

PRISON DUAL DIAGNOSIS TRAINING PROJECT

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EXECUTIVE SUMMARY

A significant proportion of prisoners have complex needs including substance use problems and mental health problems. This co-morbidity is known as dual diagnosis

The prison services that provide care for mental health and substance use have undergone massive transformations in the past few years. However service developments have occurred in parallel with little focus on the prisoners who need to navigate both services

It is recognised that integrated care is best practice for people with dual diagnosis, and this means that workers should be skilled and competent in providing comprehensive care. It is also recognised that workers in mental health and substance use services lack the skills and confidence to provide this care. This is likely to be the same in the prison service workforce.

Training has been suggested as one possible solution in terms of raising the levels of competence of the workforce and also as a way of facilitating joint working between substance use and mental health.

A training project was funded to develop and pilot training materials for workers in mental health and substance use services within prison service. The training was located in 5 London prisons: HMP Wormwood Scrubs, HMP, Wandsworth, HMP Belmarsh, HMP Highdown and HMP/YOI Feltham.

A training needs questionnaire was distributed. The outcome was that people didn't seem to use a particular framework for dual diagnosis; they mostly referred prisoners with dual diagnosis to other services and felt they needed a training course that was wide ranging and general.

Service users were consulted about their perception of worker training needs. They felt that services should be able to offer more talking therapies, be more understanding and non-judgemental, and be able to work with people at whatever

level of motivation they are at, rather than expecting everyone to be ready for change.

Two methods of training delivery were piloted; a classroom based 5 day training course, and a “blended Learning” method that involved a workbook to be completed at work, and 3 supervision sessions of 2 hours each.

The training manual was evaluated positively and people made a number of useful comments about the development of this. Service users were also very positive about the manual.

The evaluation of the training using a pre and post training questionnaire revealed that there were significant improvements in attitude and confidence in own skills after exposure to the manual and either training, or the supervision sessions in the blended learning method.

However there were a lot of negative comments about the practicalities of the blended learning method. People felt that they didn’t have time to complete the exercises or do the designated reading between supervision sessions. People in the blended learning stated that they would prefer a 5 day classroom style course.

People made the comment that it was very useful to have mental health and substance use staff together for the training, and people felt that they learnt a lot about each others’ roles and how they could work together more effectively in the future.

Recommendations from the project include a larger scale research project to evaluate the training (in particular its impact on clinician skills and capabilities), dissemination of the training in a national project with a “train the trainers” course; development of ongoing learning opportunities within prisons such as forums, supervision and access to learning materials such as internet, journal articles, policies etc; and finally strategic development of the training pack to dovetail with other prison training initiatives.

BACKGROUND/ POLICY CONTEXT

Over the past 7 years, the NHS (as well as other care services) has undergone a huge modernisation programme. Mental health services have been identified as one of the main priorities for improvement. The two main policy drivers for mental health services have been the NHS Plan (DH, 2000) and the National Service Framework for Mental Health (DH, 1999).

The NHS Plan outlined a vision of improving services by reducing the burden from the inpatient services. This is to be done by strengthening and diversifying community services. This has manifested itself in the implementation of new services such as Early Intervention for Psychosis services, Home Treatment Teams, and Assertive Outreach. In addition the government made a promise to increase access to psychological therapies and provide 10,000 new psychological therapists.

The National Service Framework (1999) set out 7 target areas for improvement in mental health, including mental health promotion, primary care, prevention of suicide, and services to support carers. The policies proposed that service users are treated with dignity, the role and skills of the carer is respected, the most effective treatment is widely available and provision of services should be linked to need. Therefore the most acutely ill have the most urgent access to care, and the people with the most complex needs have the most comprehensive package of care. All this should be delivered by a skilled and motivated workforce and based on sound evidence.

The new ethos in the NHS is about developing the capabilities of the workforce to meet the targets of the NSF. The focus is now on the skills required to do a job, not on the professional background of the employee. This has led to the diversification of traditional roles (e.g. supplementary prescribing for nurses) and the creation of new roles (graduate mental health workers in primary care).

The Knowledge and Skills Framework (KSF) (DH 2003) has set out the competencies required for different levels of working for all NHS staff (not just mental health). Job descriptions are now based on KSF competencies and people will be

assessed on their performance using the National Occupational Standards (NOS) for Mental Health (DH, 2004). Workers will be able to progress in their career by demonstrating the acquisition of advanced level skills and competencies (the Skills Escalator). In addition to this is the 10 Essential Shared Capabilities (ESC) Framework which sets out to identify core values and capabilities that all staff in mental health services should possess (DH/ SCMH 2004).

In the National Service Framework for Mental Health: Five Years On Report (2004) there is concern that despite a series of policies proposing improvements in mental health care and a huge investment in pre and post registration training, there has yet to be a universal change in the skills of the front line mental health staff and “much of training provided is unproven” (Bailey et al, 2003). There is limited research into effectiveness of skills training in mental health; in general the findings suggest that training can produce change in practitioners, but there are also numerous barriers that hamper this (Brooker and Brabban, 2005). These include heavy case-loads, lack of support from colleagues and managers for the new ways of working, and lack of appropriate supervision.

These limits to capabilities in front line staff have driven the development of the Ten essential Shared Capabilities (10 ESC's). This is a framework of 10 fundamental capabilities that all people should be able to demonstrate no matter what their role in mental health care. They apply as much to volunteers and service user consultants as well as highly skilled senior professionals. A training package has been developed and piloted for the 10 ESC's and it is being disseminated nationally. In addition to this, a number of advanced modules of the 10 ESCs are currently being developed, including dual diagnosis.

PRISON MENTAL HEALTH AND SUBSTANCE USE SERVICES

Mental health policies should apply just as much to the standard of care of prisoners as well as those in the general population – this is the so-called principle of ‘equivalence’. Prison mental health and substance use services have been undergoing huge transformations in the past few years. The main change is in how services are commissioned and funded. From April 2006 all prison mental health

care will be commissioned and managed by the NHS as opposed to the prison service. This process is almost complete. The Primary Care Trusts are expected to assess the local need for both the general population and the population of the prisons in their catchment area and commission services and workforce development initiatives to meet these needs. In addition PCTs now have a statutory responsibility to work in partnership with other key agencies (police, probation, housing etc) in the Crime and Disorder Reduction Partnerships (CDRP) (implemented by the 1998 Crime and Disorder Act). This is in recognition that reducing re-offending requires a multi-agency approach, and that improving access and quality of health and social care services, as well as improving links between prison and community, will have a positive impact on reducing re-offending.

Changing the Outlook (2001) was a joint policy document from the Department of Health and Prison Service which sets out the vision for modernising prison mental health services over 3-5 years in line with the NHS plan (2000) and the NSF for mental health (1999). One of the biggest changes to prison mental health services has been the establishment of in-reach mental health teams. Their function is to provide equivalent “community mental health care” within the prison. The aims were to reduce the use of the inpatient health care beds in prison, and to provide care in the day services, and on the wings.

The Sainsbury Centre for Mental Health (SCMH) (2006) has recently reviewed London prison in-reach teams. They report that the implementation of in-reach services is a challenge as prisons are overcrowded, there is a high level of mental health needs amongst the prison population and prison staff lack skills and confidence in working with mental health issues. This has led to in-reach teams being overwhelmed with referrals from other services. Clearly, the prison environment does not equate to the general community. Prisoners are not always accessible for security reasons, and may be relocated suddenly or released after a court hearing. This makes the provision of consistent mental health care more difficult.

SUBSTANCE USE SERVICES

With the implementation of the Clinical Guidelines for Management of Substance Use

problems in prison (PSO 3550), a number of changes have occurred in services for substance users in prison. Detoxification has improved dramatically with the use of clinically effective detoxification methods and the establishment of detoxification services. In addition there is a dedicated substance use counselling service known as “The Counselling, Assessment, Referral, and Throughcare” service (CARATs). This was created in 2001 and each prison has a CARATs team that provide drugs assessment counselling and referral to prisoners with substance use problems. Rehabilitation of Addicted Prisoners Trust (RAPT) is a non-statutory service established to provide 12-step recovery treatment and rehabilitation to prisoners with addictions. They provide rehabilitation and drug counselling in a number of prisons in the UK.

However these services are managed by different agencies and this has led to a lack of coordination leading to inconsistencies of care, ineffective working practices and failure to effectively engage and retain offenders in treatment. Under the Criminal Justice Intervention Programme (CJIP) the aim has been to develop an “end to end” approach from arrest through to sentence and beyond. Twenty five drug action teams covering the areas with the highest acquisitive crimes will be developing a virtual or dedicated criminal justice drug team. An integrated pathway will be identified that clearly maps out the course of treatment for substance using offenders. They will provide tier two interventions such as triage assessment and referral to tier 3 (detox, day programmes, inpatient care); low threshold treatment and prescribing, dedicated aftercare service for released prisoners. (Models of Care for the Treatment of Drug Misusers, National Treatment Agency, 2005)

SUMMARY

- There has been a shift in the NHS towards new roles and new ways of working with an emphasis on the capability of the front line staff to deliver effective evidence based care to meet the standards of the National Service Framework for mental Health. This has led to the development of frameworks that map out the specific capabilities required. However, there are still significant gaps in the capacity of the workforce, and training initiatives such as the Ten Essential Shared Capabilities seek to address this.

- The prison mental health service is undergoing significant change in order to provide equivalent mental health care to prisoners. The aim is for prisoners to have access to the same range and quality of mental health care as those in the general population.
- Substance use services have also greatly evolved in the quality and range of clinical interventions for substance use, as well as the development of the CARATs service and RAPt
- The Criminal Justice Integrated Programme seeks to provide integrated care pathways for prisoners with substance use problems with more consistency of care, and greater working relationships with agencies involved.
- However, there is little mention in all of these initiative about the prisoners who require input from both mental health and substance use services, i.e. those prisoners with a; “dual diagnosis”.

DUAL DIAGNOSIS IN PRISON

A significant number of prisoners in England have at least two mental disorders. Surveys (ONS 1997, 1998) estimate that 90% of prisoners have a diagnosable mental illness, or substance use problem or both. The majority of these diagnoses are personality disorder and substance dependence - typically opiate and alcohol dependence (Maden et al 1995). However there are also significant numbers of prisoners with a range of mild to severe mental disorders and other forms of substance use problems (known as dual diagnosis).

The prevalence rates for all mental health and substance use problems within prisoner are significantly higher than would be expected in the general population. In a general household survey, Singleton et al (ONS 2000) reported that 16.5% of the general population are likely to have a common mental disorder, compared with 40% of male and 63% of female remand prisoners (ONS 1997, 1998). This is about three times as prevalent. 0.5% of the general population are likely to experience

psychosis (compared to prison where the prevalence is much higher at 11%). This is very high considering the fact that people with serious mental illness are supposed to be diverted to secure mental health facilities rather than prison. 5.4% of the general population have some form of personality disorders compared with 50% of sentenced prisoners and 78% of remand prisoners. Drug dependency is substantially higher within the prison population although this is not surprising given the link between substance use and criminality. In the general population 3.7% meet the requirements for drug dependence compared to 34% of male sentenced, and 52% of female remand prisoners. However, alcohol dependency is about the same as the general population. 38% of men and 15% of females in the general population fulfil the requirements for alcohol dependency and in prisons these figures are: 19% of female sentenced, and 30% of male remand and sentenced.

Prognosis for people with dual diagnosis is typically poor and they are likely to have a substantial amount of unmet needs. Areas of vulnerability include suicide, violence, victimisation, health problems (such as blood borne infections), poor adherence to treatment and homelessness. Safer Prisons (2003) reported that 32% of people who committed suicide whilst in prison had two co-morbid diagnoses. Re-offending rates are also high as co-morbid mental health and substance use compound the difficulties (lack of housing, support, access to care etc) associated with release from prison that most prisoners experience. For example, around half of people with mental illness who are released from prison lack stable housing (Revolving Door 2002).

GUIDANCE FOR CARE

The Department of Health in 2002 published a Practice Implementation Guide for Dual Diagnosis which was aimed at people with serious mental illness and substance use, and laid out a vision of how people with combined problems should access services and how they should be cared for. The guide advocates that care for people with serious mental health problems should be delivered by mental health services with some help and support from substance use services. This is referred to as “mainstreaming”. People with primary substance use problems who have concurrent minor mental disorders should be managed comprehensively in substance use services with some support from mental health if required. The implication of this is

that workers in both settings will need to be able to work holistically and comprehensively with each individual with dual diagnosis. Therefore the workers will be expected to be skilled and competent in both mental health and substance use assessment and interventions, and have an adequate working knowledge of the issues pertinent to dual diagnosis.

The care for people with dual diagnosis within prison is also governed by the 2002 Dual Diagnosis Guide. Prison mental health and substance use workers should be able to work together to provide comprehensive care, and should possess the appropriate levels of skills, values and knowledge to be capable of delivering this care. However, there are difficulties with the implementation of the guide as it stands as prison mental health and substance use services do not replicate the configuration of services outside. For instance, there isn't an equivalent of a statutory drug and alcohol service. The community drug and alcohol team plays an essential role in the care of dual diagnosis as well as providing support for other services. They are usually staffed by people with mental health training such as approved social workers and registered mental health nurses. However, the staff in the substance use services in prisons (as well as other prison staff groups) don't have a mental health background nor have had training in mental health issues. This means that they are more likely to refer a person to mental health services rather than attempt to continue to work with them. This issue has been identified in the review of London's mental health in-reach services by the Sainsbury Centre for Mental Health (SCMH, 2006). In the review, in-reach teams felt there was a "big gap" in service provision for dual diagnosis, and stated that mental health and substance use teams tend to refer people on to other services, rather than seek to work jointly. SCMH (2006) suggests that given the high level of co-morbidity, addressing the needs of these prisoners should be core business of the mental health teams, however working with people with complex needs requires considerable skills, yet these skills are lacking in the in-reach teams. Appleby (2005) has also highlighted the fact that care for people with dual diagnosis in general is poor and highlights this as one of the key priorities for improvement in the next five years.

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

framework of interventions. There are two initiatives that are tackling these issues; the first is the development of a dual diagnosis strategy for prisons which is adapting the guidance from the Department of Health Guide and the second is the Prison Pilot Dual Diagnosis Training project which is reported here.

THE PRISON PILOT DUAL DIAGNOSIS TRAINING PROJECT

INTRODUCTION

The prison dual diagnosis training project has been initiated to improve the standards of care for prisoners with a dual diagnosis through the development of training that will help increase peoples' capabilities to deliver effective care, and which will also enable agencies to work more effectively together. This pilot was conducted in 5 London prisons.

AIM

To develop and pilot a set of relevant and effective training materials that will assist mental health and substance use staff in their care of people with dual diagnosis within the prison service.

OBJECTIVES:

1. Engage prison sites to be involved in the project
2. Conduct a training needs assessment of prison mental health and substance use staff
3. To obtain service user perspective on training needs
4. Develop training materials: trainers pack and self-directed learning pack
5. Pilot the use of the packs in prisons
6. Evaluate the training packs
7. Prepare a report with recommendations for the future development of this project.

METHODS

ENGAGEMENT OF PRISON SITES:

The first task was to recruit a sample of London prison sites to act as pilot sites for the training materials. Contact details for health care managers, In-reach team managers, detoxification services, and CARATs teams were obtained from prison mental health leads at the Care Services Improvement Partnership London Development Centre. In addition, some personal contacts at a few sites were followed up. An email was sent to as many prison personnel as possible that included an explanation of the project and a copy of the plan. Interested parties were advised to contact the project manager and arrange for face-to-face meetings. A speedy response was obtained for most of the London prisons. Three prisons did not engage with the project. This was largely to do with organisational changes that clashed with the timeframe of the project. However, 5 London prisons signed up to the pilot and these were: HMP Wormwood Scrubs, HMP Wandsworth, HMP Belmarsh, HMP/ YOI Feltham and HMP Highdown. The project manager (EH) spoke to contact people at all sites, and then conducted at least one face-to-face visit. At this meeting, the outline of the project was described, an agreement to participate was obtained, and the training needs questionnaire was given out. In addition, the options for delivery of the pilot training were discussed and the feasibility of recruitment of trainees and delivery within the timeframe was explored. Each prison was then sent an information sheet to be given to trainees outlining the project, the aims, and the dates for the training, plus the contact details of the project manager (see Appendix 1 for an example). At each site a link worker was identified who would regularly liaise with the project manager about the progress of the project, and the implementation of the training. This person would arrange the venue for the training and the recruitment of staff for the training.

TRAINING NEEDS ASSESSMENT

The training needs assessment comprised of a semi-structured questionnaire asking about a range of issues relating to the care of dual diagnosis prisoners and the

perceived training needs. The aim of this instrument was to gain an understanding about:

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

The questionnaire was distributed to mental health and substance use staff at all the recruited prison sites. (See Appendix 2). Of 80 questionnaires distributed, 23 were completed and returned, and this represents a response rate of 29%. This is not unusual for postal surveys of prison staff (Brooker et al, 2006). A more effective method would have been face to face interviews but given the time-frame, and the difficulties of accessing staff within prisons, this seemed to be the most pragmatic method. Although the respondents represented a good cross section of the services that would be targeted for the training the low numbers make it difficult to generalise the results across the service. The breakdown of respondents was as follows: CARATs- 5, RAPT-1, mental health (in-reach and inpatient services) - 10, detox-7, and health psychology- 1. Despite the low numbers, their responses gave an initial understanding of the perceived training needs.

A copy of the form is available in Appendix 2 and the responses are available in Appendix 3. The next section will highlight and summarise the main findings from the training needs.

OUTCOME OF TRAINING NEEDS ASSESSMENT

When asked about dual diagnosis and what kinds of mental health and substance use issues the most commonly mentioned mental illness was schizophrenia followed by depression and drug-induced psychosis. It was surprising that personality disorders were hardly mentioned. Unsurprisingly the most common substance use problems were heroin and alcohol (followed by crack cocaine). The staff felt their needs to be mainly about referral to other agencies and the range of health care services available in the prison. There was no mention of social needs or 'detox' managed by primary care. When asked what else they would like to offer, the

responses were general and vague. Again, when asked what evidence and values base was used to work with people with dual diagnosis the responses were vague or non-existent. No one mentioned using the Department of Health Good Practice Guide, or the integrated drug treatment approach. This suggests that the prison staff lacked a framework for conceptualising and working with dual diagnosis.

The sample asked to identify what skills knowledge and attitudes were important in working with dual diagnosis. Appendix 3 highlights the responses in more detail. People mentioned mental health and substance use awareness, communication skills and non-judgemental, egalitarian values and attitudes. They were able to describe values in this section, despite giving a poor response when asked about the evidence and values base they used currently. There was no mention of motivational interviewing, cognitive behavioural approaches, specialised assessment, or relapse prevention for this group. Again this suggests that workers have reasonable attitudes and values, but lack a theoretical framework to underpin their interventions. Again there was little mention of social issues and interventions.

BARRIERS TO CARE

When the respondents were asked about barriers to care the focus was on resource issues (lack of staff, time etc) and several people mentioned that lack of time to work face-to-face with prisoners was a real impediment. This was often due to security issues, i.e. not enough spare officers to supervise an 'unlocking' for a counselling or assessment session. Other barriers mentioned were lack of good communication between agencies both within and outside prison, lack of information sharing and separate assessments having to be done for each service.

AFTERCARE

When asked about aftercare, the respondents seemed to think that it would be straightforward if the prisoner was known to a particular service, but very difficult if the person was not known, the service was in another part of the country, or the person was of no fixed abode. They also mentioned that it is difficult to motivate the prisoner to engage with outside services once released. No one mentioned drug treatment and testing orders. They talked about responsibility and how they could

do as much as they could to facilitate the transfer of care to outside services but as soon as the person was released, they were no longer the responsibility of the prison services. They suggested ways to improve the situation with a need for more services geared up to the needs of ex-offenders with dual diagnosis (including suitable drug rehabilitation services). Other suggestions included better communication, more awareness of the needs of this group when leaving prison, and shared databases. Barriers to aftercare included lack of engagement by the ex-prisoner, poor or no accommodation after release, and poor communication. Access to educational opportunities was not mentioned.

MULTI-AGENCY WORKING

The trainees were asked if multi-agency working was effective, and the responses were quite positive. People seemed to think that it could be good but it depended on the individuals concerned and the level of understanding of each others roles and working practices. Suggestions of how it could be improved were more joint meetings, education about each others roles, and better communication.

PREVIOUS EXPERIENCE AND TRAINING

The respondents were asked what kinds of experience and training they have had related to mental health, substance misuse and dual diagnosis. Generally they reported very little relevant training apart from their professional qualification (if they had one). Generally if people reported training, it was usually in the form of brief lectures, and in house workshops. In terms of dual diagnosis training, only five of the mental health respondents had received any training, and only one of the addictions staff. That represents only 26% of the respondents. However, what is also of concern is that only four addictions service respondents reported any formal training in addictions, as did only two respondents from mental health. None of the addictions staff reported having any mental health specific training at all. Not only did the staff lack relevant training in dual diagnosis, but they also had received little training in basic mental health and substance use.

PERCEIVED TRAINING NEEDS

When asked finally what their training needs were in terms of dual diagnosis, the respondents gave general responses about wanting to know “more” about dual diagnosis.

The conclusions drawn from the training needs assessment were that mental health and substance use workers work together infrequently. Furthermore, there is a lack of communication and sharing of information. It was also apparent that the respondents understood little about each others role and how a person with dual diagnosis should be navigated through these services both within the prison and outside. People identified general basic skills, knowledge and attitudes for work with people with a dual diagnosis, but lacked a theoretical framework on which to base their interventions. Perhaps, most importantly, they did not possess an overall strategy or framework that could guide care. There was a significant lack of clarity about training needs apart from an acknowledgement that they wanted to know more about general dual diagnosis issues. Finally, it was clear that the prison staff in the survey lacked basic training in mental health and substance use awareness, as well as the more specific dual diagnosis issues.

These findings are not surprising given the lack of emphasis on dual diagnosis care and treatment both within the prisons and outside. However, the respondents do suggest an urgent need for a training strategy to address these needs; a need to clarify roles and responsibilities for care and a fundamental need to improve the communication and joint working of the relevant stakeholders for prisoners with dual diagnosis.

SERVICE USER INVOLVEMENT:

It is essential for the development of training materials to have a credible service user involvement (Brooker and Curran, 2006). In order to achieve this, service users were consulted in two major ways. First, they were asked their views about the training needs of staff. Second, they were asked to comment on the training material themselves. A small group of four service user consultants from a London mental health trust were recruited. They all had previous experience of co-morbid mental health and substance use, and had either worked with ex-prisoners or had

themselves experienced the criminal justice system. There was an initial 2 hour consultation group focused around training needs. The draft of the outcome of the meeting was circulated to the participants for comments, and then finalised. The second stage of the consultation was for the same group to review the training manual. A second meeting was convened to obtain feedback.

SERVICE USER PERCEPTION OF TRAINING NEEDS

The full responses to this are to be found in Appendix 4. In summary, the main concern was that staff in the separate services were neither competent nor confident in dealing with all aspects of a persons problems. Thus, service users were excluded from help until they have got one particular problem sorted out. One person described how he had been told that he could not continue with his psychological therapy until he had stopped drinking following a relapse. He expressed his frustration that he was drinking because of his psychological problems and found it difficult to stop without help and support for these issues. However, as the service users pointed out, this was impossible if the problems were intertwined. The service users felt that the situation would be improved if services were more willing to work with someone “where they were at” in terms of motivation and lifestyle choices rather than forcing treatment options on to them. For example, rather than just offering detoxification, services could offer counselling to help motivate people before they make the decision to reduce or stop their substance use. They also felt that more counselling should be available. When asked about the knowledge, skills and values for helping people they talked mostly about the importance of the right attitudes. This would assist in the engagement process. The service users talked about the importance of identifying and helping with social issues. In contrast the staff training needs responses did not mention these aspects. Several examples of important social issues were given including: helping people find safe housing; and helping with the move away from an unhealthy peer group.

The service users thought that a training course should explore attitudes and should include drugs awareness. They thought that training should attempt to break down the “them and us” barrier and help staff to see that “we are all service users” of some kind or another. They wanted training to increase staff empathy. They also thought

that training should help staff manage relapse better, not seeing it as a “failure” but as a learning experience. They also thought that role-play was an important way for staff to learn, and that service users should be involved in the delivery. They thought that staff should be evaluated by using case-studies and that they should be directly observed in practice.

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

Finally, the issues of needs of people with dual diagnosis within the criminal justice system were discussed. They talked about the importance of having a structure and routine, and help with ways to cope with anxieties and stresses within prison. They felt there should be more incentive to follow-up with aftercare arrangements, and people should be picked up quickly if they relapse.

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

STRUCTURE OF THE TRAINING MATERIALS:

The plan was to develop a training pack for trainers to use to with prison staff in a classroom based environment but also a work-based learning pack that individuals can work through using their own supervisory structures. The pack is modular, with each module representing 1-2 hour teaching sessions or self-directed learning sessions. Each module is structured in a similar way. The title page has an aim and approximately 4 objectives. There is also space for participants to add their own personal objectives. There is usually some reading about the specific subject, a small group discussion exercise, and a role-play/ skills practical (depending on the

subject). The module ends with recommended further reading. Most of the modules are compulsory, but there are some flexibility depending on the recipients needs.

TRAINING CONTENT

The training content has been developed from training materials developed over a number of years and utilised in two research projects and a London wide dissemination project (Brewin, 2004, Hughes et al, in submission). It aims to combines the current evidence base and government policy relating to the care of people with dual diagnosis as well as relevant prison research and strategy documents. This includes the DH Good Practice Guide (2002), the components of the integrated Treatment Approach, motivational interviewing, cognitive behavioural techniques, and relapse prevention. In addition, the Ten Essential Shared Capabilities (2004) were also used as a basis for the values and ethos of the course. The training needs assessment information and service user information collected in this study also informed the content of the materials.

The training package was developed as a manual with small units or modules representing either a 1-2 hour teaching session or 1-2 hour self-directed learning session. There are 16 modules in total. These are:

Module 1	Introduction
Module 2	Drug and alcohol awareness
Module 3	Mental Health Awareness
Module 4	Interaction of mental health and Substance Use
Module 5	Assessment Process
Module 6	Comprehensive Assessment
Module 7	Physical Health and Assessment
Module 8	Risk
Module 9	Treatment Models
Module 10	Stage 1 Engagement Phase
Module 11	Stage 2 Persuasion: Building Motivation to Change
Module 12	Resistance
Module 13	Stage 3 Active Treatment
Module 14	Stage 4 Relapse Prevention
Module 15	Multi-Agency Working and Service Delivery
Module 16	Practice Development

The initial modules on mental health and substance use awareness were intended to address the fact that many of the trainees were not likely to have had formal training in these areas. It is essential to cover the basics at the outset in order to make the more advanced and complex discussions around dual diagnosis make sense. There is a recognition though that for some of the participants this may be covering familiar ground. The participants are also directed to resources to help increase their knowledge of certain areas, and encouraged to seek out other training to meet these needs.

The aim is for the manual to be practical, simple and clear. It is not intended to be an exhaustive resource for dual diagnosis as there are already products in the public domain that serve this purpose. Neither is it intended to be a heavily referenced academic piece of work. Further reading and useful websites have been referenced at the end of each module for people to seek out if they so wish. It has been designed to accompany traditional “classroom” based learning, or as a self-directed workbook. Therefore the exercises and role-plays could be done in the classroom or in supervision sessions, or small groups within the workplace with an expert facilitator.

IMPLEMENTATION OF TRAINING METHODS

Training was piloted at 5 prison sites and two methods of training were tested. All participants completed a questionnaire that assessed their attitudes, confidence in their clinical skills and their knowledge about dual diagnosis. This was a basic questionnaire intended to assess any changes that might occur as a result of training in these areas. A copy of the questionnaire is given at Appendix 4. The questionnaire was repeated on the last day of the training. The first method examined was the “traditional” model of 5 days classroom type course. This was delivered one day per week for 5 weeks at HMP/YOI Feltham (11 participants) and HMP Wormwood Scrubs (12 participants). The training day ran from 10-4pm within the prison site in a classroom allocated for the day. In HMP Wormwood Scrubs a large classroom was booked for the entire course and was located in the training department. This was still within the prison but separate from everyone’s workplaces. In HMP Feltham, a small group room in the mental health day centre was used. The disadvantage of the latter was that people were still in their working

environment and could get easily distracted, and the room was too small to break into small groups comfortably for discussion and role-play.

The training comprised didactic teaching, small group discussion that focused on a relevant topic or case study and feedback. In addition there were several role-plays. These were modelled by the trainer first and then the trainees tried them out. In addition to this, trainees were encouraged to discuss real cases within the training environment to enable them to link theory to practice. Trainees were expected to practice skills at work in between training days and then feedback how things went to the group at the next training day. At the start of each day, the trainer would recap on what had already been covered, and refer to the manual at each point in the training. Trainees were encouraged to take notes within their manuals as a record of extra discussions. The training course ran the same way for each site (see Table 1 below).

Table 1: 5 day Training Timetable

	Day 1	Day 2	Day 3	Day 4	Day 5
Am 1	Introductions, questionnaire, Module 1 exercise 1: dual diagnosis issues	Module 5 Assessment	Module 9 Treatment models Module 10 Stage 1 Engagement	Recap on MI Module 12 Dealing with resistance	Module 14 Relapse prevention
Am2	Overview of dual diagnosis, Module 2 mental health awareness	Module 6 Assessment role-play	Module 11 Stage 2 persuasion Introduction to Motivational interviewing(MI)	Resistance exercise and role-play	Contingency planning role-play
Pm1	Module 3 Substance use awareness	Module 7 Physical health and dual diagnosis	MI skills	Module 13 Active treatment	Module 15 Multi-agency working and case-study exercise
Pm2	Module 4 Interaction of mental health and substance use	Module 8 Risk (suicide and violence) And case study	Readiness to change role play	Goal- setting role play	Module 16 Future learning needs plan and evaluation

BLENDED LEARNING METHOD

The second method of delivery was “blended learning” style. This was a combination of work-based learning and 3 group supervision sessions. The group supervision

sessions were two hours in length and consisted of an overview of sections of the manual, a clinical discussion, and some role-play or case-study exercises from the manual. They occurred at the start of training, and then once a fortnight. This format was delivered at HMP Belmarsh (7 participants), HMP Highdown (15 participants) and HMP Wandsworth (18 participants). Participants were expected to complete a number of modules within their working hours between supervision sessions. They were encouraged to “buddy up” with a colleague to work on the exercises together. They were then expected to feedback to the group how things had gone at the next supervision meeting.

All staff who attended the training in whatever format completed a brief baseline questionnaire about attitudes confidence in their own skills and knowledge about dual diagnosis (see Appendix 2). This was repeated at the end of the course. In addition to this, staff completed an evaluation form which included both quantitative and qualitative information.

TRAINING DEMOGRAPHICS

Table 2 HMP Wormwood Scrubs 5 day Training

Service	Number of trainees
CARATS	5
Mental Health day service (Seacole)	3
Psychology	1
Detox Unit (Conibeere)	1
Offender management	1
In-patient health care	1
TOTAL	12

Attendance

Day 1= 12, day 2=10, day 3= 12, day 4=11; day 5=12

Average attendance: 11

Table 3 HMP/YOI Feltham 5 Day Training

Service	Number of trainees
CARATS	3
Mental Health inpatient	3

Young People's substance misuse service	2
Detox Unit	1
Mental Health Inreach	2
TOTAL	11

Attendance

Day 1=11, day 2=cancelled, day 3=10, day 4=9, day 5=9

Average attendance: 10

Table 4: HMP Wandsworth Blended Learning

Service	Number of trainees
CARATS	4
Primary care	1
Health Psychology	2
Detox Unit	1
RAPt	3
Dual diagnosis	5
In-patient health care	2
TOTAL	18

Attendance session 1=15, session 2=8; session 3=10

Average attendance: 11

Table 5 HMP Highdown Blended Learning

Service	Number of trainees
CARATS	8
Mental Health In reach (Highdown)	5
Mental Health In reach (Downview)	2
TOTAL	15

Attendance session 1=15, session 2=9; session 3=7

Average attendance: 10

Table 6 HMP Belmarsh Blended Learning

Service	Number of trainees
CARATS	6
Mental Health In Reach	1
TOTAL	7

Attendance first session: 7; session 2=4; session 3=3

Average attendance: 5

From the above figures, it can be seen that some prisons were able to recruit more staff than others to attend the training, and some were able to get a wider mix of trainee backgrounds. Reasons for certain services inability to release staff for training were usually to staffing and workload pressures. Not one establishment, however, stated that the training was not needed. The attendance for the 5 day training was better and more consistent than for the supervision sessions. In the blended learning the attendance dropped off a bit more for each session. People in the blended learning session fed back that it was difficult to prioritise attendance at the supervision sessions if they were having a busy day at work, and that they would have preferred having the protected time that the 5 day training afforded.

STAFF OUTCOMES

Participants were asked to complete a questionnaire consisting of three subscales each comprising eight items about attitude towards working with dual diagnosis. Each item was rated on a 5 point Likert scale, 1 representing disagree strongly and 5 agree strongly. A further eight items were included which assessed 'confidence' in a series of key skills in working with dual diagnosis. There were also seven knowledge multiple-choice questions. The questions were adapted from questionnaires used in previous evaluations of dual diagnosis training (Hughes et al, in submission). The questionnaire was brief and simple as this was only a pilot study. A copy of the questionnaire can be found in Appendix 4. Respondents were given the following reassurances: the data collected was strictly for the purposes of evaluating the training; the only person to have access to the questionnaires would be the project manager and, finally, that the data would be anonymous. A total of 63 baseline questionnaires were completed. The questionnaire was redistributed on the last day of training for both types of training method. If people were absent on the day,

questionnaires were left with colleagues for the missing people to complete and post back. A total of 44 follow-up questionnaires were received (70%). This gives an attrition rate of 30%. However, 13% of the attrition can be accounted for from one prison site: the blended learning group at Wandsworth. The answers to the knowledge questionnaire were discussed after the follow-up data was collected. The data from the questionnaires was entered onto a database and analysed using SPSS 14. The maximum possible score for attitude and confidence was 40, and maximum score for knowledge was 7.

Table 7 Baseline mean scores for blended and 5 day groups

Subscale	Blended (s.d)	5 day (s.d)
Attitude	29 (3.28)	29 (3.37)
Confidence	22 (5.12)	21 (5.93)
Knowledge	6 (1.09)	5 (1.32)

The baseline scores show that the two training groups did not differ significantly before training commenced. The data was analysed in two ways. First all participants (no matter what kind of training they were exposed to) were compared on the means of the subscales at baseline and follow-up using a paired sample t-test.

Table 8 Mean Scores for all participants' baseline and follow-up

Subscale	Baseline	Follow-up	P value
Attitude	29 (3.22)	31 (3.52)	P=0.000
Confidence	22 (5.44)	25 (3.32)	P<0.005
Knowledge	5 (1.22)	6 (1.36)	P=0.138

Overall, no matter what training method had been received, there was a significant improvement at follow-up on attitudes and confidence in their skills towards people with dual diagnosis. Knowledge scores remained unchanged; however, the scores were reasonably high at baseline with an average of 5 out of 7 correct. The knowledge questionnaire would need to be expanded to include more items covering more of the overall content of the training if this were to be repeated as a part of larger more formal research exercise.

The second stage of the analysis was to see if there were any differences between the training methods. Independent sample t-tests were performed on the means of the blended and 5 day training at follow-up.

Table 9 Comparison of mean follow-up scores between blended and 5 day training groups.

Subscale	Blended (s.d)	5 day (s.d)	P value
Attitude	31 (3.66)	32 (3.34)	P=0.675
Confidence	26 (3.32)	25 (3.32)	P=0.908
Knowledge	6 (1.26)	6 (1.35)	P=0.370

There were no significant differences on any of the scales at follow-up.

Finally, in the database, the participants were divided into two groups: those in a substance use role and those with a mental health role. This was to see if there were any differences in how these groups responded to the training. Other roles such as psychology, prison officers and general nurses were excluded from the analysis (this excluded 6 people only). This resulted in 24 staff in the “substance services” group and 14 in the mental health group. An independent samples t-test compared mean scores for substance use staff and mental health staff at follow-up.

Table 10: A comparison of mental health and substance use worker mean scores at follow-up

Subscale	Mental health (s.d)	Substance Use (s.d)	P value
Attitude	30 (4.18)	31 (3.25)	P=0.494
Confidence	26 (3.49)	25 (3.49)	P=0.199
Knowledge	5 (1.35)	6 (1.17)	P=0.014

The only significant difference between substance use and mental health workers was on knowledge. Again this could be a reflection of the types of items included in the 7 items. They were focused on substance use effects on mental health and questions about interventions, that the substance use workers are more likely to be familiar with (such as motivational interviewing). This reinforces the need to ensure that a future assessment of knowledge acquisition is more comprehensive in its content.

TRAINING EVALUATION

The training was evaluated on the final day of the training. An evaluation form was devised for the project and comprised of 6 questions relating to the manual, and six

questions relating to the five-day training or supervision sessions (5 items) in the blended learning. A copy of the evaluation form can be found in the appendix 6. The overall score for the manual and the training items was out of a maximum of 30, and the score for the supervision sessions was out of 25.

Table 11 Mean Scores for Manual and training

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

The prison groups were combined to compare all participants who had completed the 5 day training will all that had completed the blended. An independent sample t-test was performed to compare the mean scores for the manual. The mean score for the blended training is 25 (s.d 3.54) and the mean score for the 5 day training is 27 (s.d. 2.07). The 5 day training groups evaluated the manual slightly higher than the blended, however this difference just failed to reach statistical significance ($p=0.067$).

QUALITATIVE FEEDBACK

In addition to the evaluation questionnaire items, participants were also invited to give qualitative feedback in a series of open-ended questions on the form. A full set of responses can be found in Appendix 6. Respondents were asked what had they found most useful about the training and six themes emerged and these were (in order of most frequent response):

- the manual itself
- motivational interviewing techniques
- Role-play
- Theoretical models and intervention tools.

- Combining mental health and substance use workers for training
- Group discussion

When asked what was least useful, the themes were:-

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

Interestingly, role-play was mentioned in both the “most useful” and “least useful” categories but this is not surprising given that some people dislike it and others find it useful.

When asked what was missing that should have been included the comments were mainly about:-

- more on mental health both in the manual and the training.
- personality disorders
- Attention deficit
- Aspergers Syndrome,
- more exercises and case-studies
- information on mental health medications.

It is likely that those people who wanted more on mental health would be the substance use workers, and perhaps this training need may be met by the Prison Mental Health Awareness training. This issue will be discussed in the recommendations section. When asked what there should be less of, there were few responses, and these consisted of:-

- less discussions
- less drug awareness/ knowledge (again from the Substance use workers).

When asked what there should be more of people mentioned:

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

Finally people were asked to give “any other comments”:-

- These were generally very positive with people using terms like “enjoyable”; “interesting”; “excellently researched”; “useful”.
- People were very positive about the manual and felt it would be a useful on-going resource.
- People who did the blended learning mentioned that time given for the supervision could have been longer.
- People expressed a wish for further training, and about extending this training to prison officers.

DIFFICULTIES WITH THE “BLENDED LEARNING”

A synthesis of data from the participants in the blended learning groups demonstrated that this might not be the most preferred mode of learning. First, the attendance was poorer in the blended learning with more attrition than the five day groups. It is likely that this occurred because attendees were not given protected time during their working week to read the manual and do the exercises. They were thus less likely to attend the follow-up sessions. Second, very few people were able to report that they had completed all the tasks in the manual between the sessions. Finally, they felt that three two hour sessions was not sufficient time; they would have preferred more supervision sessions, which could be spread out over a longer period of time, allowing them more opportunity to complete tasks between sessions.

SERVICE USER FEEDBACK ON MANUAL

The overwhelming response from the service users was that they were very positive about the manual. They thought it was clearly set out, simple to read, and succinct. One service user commented that it mapped out the process of working with someone with dual diagnosis very well; it read like a “journey”. They agreed that the values that they had discussed at the first meeting were clearly represented. They thought that the manual would be accessible to anyone, including service users and carers. They liked the case examples, thought they were credible, and felt there could be more of this. There was a debate as to how much information should be included about 12-Step approaches such as Alcoholics Anonymous and Narcotics Anonymous and RAPt. One service user thought there should be more information, but another felt that these kinds of approaches were not always that helpful to everyone, so there should be caution in how they are recommended. We agreed that the 12 step was helpful for some people and perhaps the information could be expanded somewhat more in the manual. The service users agreed that it would be good to have the service user voice set out more clearly in the manual, so they agreed that they would provide some (anonymous) quotes to be inserted at key sections to emphasize certain points that they felt strongly on. The other key issue discussed was the format of the manual where the following was agreed:

- reduce the amount of free text
- summarise more frequently using bullet points
- The more imaginative use of colour
- The inclusion of more pictures and diagrams

SUMMARY OF EVALUATION

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

There was no difference in outcomes between the two methods of training using items from the DDAQ. However, the participants had clear preferences for the five day programme.

The overall feedback was highly positive across all professional groups and demonstrated that a relevant, credible and useful training product had been developed which was acceptable to the target recipients. This was the most important overarching objective of the project.

A number of useful suggestions were received about how to further refine the product for further dissemination (including the inclusion of more material in the mental health module and more teaching on Attention Deficit Disorder and Asperger's Syndrome) alongside some highly useful insights into the practical application of such training in prisons.

The project achieved service user feedback for the manual which was also very positive. This might be the first time that such feedback has been obtained from routine prison settings in the development of mental health training materials.

Participants found the five day programme more beneficial (compared to 'blended learning') although the DDAQ was not sensitive enough to detect these differences.

There were more practical difficulties for the "blended learning" style as attrition was high as it was not always easy to prioritise two hours of training within a busy working day. In addition people it difficult to complete the exercises in the manual without protected work time

Some people commented that it was the first time some of the services had all sat in a room together for training. They felt this was a real strength of the training as they could discuss dual diagnosis issues together, get different perspectives as well as learning about each others roles. This benefit was not measured objectively and this could be addressed in a larger national roll-out of the training using existing measures (using the Teamwork Inventory for example).

DISCUSSION AND RECOMMENDATIONS

This pilot study had several aims including: the testing of new teaching materials, an examination of the practicalities of delivering training such as this in prison settings, and the development of an understanding about how a larger national roll-out of such training might be more formally evaluated. .

Despite the view that it is difficult to set up and deliver training in prison, this project has demonstrated that, even given a relatively brief time-frame, it is feasible. This is an important message for other prisons in thinking about the wider dissemination of this package. Critical to the success of the project within each London prison, however, was the identification of a local “champion” who had power and influence. In these circumstances, training was set up very quickly and easily, and recruitment and commitment of staff was high. It was difficult to arrange training in prisons where organisational change was occurring.

The training needs assessment has highlighted that the prison mental health and substance use staff lack the capabilities to provide coordinated and evidence based care for people with dual diagnosis. Therefore it is imperative that a national prison dual diagnosis initiative is implemented to rectify this situation in order for prison services to be able to deliver on government targets (DH, 2002; NSF-5 Years on, 2005)

The project has produced a training manual that has been evaluated positively by both staff and service users and has indicated that it has some positive benefits on participants’ attitudes and confidence in their skills. Money has been obtained from the NIMHE/CSIP lead for Dual Diagnosis to develop the training materials into a high quality product. This would need to be further evaluated in a more rigorous national research project.

There are four broad areas of recommendations for the future of the prison dual diagnosis training project.

1. Research and evaluation
2. Development of training pack

3. The national dissemination of the training
4. Service development for dual diagnosis care in prison and in the wider criminal justice system

1. Research

A. It is essential that dual diagnosis prison training is evaluated using more rigorous and robust research methods such as a randomised controlled trial, and using valid and reliable tools to measure staff changes in attitudes, confidence and knowledge. There is also the issue of skills acquisition. This is because there is often a lack of formal evaluations of training and as Appleby (2004) points out, a lot of training initiatives are “unproven” in effectiveness. This pack has already been scrutinised more than most training initiatives even though this was limited in comparison to what could have been done. Future training research should conduct a form of skills assessment both at baseline and at follow-up points after training. This is not always easy to do practically, but ideas may include independent assessment of role-play videos; case-note audits; interviews with service users on the trainee’s caseload, and assessment of audio-taped sessions with service users.

B. It is essential that training research can demonstrate that trainees are capable of implementing what they have learnt through training in their practice. In addition to this, training research should endeavour to assess outcomes for service users as well. The hypothesis would be that if trainees obtain new skills and subsequently implement more effective interventions then there should be a discernible benefit for service users. Outcomes could be satisfaction with services, level of engagement, levels of functioning and psychopathology, drug and alcohol use (including measures of craving), quality of life and needs.

2 Further Development of the Training Pack

A) Strategic Development of DD Training

The dual diagnosis training should be developed in collaboration with other prison training initiatives to ensure consistency of message and content and avoid the duplication of materials. This also may mean that in the future people may be able to omit certain modules of the dual diagnosis manual if they have completed an equivalent module in another course. An example of this could be substance use

workers omitting basic drug awareness and mental health if they have already undertaken such training.

There should also be an expectation of the minimum level of knowledge about the topics covered in the dual diagnosis training. For example, substance use staff (CARATs) don't usually have mental health awareness training, therefore it would be advisable that they access the Mental Health Awareness training prior to the dual diagnosis training.

In a similar vein, mental health staff should have as a minimum basic drug and alcohol awareness, so they may need to be directed to appropriate courses before the dual diagnosis training.

B) Development of the Manual

- In terms of the manual, service user quotes will be used to illustrate point in the text, and there will be a glossary of terms.
- It will be presented in a user-friendly format which will include more diagrams, pictures and boxes, and will have an accompanying CD-ROM and web-links. There will be video-clips on the CD-ROM to demonstrate all the role-plays, and more case studies within the text.
- There will also be an accompanying manual for trainers. This will outline timetables and practical issues of recruitment, delivery and evaluation.
- In terms of options for method of delivery the outcomes of the pilot suggest that 5 day "classroom based" training plus manual is the preferred method of delivery. Attrition rates were poor for blended learning and qualitative feedback suggested that the 5 day programme was superior.

3 Dissemination

- A national dissemination of the dual diagnosis training could be coordinated with support from the appropriate leads in the CSIP Regional Development Centres.
- This could be overseen by the current project team. The joint-leads for

implementation of the project should be the CSIP leads for dual diagnosis and prison mental health.

- It is envisaged that trainers would be identified from each prison who are experienced and competent in delivering training as well as dual diagnosis. They would be able to access a regional train-the-trainers course to familiarise themselves with the materials, ensure fidelity to the training materials, and support them in delivering the training in their own setting.

4 Service Development

- The dual diagnosis training should be mapped to the Prison Dual Diagnosis Strategy that is currently being developed.
- This will help clarify roles and responsibilities between the agencies and how they can work together.
- In addition, to this the dual diagnosis training should not represent an end point in itself. It is likely that attendees will identify learning needs as a result of it, and there should be opportunities within the prison and outside to pursue these.
- It is important that there is a forum set up for the discussion of dual diagnosis issues, and an opportunity to update peoples' knowledge with regular presentations and case presentations. This could be coordinated by the dual diagnosis trainer/lead. Ideally this would take place every two months. This will again help share skills and knowledge, facilitate more effective working relationships between services, and promote an atmosphere on continued learning and development.
- There should be a named person for every prison who has an expert knowledge of dual diagnosis issues. This does not have to be someone within the prison itself, it could be from the local services, such as the local mental health trust. Workers should be able to access advice, support and information from this person. There should also be access to information about all issues related to dual diagnosis.
- Workers should be aware and have access to relevant resources on the internet such as the Rethink Toolkit, and the NIMHE Dual Diagnosis Information Resource.

- There is a training package in development which will form one of the advanced modules of the Ten Essential Shared Capabilities Framework. This is being developed by the same team as this prison pilot project. It is expected that the prison dual diagnosis training would be developed in line with the content and philosophy of this product. This will ensure that prison dual diagnosis training is developed in parallel with other national mental health training initiatives.

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APPENDIX 1- FLYER

Prison Dual Diagnosis Training Project Pilot Training February/March 2006 *HMP Belmarsh*

A significant proportion of prisoners have multiple and complex needs. These often include both mental health and substance use problems. Typically the needs of this group are not always addressed adequately and this leads to relapse and re-offending following release from prison. This group is also especially risky as the rates of self-harm, suicide and violence are very high both within prison and in the community. Staff often report that they lack confidence, knowledge and skills to work with combined needs, and this often leads to people not receiving the care that they need. One solution is to train key mental health and substance use staff (and other relevant health care staff) to work more effectively with this group within the prison system.

This project (October 2005 to April 2006) aims to develop, and pilot training materials for staff who work with prisoners who have combined mental health and substance use problems. The project is not only considering the training needs of the staff via a semi-structured interview, but will also report on the service user perspective. The materials will be fully evaluated by the participants and service user consultants, and different modes of delivery of the training will also be evaluated by measuring staff at baseline and post training on attitudes, knowledge and skills. This project has been commissioned by the Department of Health.

In HMP Belmarsh, we will be piloting a “blended learning approach” which will combine classroom style learning with self-directed learning that can be completed “on the job”. The training will consist of a baseline questionnaire on attitudes, knowledge and skills for dual diagnosis work, a work book, and three 2 hour teaching/ clinical supervision sessions in the prison facilitated by Liz Hughes, Project Manager. The dates for the training are Thursday 9th February, 11-1pm, 23rd March, 10.30-12.30, and 9th March 11-1pm, when the training will be evaluated and the baseline questionnaire will be repeated. The information that you provide will be anonymously recorded and collated into a report that will be submitted to the Department of Health at the end of April 2006. The feedback from the training will be used to modify and improve the training pack.

Thank you for your interest and participation in this project.

Liz Hughes, Project Manager

Centre for Clinical and Academic Workforce Innovation (CCAWI)
University of Lincoln

<http://www.lincoln.ac.uk/ccawi/DualDiagnosis.htm>

Tel 07951 602199. email lhughes@lincoln.ac.uk

APPENDIX 2 - PRISON DUAL DIAGNOSIS TRAINING NEEDS ASSESSMENT

Job title:

Professional background (e.g. nurse, counsellor, drug worker, doctor etc):

Prison:

**PLEASE RETURN TO:
LIZ HUGHES
POBOX 30, HSRD
INSTITUTE OF PSYCHIATRY
DENMARK HILL
LONDON
SE5 8AF**

ANY QUERIES, PLEASE CONTACT LIZ ON 07951 602199

THANKS FOR TAKING THE TIME TO COMPLETE THIS!

15. What other services within the prison would you work with for dual diagnosis?

16. How effective is multi-agency working within the prison?

17. How could this be improved?

18. What previous work experience have you had in terms of mental health/substance use/ dual diagnosis?

19. What training have you had around mental health/substance use/dual diagnosis?

20. What do you perceive are the training needs for workers such as yourself?

APPENDIX 3 - RESPONSES FROM THE TRAINING NEEDS QUESTIONNAIRE

1. Types of problems encountered

The most frequently mental health problems mentioned were: schizophrenia, followed by depression, then drug-induced psychosis. The most frequent substance problems were heroin and alcohol, followed by crack and cannabis

What staff perceived to be the prisoners' (with dual diagnosis) main needs:

most commonly mentioned were: psychiatric medication, managing withdrawals and other aspects of detox, aftercare, and referral to other services

2. What is currently offered?

The most popular response was referral to other agencies (both within prison and outside). Apart from this, it depended on the prison site and service as to what could be offered. This ranged from deter and stabilisation of substance use, monitoring mental state, gym, group work, education and counselling, and treatment programmes.

3. What else would you like to offer?

People mentioned that they would like more specialised knowledge and skills in working with this group, a psychiatric nurse to work within the substance use team, more access to prisoners in a more "natural environment" people felt constrained by the prison regime

4. What evidence base is used for working with dual diagnosis?

When asked about the evidence base used for dual diagnosis, most people either left this blank or left a vague answer.

5. What Skills attitudes and knowledge are Important in working with dual diagnosis?

Knowledge of mental health and substance use issues (including signs and symptoms, assessment, Mental Health Act), interactions of prescribed and street drugs, interaction of substance use on psychosis, urine and drug screening methods, harm minimisation including blood borne viruses, injecting and physical health.

Skills included communication skills, being a good listener, motivational skills, knowing the right questions to ask and why, empathy, open, honest, patience, supportive

Attitudes: non-judgemental, flexible, egalitarian, respect, unconditional acceptance, inmate involvement, treat as unique individual, open-minded.

People also mentioned attitudes that were unhelpful: “they could stop if they wanted to”; many people think it’s their own fault and have little sympathy; blame substances for the symptoms

6. What are your training needs:

People tended not to be specific in their responses to this. The responses tended to be about wanting training that covered the whole topic. These included: more in depth knowledge of both mental health and substance use; more lectures/information on the subject; general training, comprehensive training; more in depth knowledge of the relationship between mental health and substance use; “I have training needs across the board”.

APPENDIX 4 - TRAINING QUESTIONNAIRE (DDAQ)

Prison:

Please tick which service you work for:

Detox

Carats

RAPt

Mental Health Inreach

Mental health in patient

Mental Health day centre

Primary Care

Other (please state)

A Please rate the following statements in terms of how much you agree with them where

1: disagree strongly

2: disagree

3: not sure

4: agree

5 agree strongly

1. I feel that it is part of my role to work with people with dual diagnosis

1-----2-----3-----4-----5

2. I don't find working with people with dual diagnosis very satisfying

1-----2-----3-----4-----5

3. There is not much hope of a positive outcome for people with dual diagnosis

1-----2-----3-----4-----5

4. I have enough support to help me work with people with dual diagnosis

1-----2-----3-----4-----5

5. I feel I have the skills and knowledge to work effectively with people with dual diagnosis

1-----2-----3-----4-----5

6. I want to work with people with dual diagnosis

1-----2-----3-----4-----5

7. I feel the best I can offer someone with dual diagnosis is referral to someone else

1-----2-----3-----4-----5

8. I am interested in the nature of dual diagnosis and complex needs

1-----2-----3-----4-----5

B Next rate how confident you are about your skills in working with people with dual diagnosis for the following, where:

1: not confident at all

2: a little confident

3: quite confident

4: very confident

1. Utilising engagement skills to form effective working relationships

1-----2-----3-----4

2. Assessing substance use and mental health

1-----2-----3-----4

3. assessing readiness to change

1-----2-----3-----4

4. working with people's ambivalence

1-----2-----3-----4

5. devising a collaborative action plan

1-----2-----3-----4

6. developing contingency plans to prevent relapse

1-----2-----3-----4

7. promoting safer drug and alcohol use using harm minimisation strategies

1-----2-----3-----4

8. Working effectively with other services within the prison

1-----2-----3-----4

C Please circle the answer which you think is correct:

- 1. Heroin:**

a) causes psychosis,

- b) alleviates psychosis,
- c) is hallucinogenic,
- d) is made from leaves grown in South America

2. Cocaine:

- a) causes psychosis,
- b) alleviates psychosis,
- d) is hallucinogenic,
- d) is produced from poppies

3. Cannabis

- a) is a herbal remedy for depression
- b) is a causal factor in schizophrenia
- c) causes bedwetting,
- d) has been legalised

4. Alcohol withdrawals

- a) can be fatal
- b) don't need medical care
- c) cause heart problems
- d) can be treated with caffeine

5. Harm Minimisation is an approach that:

- a) advocates a person continues to use substances
- b) promotes the positive benefits of illicit substances
- c) is the opposite of abstinence
- d) involves working with small changes in use

6. If a person seems resistant to change:

- a) you modify your approach
- b) you vigorously confront their resistant behaviour
- c) you discharge them from your service
- d) you hand them over to someone else to work with

7. Lapses into substance use are:

- a) expected and normal
- b) due to a lack of will power

- c) because the person isn't taking treatment seriously
- d) an indication that they will never change

APPENDIX 5 - EVALUATION OF TRAINING FORMS

Prison Dual Diagnosis Pilot Training Evaluation

Supervision plus manual

Please answer the following questions by circling the number that corresponds to your answer.

- 1- Strongly agree
- 2- Slightly agree
- 3- Neither agree or disagree
- 4- Slightly disagree
- 5- Strongly disagree

With regards to the manual:

- 1. It was easy to read
1---2---3---4---5
- 2. It contained useful information
1---2---3---4---5
- 3. the content was relevant to my clinical work
1---2---3---4---5
- 4. I was able to complete most of the manual exercises
1---2---3---4---5
- 5. It was too long to read
1---2---3---4---5
- 6. it was well presented
1---2---3---4---5

With regards to the training supervision:

- 1. The trainer was knowledgeable about the subject matter
1---2---3---4---5

2. The course had clear aims and objectives

1---2---3---4---5

3. The supervision was sufficient to complement the manual

1---2---3---4---5

4. The activities within the supervision were useful

1---2---3---4---5

5. I found the sessions useful and enjoyable.

1---2---3---4---5

What did you find most useful about the training?

What did you find least useful about the training?

What was missing that should have been included?

What would you like to see less of in the training?

What would you like to see more of in the training?

What other comments would you like to make about the training?

Prison Dual Diagnosis Pilot Training Evaluation

5 day training plus manual

Please answer the following questions by circling the number that corresponds to your answer.

6- Strongly agree

- 7- Slightly agree
- 8- Neither agree or disagree
- 9- Slightly disagree
- 10- Strongly disagree

With regards to the manual:

- 7. It was easy to read
1---2---3---4---5
- 8. It contained useful information
1---2---3---4---5
- 9. the content was relevant to my clinical work
1---2---3---4---5
- 10. it complemented the training well
1---2---3---4---5
- 11. it was too long
1---2---3---4---5
- 12. it was well presented
1---2---3---4---5

With regards to the training:

- 6. The trainer was knowledgeable about the subject matter
1---2---3---4---5
- 7. The course had clear aims and objectives
1---2---3---4---5
- 8. The course had a good structure
1---2---3---4---5
- 9. The content of the training was relevant to my work
1---2---3---4---5
- 10. The activities within the training were useful

1---2---3---4---5

11. I found the course useful and enjoyable.

1---2---3---4---5

What did you find most useful about the training?

What did you find least useful about the training?

What was missing that should have been included?

What would you like to see less of in the training?

What would you like to see more of in the training?

What other comments would you like to make about the training?

Thank you very much for your participation and important contribution to this project!

Liz Hughes
Project Manager

APPENDIX 6 - EVALUATION COMMENTS

1. What people found most useful

Increased awareness of DD and useful practical elements.

It gave me confidence to talk to clients on the subject matter

The manual

The group discussions as the group was a mixture of mental health and drug workers

Found all sections useful and informative.

I found the manual most useful as a form of reference to look back on in future as it is very comprehensive.

Having a comprehensive resource pack to keep and access

Referencing the manual, watching the assessing motivation exercise

Group discussions.

For the first time it brought together mental health inreach and CARATs together for discussions. All the chapters (modules) gave a short digestible guide, yips and theory. Case studies were particularly useful (very accurate!!). its an excellent guide to refer to as all modules were relevant.

The in-session exercises (e.g. skills practice) and discussions

There was room within the material presented in the manual for exploration and discussion

Bridging the gaps between addiction counselling and dual diagnosis team

It allowed me to realise how much I already knew about dual diagnosis and that I already use some of the skills highlighted.

Motivational Interviewing relapse prevention, learning about the complexity of dual diagnosis

Role=plays of motivational interviewing and triggers. These directly help my work and put things into practice. Can give my work some structure thus affecting my confidence as a drugs worker.

The activities for us to do were very helpful in understanding just how hard it is to change a habit or way of life

Readiness to change and learning new things on the whole subject.

Day 1 definitions of dual diagnosis

Whats available for clients (services) who have dual diagnosis and what skills to use in order to assess their needs.

The timeline

Role-play- trying the tools out!

Thinking about addressing complex needs in an integrated rather than a fragmented way.

Assessment tools/treatment models.

I found it useful to have a multi-disciplinary input in our group and to become aware of the whole umbrella of dealing with the needs of dual diagnosis.

Drug and alcohol awareness, identifying signs and symptoms. This I found particularly useful as I am new to working with people with drug and alcohol issues.

Brought my knowledge/extended clarified issues.

The course enabled me to identify and refer quicker and identify signs

2. What was least useful

Descriptions of drugs.

Less time

General discussions

People's reluctance to share experiences

Brain-storming/open discussion

Time constraints, more structure in sessions

I could have done with more on mental health treatments

Reading through the manual; having each section explained

The training should have been continuous for 5 days rather than spread over a whole month

Role-playing

A lot of focus on drugs rather than a firm focus on dual diagnosis.

I already knew most of the material

I always find role-playing unbeneficial to me.

The assessment process, coming from a social work background I have covered a majority of assessment processes. However the physical health assessment was more useful than others.

Some terminology I didn't understand

3. What was missing that should have been included?

Maybe some referral choices regarding different mental health issues

More on personality disorders. Medications for each disorder.

Other disorders such as Aspergers and ADHD

Possibly some more practical group exercises

I find an explanation re neuroreceptors/ drug use, blockers would have been beneficial.

More case studies and review of outcomes

Did not have time to read through the manual properly enough to comment.

As a RAPt counsellor, I was surprised to see the 12 step (Minnesota model) not even talked about as an alternative form of treatment. I found it one sided towards CBT and harm minimisation approaches

More information on the relationship between mental health and substance use

Pictures, colours. Should have been made easier to read like a magazine, article etc not just black and white.

Subject dividers for each module in the manual

Discussing mental illness in more depth

More interactive presentations and videos etc

There should have been more information about dual diagnosis from the mental health side- I work in substance misuse field and therefore knew much of the information presented.

More structure is needed in terms of the dual diagnosis being the main focus for the course. It was easy to sway from the subject.

Very little focus on mental health issues. Excellent for drug issues but perhaps not so useful to workers that have been involved in the field for some time.

More basis on mental health

Info on drugs

Drugs used for mental illness and their impact and effect when coincide with illicit drugs. More mental health awareness

4. What would you like to see less of

I thought it was all useful

Nothing, it was OK

General discussions

Less work to do between sessions which did not get prioritised (by trainees!)

(-Blended learning)

Less discussion and more practical training in the supervision sessions

Drug awareness

A few too many group exercises

Drug information, but that is only because I know it already. For someone who did not know it then it was extremely useful.

Less focus on subjects not related directly to dual diagnosis

Less focus on just drugs.

Basic drug info could have been gone over more quickly (although the more detailed information e.g. interaction effects was very interesting)

Exercise in pairs or groups. I found it more beneficial as a shared group as some exercises did not warrant paired groups

5. What would you like to see more of?

Role-plays

More diversity of areas of work to get their views on the subject; there were mostly CARATs workers on our course (*Belmarsh*)

More group/class based tutorials

Would have liked more sessions

Practical exercises in order to relate to future situations

Wider selection of multidisciplinary staff to share experiences

Videos/tapes of real sessions

Could be longer

More group discussions and using present cases as examples (without breaching confidentiality)

Different people introducing their own personal/professional experience- could give lectures/do workshops

More case studies and more around mental health and impact of drugs

Practical exercises; it would have been better for me to have two full or half allocated days as it is easier to focus on training activities this way, rather than read through the manual in our own time.

Other models besides CBT represented (still a good experience though)

Practical bridge building diagnostic case studies e.g. cannabis and schizophrenia

Another supervision session

More research work done in other clinical areas based in a forensic setting

More training looking into dual diagnosis

More mental health

More information on working with dual diagnosis

More focus on the combination of mental health and drug use

Information on mental health- impact on behaviour

More detailed/ in-depth explanation of the interaction of different diagnoses/
substance abuse and how to assess and address this in clinical work.

I would like to see this training extended to all HMP staff

6. Other comments

It was difficult to find the time to complete the exercises. Perhaps some dedicated time would have been useful.

Should be either more intensive 3 day course or over a longer period to give time to read up on the subject and use ideas brought up in day to day work

Relevant, excellent manual but time span a bit short

Have enjoyed the training, found it useful and informative and it has enabled me to feel more confident in working with dual diagnosis

Slightly more structure would have been more use to me personally although I only attended one and three.

Situational role-play was helpful; to pull together manual exercises.

The manual could potentially contain more information as I have found it useful as a desk reference. Follow-up sessions for actual case discussions could be helpful.

Good in relation to disciplines within prison coming together from different perspectives though dealing with a similar client group and exchanging ideas experiences and knowledge

The manual is very useful, informative, and easy to understand. The theory goes into just enough depth. It has allowed me to understand why one particular client is resistant and given me ideas on how to modify my approach.

I would like to have further training with more details about dual diagnosis beyond offering the basic knowledge (as an extra workshop)

I very much enjoyed the clinical discussions and in session exercises. I loved the opportunity to practice (learn and/or improve) skills and the role-play exercise we

did in session 2. I also found extremely useful the multi-disciplinary discussions and the trainers personal input from own professional experience (e.g. clinical anecdotes).

Very good, given me more insight; knowledge about dual diagnosis. The importance of other professionals working towards achieving similar goals.

More training provided by the prison will help people to naturally work together between departments therefore covering all therapeutic options for the client

The training was good but I feel I would have got more from it had it been a two-four day full time course.

I thought it was fantastic!

Liz's style was very encouraging, and I have really enjoyed using the group as a sounding board

Just to say thanks for a very interesting course which has given me an insight into dual diagnosis.

I felt the training was excellently researched and the handbook is definitely going to be of use to myself.

The trainer presented the course well and was able to deliver in a way that was easy to follow. I learnt a lot about dual diagnosis and a lot of what I have learnt will be useful in my work now.

Liked the style of delivery from the trainer.

Well presented. However is mostly focused on drug misuse.

It was an enjoyable course- Multidisciplinary work

Overall I found it a useful and enjoyable course. The range of information presented and references websites etc was very useful. The trainer communicated the course content well- varied talk/exercises; also relaxed and responsive style.

Clinical staff already have a basic understanding. This training would be easily

understood by officers who deal with dual diagnosis clients on a daily basis. This would make their job easier.

I felt that what was delivered was adequate and relevant considering the time scale.

I presently post training feel more knowledgeable and confident in dealing with dual diagnosis clients- thank you.

Clear objectives, fully explained, able to put into practice, thanks.

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