contexts. In prison, this could mean that an individual who feels sad, hopeless, traumatized, angry and depressed might be withdrawn or self-harm, and they might be immediately identified by staff as needing professional mental health support. Equally, negative feelings and emotions could result in angry and aggressive behavior from an individual, and so get a very different reaction from staff and inmates around them. As prison support staff, we need to be aware of, and question, our own ethnic minority stereotypes.

In 2017, Right Hon. David Lammy conducted a review into the support and opportunities the BAME (Black, Asian, Ethnic Minority) community receive in prisons in England and Wales. Listen to the conversation he describes with a young black man about access to therapy in prison, and how the system needs to step back, consider and change some of the stereotypes deployed in relation to ethnic minority prisoners.

Transcript of David Lammy on Education, Race and Criminal Justice (10.09.2020), from 24:00 minutes in:

"What is the cultural relevance of what you are teaching them? And that starts at the beginning]of the prisoners' life]: Is there a pupil referral story? Is there a care system story? Are there issues of drugs, alcohol, anger in the home? What, or are there profound issues of trauma? As are appearing unfortunately in parts of communities like mine, where the trauma really is about knife crime, and gang activity. Have they been pimped, effectively, by adults, to run drugs across the country? And therefore, because those adults have badly let them down, what's their response to you]the prison staff] now, as the adult in front of them, that's meant to be empowering them? You've got to understand all of that business.

"I was very struck by a man who was talking about access that he found white prisoners were getting to therapy. I am, by the way, hugely impressed by therapeutic prisons, I wish there were more in our system. But therapy can play a real role for having prisoner who are ready to confront what they have been up to and what they've done and go back and reform.
And this prisoner said, 'look, when the white guy cuts his wrists or… y'know… threatens to kill himself, he gets to see the shrink]psychiatrist] he gets all this support, blah blah blah. Erm, when I do the same, I get nothing.'
And I said, 'Really? I can't believe it, what do you mean when you do the same you get nothing, that cannot be right!'
And he said, 'Well look, I punched the wall the other day, y'know, my hand was set in plaster, you know, I broke some bones. But that wasn't seen as self-harm. It was seen as violence. And I got nothing.'"

Guidelines for assessment

Encourage a discussion around the following questions/guidelines:

- Do you recognize a need to think about cultural stereotypes and mental health in your prison? Why?

• Which minorities are most prevalent in your context? What resources do you have to help your staff learn more about how mental health is dealt with in these cultures? (such as staff members who represent ethnic minority groups, local community organisations etc.) • Using this timeline, make an action plan.
Reference material
https://www.prisonerseducation.org.uk/2020/09/in-conversation-with-david-lammy/

Title of activity 3	Mental Health Focus Groups
Suggested timing	1 hour
Materials and resources needed	A mobile device or handouts with the focus group method
Learning outcomes	
Show one way to set up and maintain a focus group on mental health, which proactively improves how existing resources are used.	
Methodology	
Prisoners who are dealing with hopelessness, trauma, anger, depression, isolation and other mental health issues might find the opportunity to talk to staff about mental health support in prison helps them to stay involved in their own recovery. People with lived experience of mental illness in prison may be able to highlight specific issues with navigate the health- and social-care system, and how they access advice and support at times of crisis. For this group, a regular focus group can be set up, to make sure staff and inmates are on the same page about how mental health problems can be addressed with the resources, which already exist. However, before we describe the focus group method, remember that there are also many other prisoners who would not be able to discuss these issues at all – 40% of prisoners AWARE surveyed do not talk to prison staff because they are afraid about the lack of confidentiality in mental health processes. <u>Focus group method:</u> *Step 1: Talk to your managers about setting up a user-group for mental health issues. Decide on who needs to be in the room from the staff's perspective (might prisoners be intimidated to speak with the governor present? Could the prison doctor attend? And so on), and how regularly you would have the meetings (is just one meeting enough? How about one every six months?).* *Step 2: Make a poster to invite to meetings and talk to prisoners about being involved in decision making.* *Step 3: Develop a prisoner-friendly survey that can be shared, and involve community and faith based services to make sure you are gathering the views of as many prisoners as possible*	

Step 4: Based on the feedback you receive from colleagues, inmates and community groups, develop a set list of around 10 open and non-judgmental questions, which allow prisoners and staff to elaborate on their thoughts or personal experiences. *Step 5: On the day, have a set time of around 1.5 hours, and prepare some drinks and refreshments as a thank-you for attending. As a moderator, ensure all participants have their say. Be prepared to tactfully ask a dominant participant to let others have a say, and to make eye contact with shy participants, or ask them directly for their thoughts.* *Step 6: Feedback to prisoners and to staff on what you learned from the even, and action which will be taken as a result of their feedback. Make sure that you let prisoners know what you are doing (or not doing) with their feedback. Explain your decisions honestly.*
Guidelines for assessment
Use the questions below to guide a discussion among participants • Have you ever conducted a focus group with prisoners and staff at your prison, on any issue? • Would this approach work in your prison? Why/ Why not? • How would you implement this focus group?
Reference material

Title of activity 4	Pairing professionals to listen to the specific mental health needs of specific groups
Suggested timing	1 hour
Materials and resources needed	Mobile device with internet connection
Learning outcomes	
The aim of this activity is to concentrate on these groups of inmates, to look at some good practice and to see if another approach evolves.	
Methodology	
A recent study in America showed that the police often come into contact with people suffering from mental health and substance abuse problems and that there is evidence to suggest that these individuals are concentrated in small geographic units ((Lamb, Richard, n.d.)). Similarly, prison staff often find that inmates with substance abuse issues also have mental health problems, and that these individuals tend to form a group within the inmate population. In this pilot study, police officers were paired with mental health clinicians (psychologists). Together, they spent time with these groups, listening to their issues, to build trust and a connection with people	

who suffer from mental health and substance abuse problems. These police + psychologist 'teams' found that there were more effective ways resources and services could be provided: Police officers had a better understanding of mental health problems, and said they were better able to identify mental health issues and know where an individual could be referred for help. The groups of substance abusers said they had improved perceptions of the police, and that they trusted the police to refer them to drug use and mental health services.
Guidelines for assessment
Encourage a discussion around the following questions: • Do you or could you implement a pilot like this in your prison? Why/ why not? • What would be the challenges? • What would you do with the results? • Could you implement similar 'pairs' of professionals to respond to the needs of other groups in your prison? Think about vulnerable groups, 50+ prisoners, prisoners who are parents, and so on
Reference material

Title of activity 5	The Listener Scheme: training prisoners to provide emotional support to other prisoners
Suggested timing	1 hour
Materials and resources needed	Mobile device with internet connection
Learning outcomes	
The aim of this activity is to give one example of how some prisons are addressing this resource issue, by selecting and training prisoners to become a 'Listener' and provide emotional support to other prisoners.	
Methodology	
41% of AWARE prisoners surveyed said they do not know who to turn to if they are sad or depressed, and every 5th inmate asked said he asked for mental health support but did not receive it: the need for someone to listen to prisoners' mental issues outweighs the trained staff available to support them. About the Samaritans Listener Scheme: Selected prisoners attend an intensive training course. This is based on the training that Samaritans' volunteers undertake but is adapted to the prison setting. On completion of their training, Listeners receive a certificate and agree to follow Samaritans' policies and values. Prisons aim to have enough Listeners available to talk to on the phone, 24 hours a day, 7 days a	

week, for anyone who needs them. Support is given in private to allow complete confidentiality. Even after a Listener has left prison, their work as a Listener must remain completely confidential. Listeners are not paid and do not receive any form of benefit for their role. Listeners receive regular support and meet often with Samaritans volunteers. Listeners can also phone Samaritans at any time to access support. Listen to Linda talking about why she became a Listener in prison, and how this invaluable support worked in her prison.
Guidelines for assessment
Guide a discussion around the following questions: • Do you have something similar to the Listener Scheme in your prison? Do you have any prisoner-run services or activities? • Prisoner-Listeners say that sometimes it is difficult for prison staff to accept what they do, and to see that this is an important service. What would prison staff think of this in your prison? • What other challenges and opportunities do you see with implementing a Listener Scheme in your prison?
Reference material
Listen to Linda talking about why she became a Listener in prison, and how this invaluable support worked in her prison. https://www.facebook.com/uservoiceorg/videos/being-a-listener-in-prisons/1743866642421261/

Title of activity 6	Designated mental health lead for thorough, through the gate support
Suggested timing	1 hour
Materials and resources needed	Mobile device with internet connection
Learning outcomes	
The aim of this activity is to discuss a model of Mental Health Lead and how the role can be applied in the prison context.	
Methodology	
Different organisations use different methods to identify who needs access to mental health care, and how these requests are processed. Prisoners who took part in the AWARE survey said one of their main concerns is that this process in prison is not transparent. In a consultation exercise with young people, students and schools, the UK Department of Social Health and Care developed the model of a Mental Health Lead in schools and universities ("Consultations-	

with-young-people-on-the-green-paper-Transforming-children-and-young-people's-mental-health-provision.pdf," n.d.). Young people felt a mental health lead would have a positive impact on the culture around mental health in the school environment. The people who attended the consultation felt that it was important for all school staff to have a basic level of understanding of young people's mental health, and that having a designated lead would help to encourage this. Young people also said they hoped the mental health lead would be a 'care navigator' who could explain the purposes of different mental health services and interventions to the young person, and help them to understand the process of seeking that help. The lead would also be in a good position to ensure good communication between all professionals working with the young person, both inside and outside of the school, so that young people would not have to keep repeating their story.

They agreed that this role of designated lead as being highly skilled and demanding, and therefore could not be 'tagged on' to a teaching role, but a dedicated role within the school and were concerned about it being 'dumped on' already overburdened teaching staff. Young people felt that if this was to be implemented properly, the post holder should have the proper training, and be well supported in order to carry out their duties effectively. The following text is taken from their outline of this role:

The Mental Health Lead should have authority to:

- Sign young people out of lessons if needed
- Refer young people on to/link with other services outside of the school
- Arrange training for all teachers in basic mental health awareness
- Carry out basic interventions
- Manage a chill out/drop in area for young people to 'take a break'

Have knowledge of:

- Young people and the issues they face
- The local mental health system and how to navigate it
- A range of mental health interventions and how they can work for different people
- Confidentiality and safeguarding procedures
- Young people's rights and entitlements
- The different needs of young people, including race, gender and culture
- Specific barriers faced by certain groups of young people, for example young carers and those in the care system

Have the following attitudes and qualities:

- Respectful
- Non-judgmental
- Non-stigmatizing
- Trusting and trustworthy

- Be a good listener
- Tell you things straight, 'not just what you want to hear'
- Sympathetic
- Relatable

Some of the concerns and questions that young people had relating to this proposal were:

- Will this be properly funded?
- The proposals are not compulsory, what will happen to the young people in a school that does not choose to appoint a designated lead?
- How will the confidentiality of the young person be protected in a school environment?
- How can one person support a whole school, especially in larger schools?
- Young people felt that this should be a separate job in the school as it would be too much additional training, work and responsibility for a teacher to do as well as teach lessons.

Guidelines for assessment

Guide a discussion around the following questions

- Have you ever had a mental health consultation in your prison?
- What do you think about the idea of a Mental Health Lead? Do you already have this role or something similar?
- Would this role be useful in your prison? Why/ Why not?

Look through the four lists of authority, knowledge, attitudes and problems:
- If you don't already have a mental health lead, what would be the same for a mental health lead in your prison? What would be different?
- If you do already have a mental health lead, do you cover all the same duties? How have you approached the problems which the young people identified?

Reference material

Consultations-with-young-people-on-the-green-paper-Transforming-children-and-young-people's-mental-health-provision.pdf, n.d.

Lamb, Richard, W., Linda, n.d. (PDF) The Police and Mental Health [WWW Document]. ResearchGate. https://doi.org/10.1176/appi.ps.53.10.1266