# A Randomised Control Trial of Mental Health Awareness and Safeguarding Training (MAST)

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# Executive Summary

Mental health is a core business for MOPAC, policing and partners. In 2014 MOPAC set out key strategic ambitions to reduce the harm caused by gangs, split into the three elements of prevention, intervention and enforcement. The MAST programme feeds into these ambitions by consistently identifying and addressing mental health/emotional trauma of gang members. Furthermore, there is recognition of the need for frontline practitioners to be able to identify and address mental health issues in relation to gangs. MPS officers are often required to act as gatekeepers for those in crisis and regularly face the challenge of having to respond appropriately. Effective police intervention (i.e., identification, timely referrals and a partnership response) can play a significant role in managing mental health needs.

Over the past decade there has also been an increase in both awareness and a concentrated effort to tackle gang crime – with London identifying approximately 3,500 offenders across 182 gangs who are responsible for 9% of all personal robbery; 16% of serious youth violence; and 40% of shootings. Individuals involved with gangs and violence are well recognised to have complex needs, experiencing higher levels of victimisation and a higher incidence of mental health needs, above both the general population and other entrants to the criminal justice system.

In April 2014 the MPS and MOPAC introduced MAST (Mental Health Awareness and Safeguarding Training), with the core aim of promoting the safety of London's youth, by ensuring practitioners take appropriate and timely action when there are signs of mental health needs and/or emotional trauma.

Tasked with evaluating MAST, Evidence & Insight—the research capacity of MOPAC—used an innovative Randomised Controlled Trial (RCT) design, so any differences in responses to a knowledge survey could be directly attributable to the impact of the training. Over one thousand practitioners were included in the research.

**Key Findings**
- Results indicate that general practitioners (i.e., regardless of treatment or control) appeared to have a good base level understanding on issues surrounding mental health. However, feedback about the training was very mixed; less than a third of practitioners were satisfied with the MAST training and negative feedback was received in terms of delivery, venue, equipment and information. Practitioners were most positive towards the use of discussions within the training.
- Despite the negative feedback, MAST was found to have a significant positive impact upon practitioner learning - in particular around understanding mental health, stereotypes, service delivery and overall confidence. Given the RCT methodology employed, we can have confidence in stating it was attending MAST that led to these improved learning outcomes.
- The results indicate clear potential in MAST, which potentially could be enhanced if delivery issues were addressed.

# 1. Introduction

**Policing and Mental Health**

Mental health is a core business for policing. It is estimated that within London more than one million residents live with mental health needs, a higher prevalence than in other counties across the UK.[i] As a result, the MPS routinely come into contact with members of the public, victims of crime and offenders who are experiencing mental health needs.[ii] The MPS Territorial Policing Mental Health team estimate that mental health accounts for over 40% of policing work[iii] and the college of policing estimate that a typical officer might deal with an average of 14 incidents associated with mental health per day. To illustrate this demand, between April 2014 and March 2015, the MPS dealt with 79,811 emergency (999) or non-emergency (101) calls receiving a mental health qualifying code at an average of 14 incidents per day. In addition, the number of mental health related CRIS records captured by the MPS between 13/14 and 14/15 increased by 31% (from 7605 – 9978)[iv] indicating the increasing demand. This is a challenge that needs to be addressed.

Within such encounters police often act as gatekeepers for those experiencing a mental health crisis and regularly face the challenge of having to respond appropriately. Effective police intervention (i.e., identification, timely referrals, strong partnerships etc.) can play a significant role in managing mental ill health. However, historically this has been a difficult challenge for policing to meet, with many notable cases of mismanagement and numerous government reviews/official reports calling for the police to improve their understanding and treatment of people with mental health needs.[v] The most recent of these being the Independent Commission led by Lord Adobowale subsequent to the death of Sean Rigg in police custody in 2008. These reviews consistently highlight challenges around officer training, knowledge, data capture and partnership working. Subsequent to the Adobowale commission there have been a number of innovations seeking to enhance police (and partners) working with mental health such as the Street Triage, recommendations from the Crisis Care Concordat[vi] and Liaison and Diversion[vii] - indicating positive strides on this critical issue.

**The Specific Needs of Gangs and Mental Health**

Over the past decade there has been an increase in both awareness and concentrated effort to tackle gang crime. To illustrate, this includes Government initiatives (e.g., The Home Offices' Tackling Gangs Action Programme, 2007), Ending Gang and Youth Violence (2015), MOPAC Strategic Ambitions document (2014), Policy changes (e.g., mandatory sentences for knife and gun crimes), and the launch of the MPS's Trident in 2012, along with a wealth of original academic research.[viii]

The MPS estimates that in London, there are approximately 3500 gang offenders and 182 gangs and that gang members are responsible for **9%** of all personal robbery, **16%** of serious youth violence and **40%** of shootings.[ix] Offenders are almost exclusively male (97%), of black ethnicity (72%) and the majority are under the age of 19 (47%).[x] Criminal career analysis, conducted by MOPAC Evidence & Insight indicated a typical gang member had on average 9

proven offences in their history, and were on average 15 years old when they committed their first offence.[xi] Other research demonstrates gang individuals are more likely to be stopped and searched by the Police[xii] and experience higher levels of victimisation. These findings indicate the increased potential number of encounters between police officers and other practitioners and gang individuals. Following a reduction in gang crime in 2012, the figure has since been increasing (1579 gang flagged offences in 2013 (CY), compared to 2094 in 2015 (CY)).[xiii]

Research shows that gang members have a higher incidence of mental health needs, not just above the general population, but also above other entrants to the criminal justice system.[xiv] Broader research illustrates wider complex mental health needs associated with youth violence and gang membership, showing high levels of psychiatric morbidity, post-traumatic stress disorder, anti-social personality disorder, psychosis, suicide attempts and anxiety disorders.[xv]

To further illustrate, within a sample of 100 young gang members, it could be expected that[xvi]:
- 86 will have conduct problems (<18 years) or antisocial personality disorder (18+ years)
- 59 will have anxiety disorders (including post-traumatic stress disorder)
- 34 will have attempted suicide
- 25 will have psychosis
- 20 will have depression

The relationships between gang-affiliation and poor mental health operate in both directions, with many of the factors that push or pull young people towards gangs relating to their mental wellbeing and involvement in gang-related activities potentially damaging mental health.[xvii] Such complex needs place a heavy burden on mental health services and highlight the need for an effective partnership response.

**What is MAST?**

In April 2014 MOPAC and the MPS decided to address the need for specific gang-related mental health training by introducing MAST (Mental Health Awareness and Safeguarding Training). The core aim was to promote the safety of young people in London, by ensuring practitioners take appropriate and timely action when there are signs of mental health needs and/or emotional trauma. The provision of joint agency training for practitioners[1] aimed to break down a lack of understanding that can exist between professionals. There was a particular focus on the link between mental health, offending in general and the harm caused by gangs – both to gang members themselves and to vulnerable victims.

In July 2014, MOPAC and the MPS secured the bid from the Home Office. The MAST programme was set to cost £1.41m over two years (£0.84m funded from Innovation Fund). The training consisted of structured delivery sessions, with a mixture of individual and group work, along with short facilitator inputs through video clips, testimonials, contextualised scenarios and case studies demonstrating relevant theory and practice linked to gangs and mental health issues.[xviii] The MOPAC Evidence & Insight team were tasked with evaluating MAST.

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[1] This includes; police, teachers, gang workers, Youth Offending Service, community safety officers, health practitioners, housing officers, young offender institutions, third sector organisations, other emergency services, Child Adolescent Mental Health Services (CAHMS).

# 2. Methodology

A Randomised Controlled Trial design (RCT) was selected to evaluate MAST. In this type of design, the allocation of individuals (or groups/areas) to receive an intervention is determined by random chance, with analysis then comparing those that (randomly) did and did not receive the intervention. RCTs are conceptualised as the 'gold standard' in determining whether a cause and effect relationship exists between the 'treatment' and 'outcome'.[xix] Previous research has successfully demonstrated the feasibility of using this design in evaluating training.[xx]

The research randomly allocated practitioners to either *control* or *treatment* conditions. Surveys were split into two sections: 1) general feedback about the content and delivery of the training and 2) a series of knowledge based ('true' or 'false') statements and scaled attitudinal questions. The control group received section two **before** the training and section one after. The experimental group received section one and two together **post-training**. Due to the random nature of selection, any differences in responses to section two could be directly attributable to the impact of the training. Figure 1 below shows the process of when the surveys were sent out, in relation to the training.
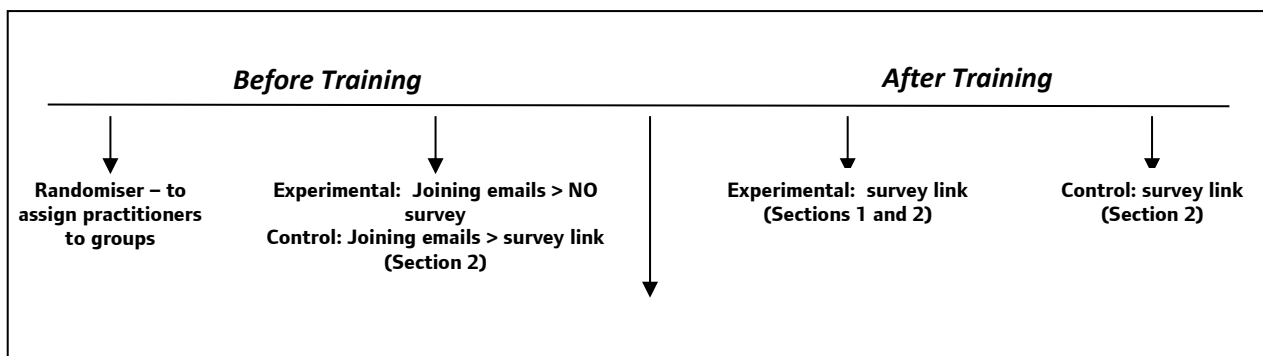


**Figure 1.** When surveys were sent out and randomisation for the MAST evaluation

# 3. Results

This section summarises findings from the trial including demographics of practitioners, feedback on the *experience of attending MAST training*, and the *impact of the training*.

All practitioners who received MAST between 1st June 2015 and 10th January 2016 were included within the current study and randomly allocated to treatment or control. The sessions lasted for a whole day, and each participant only attended one session. Of the total 1020 practitioners, the majority of participants were female (70.8%, n=738), aged between 35-44 years (29.7%, n=305) and involved with policing (34.3%, n=273), followed by those in the education sector (18.2%, n=145). There was no difference between demographics comparing control and treatment groups indicating the randomisation was successful.

**The MAST Experience**

Practitioners reported far more negatives than positives when giving feedback on the MAST training. To illustrate, **less than a third** of practitioners reported being satisfied with the session (28%, n=280). In terms of delivery techniques, there was limited support for the PowerPoint slides (35%, n=367 reported them as useful), hand-outs (43%, n=458, reported them as useful) and exercises (51%, n=543, reported them as useful). Few practitioners reported the event materials being clear and easy to understand (15%, n=146). Only 32% (n=324) of practitioners felt the training was pitched at the right level, the majority felt the training was delivered too quickly (64%, n=648) and very few thought they were given time to ask questions (7%, n=68). The practitioners also gave negative feedback regarding the venue of the training itself, with only 14% (n=139) agreeing it was satisfactory with specific comments on the venue focused upon the lack of refreshments making the day unpleasant.

> *'The training was not specific to anyone's role, therefore it felt ineffective'*
> *'The training was basic and not pitched to the right level of service'*

In terms of the positives, the majority of practitioners reported the 'group interactions' were positive (70%, n=745) and were generally positive towards the facilitator (e.g., they were engaging (73%, n=767) and knowledgeable (66%, n=692)). Practitioners suggested the trainers were more akin to 'facilitators' with most learning coming from discussions with one another.

> *'Discussions/sharing practice was very informative'*
> *'Excellent for meeting other services and building links for the future'*
> *'There was a lot of time for discussion and coming up with ideas together but very little actually taught'*

Of note for future sessions, around half of respondents (54%, n=535) said that learning about the *'resources available to individuals'* would be beneficial and that they found the topic *'gangs and associated mental health needs'* to be the most useful (60%, n=675). Finally, the understanding of cross-partner working is clearly something practitioners in both groups are keen to develop, as the majority (61%, n=535) stated *'joint agency training'* would be useful.

Whilst the practitioner experience of MAST appears to be more negative than positive, the above should be seen as learning opportunities. Each of the negatives raised by practitioners could be designed out and improved upon by revising the MAST training manual.

### Impact of MAST training

It should be stated upfront that practitioners in general (i.e., regardless of treatment or control group) appeared to have a good base level understanding on issues surrounding mental health. In 8 of the 18 'true' or false' questions (all survey questions and % in appendix) there were no difference between treatment and controls - both were equally likely to answer correctly. These questions focused on the practical and common sense aspects of mental health knowledge, such as risk factors and types of mental health need. This was a positive and welcome finding given what has been written before around mental health training.

However, analysis suggested there are significant differences between the experimental and control groups on a number of other questions relating to knowledge and confidence. Results are therefore outlined in two thematically based areas: 1) Understanding mental health and stereotypes and 2) Service delivery and confidence.

### Understanding Mental Health and Stereotypes

The experimental group (i.e., those to receive the survey **after** the training) were significantly more likely to answer **correctly** to the following questions:

- **'*people with mental health issues cannot be cured'*** (more likely answer false: 94%, (n=413) vs 88% (n=443), p=.004).
- **'*people with mental health needs are more likely to be violent'*** (more likely to answer false: 81% (n=355) vs 73% (n=367), p=.006)
- '**... *can identify warning signs that someone is gang affiliated'*** (more likely to agree, 49% (n=212) vs 28% (n=138), p=.000).

We see the majority of all practitioners answer correctly to the above questions; however, the treatment group do significantly better - indicating the training has successfully increased knowledge and reduced stereotypes.

**Service Delivery and Confidence**

The experimental group were significantly more likely to answer correctly to the following questions:

- **'*I know how best to help*'** (more likely to agree, 34% (n=151) vs. 16% (n=79), p=.000).
- **'*I understand the services on offer from different organisations'*** (more likely to agree, 45% (n=192) vs. 20% (n=97), p=.000).
- The experimental group felt more confident in ***making a referral to the appropriate organisation*** (54% (n=233) vs. 32% (n=156), p=.001).
- The experimental group were also **less likely** to feel worried about taking the wrong choice of action (34% (n=147), vs. 24% (n=118) (p=.001).
- The experimental group were ***significantly more confident*** in understanding the most common types of mental health and emotional trauma (69%, (n=331) vs. 32% (n=152), p=.000).
- The experimental group were ***significantly more confident*** in understanding how mental health issues may present themselves in young people (71%, (n=341) vs. 29% (n=141), p=.001)

These findings indicate that MAST has had a positive impact upon service delivery and overall confidence for practitioners working with mental health and trauma.

# 4. Discussion

Many reports have highlighted the complex relationship between mental health and the police alongside the challenges officers (and other practitioners) face. Evidence indicates that the police are facing an increasing mental health demand and often report feeling unprepared to meet this challenge. In this instance the development of MAST training is timely.

In terms of the results - a decidedly mixed picture emerges. Less than a third of practitioners were satisfied with the MAST training, and there was negative feedback in terms of delivery, venue, equipment and information. The only aspect of MAST that practitioners were mostly positive about was the use of discussions within the training. These design issues are obviously important, although are all able to be designed out in subsequent iterations of MAST. However, such negative feedback did not appear to impact upon practitioners learning, as the research found that MAST had a positive impact upon practitioner learning - in particular around understanding mental health, stereotypes, service delivery and confidence. Given the methodology employed, that of a Randomised Control Trial, we can have confidence in stating that it was attending the MAST that led to these improved learning outcomes.

Stage two of MAST was originally planned as part of the evaluation - although delays in rollout of the second part made further follow up questions impractical. However, further work would be welcome on this second stage to explore impact and issues of sustainability around the learning. Indeed, whilst this evaluation suggests knowledge has increased, this is no guarantee it will be retained or how it can be practically used. Nonetheless, the findings are most encouraging at this stage. Given there is a significant impact upon learning at this stage, especially considering the generally negative views of participants - imagine the results if these delivery issues were designed out. There is clear room for increased impact.

Finally, the methodology employed here is also noteworthy. Many authors describe Randomised Controls Trials as complex, time consuming and/or expensive.[xxi] The current research demonstrates this is not the case and RCTs can be used in a cost free and quick time environment. Further opportunities should be sought to utilise this design when appropriate.

# Appendix A

| Question | Measure | Experimental % (n) | Control % (n) | x2 | p |
|---|---|---|---|---|---|
| Resilience to developing mental health needs is not something that can be learnt | False | 84.6% (374) | 79.9% (401) | 3.585 | .058 |
| People with mental health needs are more likely to be violent | False | 80.5% (355) | 73% (367) | 7.412 | .006 |
| 1/20 adults will be diagnosed with a mental health need at some point in their life time | False | 45.1% (199) | 29.7% (149) | 24.046 | .000 |
| Just under 50% of people don't mention their mental health needs on forms | False | 23.6% (104) | 14.9% (75) | 11.402 | .001 |
| Just over 60% of young people who reported having a mental health need stopped hanging out with friends | False | 28.6% (126) | 21.5% (108) | 6.267 | .012 |
| Just over 40% of young people who reported having a mental health need did not tell their families | True | 93% (410) | 86.7% (435) | 10.060 | .002 |
| Having a clear sense of identity promotes resilience to developing mental health needs | True | 88.9% (392) | 80.9% (406) | 11.583 | .001 |
| People with mental health needs cannot be cured | False | 93.7% (413) | 88.2% (443) | 8.186 | .004 |
| Just under 80% of those in a gang will have a drug dependence (mainly cannabis) | False | 40.7% (179) | 33.9% (170) | 4.672 | .031 |
| Good educational experience is a key factor in promoting resilience to developing mental health needs | True | 88.2% (388) | 81.1% (407) | 8.991 | .003 |
| 80% of gang members will have conduct problems | True | 74.4% (328) | 73.9% (371) | 0.027 | .869 |
| Lack of social inclusion is a joint risk factor for those who have mental health issues and are gang affiliated | True | 93.4% (412) | 95% (478) | 1.123 | .289 |
| Mental health issues frequently affect people's ability to function | True | 78% (344) | 79.3% (399) | 0.244 | .621 |
| Risk factors are cumulative | True | 78% (344) | 73.2% (368) | 2.974 | .085 |
| Domestic violence is a joint risk factor for those who have mental health issues and are gang affiliated | True | 82.1% (362) | 84.5% (424) | 0.955 | .328 |
| A lack of positive interactions with others can be a risk factor in mental health issues | True | 91.4% (459) | 91.8% (408) | 0.050 | .824 |
| People with mental health issues are less likely to be a victim of crime | False | 97.2% (489) | 96.1% (424) | 0.850 | .357 |

| | | | | | |
|---|---|---|---|---|---|
| 9/10 young people who describe mental health problems experience stigma and discrimination | True | 89.3% (394) | 92.4% (465) | 2.761 | .097 |
| I know how best to help | Agree (scoring 7-10) | 34.6% (151) | 16% (79) | 66.448 | .000 |
| I am worried about taking the wrong choice of action | Disagree (scoring 1-4) | 33.7% (147) | 23.9% (118) | 15.100 | .001 |
| I am concerned the individual will lash out and be violent | Disagree (scoring 1-4) | 53.2% (232) | 49.2% (243) | 1.864 | .394 |
| I am confident my colleagues will know what to do | Agree (scoring 7-10) | 46.6% (203) | 24.7% (122) | 51.072 | .000 |
| I can identify warning signs that someone is gang affiliated | Agree (scoring 7-10) | 49.3% (212) | 28.3% (138) | 54.537 | .000 |
| I can understand the services on offer from different organisations | Agree (scoring 7-10) | 44.7% (192) | 19.9% (97) | 79.889 | .000 |
| I am confident in making a referral to the appropriate organisation | Agree (scoring 7-10) | 54.2% (233) | 32% (156) | 56.398 | .000 |
| There is a good integration between services with those working with mental health needs | Agree (scoring 7-10) | 25.1% (108) | 12.9% (63) | 26.467 | .000 |
| There is confusion as to what responsibilities lie with which organisation | Disagree (scoring 1-4) | 22.1% (95) | 12.3% (60) | 17.553 | .000 |
| Q10: How confident are you in your understanding of the most common types of mental health and emotional trauma? | Confident (scoring between 7-10) | 68.5% (331) | 31.5% (152) | 165.259 | .000 |
| Q11: How confident are you in your understanding of how mental health issues may present themselves in young people | Confident (scoring between 7-10) | 70.7 (341) | 29.3% (141) | 202.229 | .000 |
| I am worried about the legal reprisals of the actions I take | Agree (scoring between 7-10) | 15.1% (66) | 15.65 (77) | 3.672 | .159 |
| There are barriers to timely and appropriate sharing of information between organisations | Disagree (scoring between 1-4) | 55.3% (241) | 49.4% (244) | 3.672 | .159 |
| There are lots of unknown circumstances | Disagree (scoring between 1-4) | 8.5% (37) | 7.7% (38) | 0.455 | .796 |

# References

[i] Hobson, Z. (2015) *Mental Health Street Triage Pilot.* London (Internal MOPAC report)

[ii] Independent Commission on Mental Health and Policing Report (2013)

[iii] London Councils, January 2014

[iv] Hobson, Z. (2015) *Mental Health Street Triage Pilot*. London (Internal MOPAC report)

[v] 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: DH; Flanagan, R. (2008). *Final report of the independent review of policing commissioned by the Home Secretary and conducted by Sir Ronnie Flanagan.* London: Home Office; Cabinet Office (2007). *The Cabinet Office Policy Review, Building on Progress: Security, Crime, and Justice.* London: The Cabinet Office; IPCC (2006). *Deaths During or Following Police Contact.* Available at: www.ipcc.gov.uk; including the Independent Commission on Mental Health and Policing chaired by Lord Adebowale, the subsequent Mental Health and Policing report the Mental Health Crisis Care Concordat and the Home Affairs Select Committee Mental Health and Policing Inquiry.

[vi] Mental Health Crisis Care Concordat (2014). http://www.crisiscareconcordat.org.uk/

[vii] NHS Commissioning: Liaison and Diversion (2015). https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/

[viii] http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/DyingtoBelongFullReport.pdf; https://www.ncjrs.gov/pdffiles1/nij/188741.pdf

[ix] Specialist Crime & Operations Intelligence Department (April 2014 – March 2015)

[x] MetMis

[xi] Strategic Ambitions for London: GANGS AND SERIOUS YOUTH VIOENCE. 2014.

[xii] Stanko, B., Dawson, P. (2012) Reflections on the offending histories of those arrested during the disorder.

[xiii] MetMis

[xiv] http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1726661; 'A need to belong: What leads girls to join gangs' Lorraine Khan, Helena Brice, Anna Saunders & Andrew Plumtree. Centre for Mental Health; http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf

[xv] Coid, (2013). Gang membership, Violence, and Psychiatric Morbidity.

[xvi] Madden, V (2013) Understanding the Mental Health Needs of Young People Involved in Gangs: A Tri Borough Public Health Report produced on behalf of the Westminster Joint Health and Wellbeing Board. The Westminster Joint Health and Wellbeing Board. http://www.mac-uk.org/wped/wp-content/uploads/2013/03/Mental-Health-and-Gangs-Report-2013.pdf

[xvii] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398674/The_mental_health_needs_of_gang-affiliated_young_people_v3_23_01_1.pdf

[xviii] http://www.masttraining.co.uk/mast-awareness.html

[xix] The Magenta Book, 2001. Available at: https://www.gov.uk/government/publications/the-magenta-book.

[xx] Skogan, W (2014). Training police for procedural justice. Journal of experimental criminology.

[xxi] Gondolf, E. W. (2001). Limitations of Experimental Evaluation of Batterer Programs. *Trauma, Violence and Abuse, 2,* 79–88; Hollin, C. (2008). Evaluating Offending Behaviour Programmes: Does Only Randomization Glister? *Criminology & Criminal Justice, 8,* 89–106.