



**Better health, better lives for prisoners:
A framework for improving the health of Scotland's prisoners**

**Volume 2:
Supporting material for the framework**

Contents – Volume 2

Annexes

Annex A	Project Group Members	3
Annex B	Health Care Standard 6	4
Annex C	Methodology	6
Annex D	Literature and policy review	9
Annex E	Focus group results	58
Annex F	Stakeholder questionnaire results	63
Annex G	Comments from stakeholder event - 29 March 2011	72

Annex A: Project Group

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Annex B: Health Care Standard 6

Clinical and related services for preventing illness and promoting health

Standard statement

To develop and provide clinical services focused on preventing illness and promoting health.

6.1 Criteria: Organisational

1. Each establishment will have a Local Health Promotion Action Group. Membership will be multidisciplinary and will include healthcare staff who will contribute on matters relating to prisoners' health and at least one external health promotion specialist member (preferably a senior health promotion officer from the local NHS Health Promotion Department).
2. A senior operational manager responsible for managing prisoners will chair the local Health Promotion Action Group.
3. The Local Health Promotion Action Group will devise an annual activity plan for their establishment. The activities identified within the plan will mirror local and national health promotion priorities and be delivered in partnership with local/national healthcare partners.
4. Healthcare focus groups will be established to provide prisoners with the opportunity to contribute to decisions about their care and wider health promotion issues within their establishment.

6.2 Criteria: Delivery

The Health Promotion Action Group will:

1. Identify a minimum of four health promotion initiatives/events per year within NHS Health Scotland calendar.
2. Each establishment will provide a range of current health promotion and educational materials that are easily accessible to the prisoner population.
3. Health promotion will be a key planned component of the delivery of care by each practitioner nurse.
4. Healthcare staff will participate in each prisoner's induction and pre-release processes.
5. Health promotion events will be evaluated by the local health promotion action group.

References:

Mental Health provision in prisons, WHO (2000)
The Health Promoting Prison - A Framework for Providing Health in SPS (2002)
Towards a Healthier Scotland (1999) SE
National Plan: Plan for Action, Plane for Change (2001) Scottish Executive
Same as You (2000) Scottish Executive
Clear Direction: A guide for Forming Health Events, HEBS (2000)
Delivering for Health
Improving Health for Scotland (SEHD 2003)
Better Health Better Care (Scottish Government 2007)
Equally Well SGHD
Keep Well SGHD

Annex C: Methodology

The process started in November 2010 and comprised:

- project scoping with the Project Steering Group
- literature and policy review
- focus groups with prisoners
- stakeholder questionnaire
- stakeholder event – Tue 29 Mar 2011. (This consisted of presentations and 2 workshops to gather stakeholder opinions on health improvement outcomes and discussion of the best way forward.)
- drafting
- external stakeholder consultation
- final draft preparation incorporating stakeholder comments.

Literature review

Promoting health in Scotland's prisons: Literature review questions

Key search words are in **bold**:

1. What evidence is there that **health interventions/improved health in prison** are associated with reduced **re-offending**?
2. What evidence is there that **health interventions/improved health (mental health and physical health)** are associated with less **disciplinary issues in prison**?
3. What is the evidence that **healthy behaviour in prison** will be continued **post-release** for [insert time period]? e.g. 3m, 6m, 1yr, 1yr+

Supplementary questions to (3):

- What is the evidence of **discontinuation of healthy behaviour after admission to prison**?
 - What is the evidence of the **impact of prison on pre-existing health behaviours** (positive and negative)?
4. Which **theories of health promotion** have the longest lasting (**duration**)/best effects in **prison**?
[Examples of well-known theories are:
 - Health Belief Model
 - Theory of Reasoned Action
 - Transtheoretical (stages of change) Model
 - Social Learning Theory]
 5. What **risk factors** contribute to **poor health in prisons/after leaving prison**?
 6. What is the evidence that a **holistic/whole prison/healthy prison** approach leads to improved **health outcomes** for prisoners?
 7. How is a **holistic/whole prison/healthy prison** approach best **implemented**? What evidence is there regarding the most effective **elements/factors** to include?
 8. What **health promotion** interventions are **most effective** (ideally in **prison** setting) to:
 - a. reduce **smoking**
 - b. reduce harmful use of **alcohol**
 - c. reduce harmful use of **illicit drugs**
 - d. increase **physical activity**
 - e. increase uptake of **healthy eating**
 - f. encourage better **dental hygiene/health**

- g. increase safer **sex**
 - h. reduce **transmission of blood borne viruses**
 - i. improved **mental wellbeing**.
9. What is the evidence that **peer educators** improve **health outcomes** among **prisoners/in prison**?
10. What is the evidence of effectiveness of **health promotion delivery/implementation** among non-healthcare professionals in prisons? i.e. **Prison staff/officers, prison chaplains**, etc.
11. What are the most useful **outcome variables** to **measure** to assess **health improvements/health outcomes**?

Search strategy

The following databases were searched by the NHS Health Scotland Researcher and NHS Scotland Librarian:

- OVID Medline
- Embase
- CINAHL
- PsychInfo
- PubMed
- Cochrane Database
- Social Policy and Practice (via OVID)
- Applied Social Sciences Index and Abstracts (ASSIA)

Each literature review question was treated as a separate search, which was then conducted in each of the eight databases above. The search terms used are those highlighted in **bold** in the literature questions. We used subject headings (specific to each database), as well as search terms defined by those undertaking the review. Duplicate papers were excluded.

The time period searched included papers over 10 years, between November 2001 and (present) November 2011.

Inclusion/exclusion criteria

Studies were considered eligible for inclusion if English-language and conducted in developed countries. Studies from developing countries were excluded as it was considered unlikely that their results would be applicable in Scotland.

Results

Once the search was complete, we reviewed 383 titles and abstracts and requested the full text for all papers that were considered relevant. This resulted in requesting 139 full papers. The identified studies were scanned for further references. Additionally, 14 full papers were found by hand searches and librarian intelligence, with a total of 153 full papers reviewed.

A hierarchy of evidence was then applied, with studies holding varying weight depending on their underlying methodology. Randomised controlled trials and meta-analyses hold the most weight but only two such studies were found. Next in weight are case control or cohort studies, followed by cases series and expert consensus and then case reports. The vast majority of papers found for this review were qualitative studies, which are the lowest ranking studies in the hierarchy.

Focus group methodology

Four focus groups were held in prisons detaining young offenders (YOs), women and men in both open and closed conditions. The following prisons were visited:

- YOI Polmont (male, YO, closed)
- YOI and HMP Cornton Vale (female, YO and adult, closed)
- HMP Glenochil (male, adult, closed)
- HMP Castle Huntly (male, adult, open)

YOI = Young offender institution

HMP = Her Majesty's Prison

Focus groups were facilitated by pairs of interviewers, using a topic guide concerned with experiences of, and interest in, health promotion in prison. Sessions were audio-recorded and transcribed. Data were analysed thematically, providing both a longer analysis and a shorter summary (which is published in Annex F).

Stakeholder questionnaire

An electronic copy of the stakeholder questionnaire was distributed widely to stakeholders within the Scottish Prison Service (SPS), the NHS and voluntary organisations. This generated 26 responses. The questionnaires came mainly from SPS (healthcare and non-healthcare staff) but also included some NHS Health Promotion Managers and a few non-governmental organisations (NGOs).

Annex D – Literature and policy review

What evidence is there that health interventions/improved health are associated with reduced re-offending?

1. The formal literature charting the association between improved health and reduced offending is limited. This is likely to be related to the inherent complexity of both health and offending behaviour. However, the Social Exclusion Unit lists mental and physical health and tackling drug and alcohol misuse as two of nine key factors influencing reoffending¹. Other key factors include housing, employment and education and training.
2. Supporting this, in a study of young offenders, Evans Cueller et al found that 'there is the potential for some health interventions, such as for mental illness and drug and alcohol misuse, to have an impact on the trajectory and lethality of recidivist behaviour.'^{2,3}
3. There are few specific health interventions that have robust supporting evidence; however, improved diet is one of them. Gesch et al observed 'that supplementing prisoners' diets with physiological dosages of vitamins, minerals and essential fatty acids caused a reduction in antisocial behaviour [prison-defined disciplinary breaches] to a remarkable degree'.⁴ Lester et al observed that even where the prison menu allowed for at least the recommended five portions of fruit and vegetables a day, prisoners did not make use of this. She found that this was in keeping with the dietary choices of the local population from which the prisoners came. Lester et al concluded, extrapolating from Gesch et al's findings, that 'if dietary habits are improved in prison and maintained on release, it is possible that criminality could decrease'.⁵
4. Treatment of prisoners with schizophrenia seems to reduce their rates of re-offending.⁶

What evidence is there that health interventions/improved health are associated with less disciplinary issues in prison?

5. This is an important issue where the prison health promotion and the security and control agendas need clarity on how they can support each other.
6. A paper by Cloyes reports the correctional centre mental health program (CCMHP) in Washington state prisons, USA.⁷ Prisoners were on long-term sentences. Prisoner screening

¹ Social Exclusion Unit (SEU) (2002), *Reducing re-offending by ex-prisoners*, Office of the Deputy Prime Minister.

² Evans Cueller A, McReynolds LS, Wasserman GA. A cure for crime: Can mental health treatment diversion reduce crime among youth? *J Policy Analysis Management* 2006; 25(1):197-214.

³ Chapman J, Desai R, Falzer P. *Child Adolesc Psychiatr Clin Am* 2006;15:445-58.

⁴ Gesch CB, Hammond SM, Hampson SE, Eves A, Crowder MJ. Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners. Randomised placebo controlled trial. *British Journal of Psychiatry*, 2002;181:22-28.

⁵ Lester C, Hamilton-Kirkwood L, Jones NK. Health indicators in a prison population: Asking prisoners. *Health Education Journal* 2003. 62:341.

⁶ Fazel S, Yu R. Psychotic disorders and repeat offending: systematic review and meta-analysis. *Schizophr Bull* 2009; published online Dec 3.

⁷ Cloyes KG. Challenges in Residential Treatment for Prisoners With Mental Illness: A Follow-up Report. *Archives of Psychiatric Nursing* 2007;12(4):192-200.

on entry for serious mental health problems was considered unreliable. The other option was seclusion when mental health problems became acute. An intermediate intervention was considered necessary: a residential psychosocial skills program for prisoners to help them manage their symptoms in collaboration with prison staff and adjust to life in prison. This was considered worth doing for reasons other than simply the intrinsic worth of better health, since mentally ill patients were associated with higher rates of disciplinary issues including violent assaults on staff, and consequently failure to earn remission for good behaviour. The programme consisted of therapeutic interventions and coping skills training. The qualitative part of the study comprised 13 interviews: 5 prison staff, 5 prisoners and 3 mental-health staff. The paper describes how professional antagonisms and differing views of appropriate treatment for prisoners between prison officers and mental health counselling staff affected the program. The counsellors had to appear to meet prison officer expectations of 'hardness' while continuing to be effective therapists. Although this custody/care dilemma was a pressure, the programme held to its goals.

7. De Viggiani reported a good ethnographic study, involving five months intensive on-site contact, which was conducted in an adult male training prison in England, using participant observation, group interviewing, and one-to-one semi-structured interviews with prisoners and prison officers. Prisoners were stripped of their identity on arrival through surrendering clothes and personal possessions, and the system was engineered to disempower them, and then to rebuild them through an induction process with rewards for good conduct.
8. An important finding was that the earned incentives scheme was perceived as a control rather than a reward strategy by prisoners, those who participated were seen as 'collaborators'. They felt they were treated like children, and experienced negative effects on their mental wellbeing. The daily routine was monotonous with 23 hours in a cell not conducive to maintaining bodily or mental fitness.

'The prison regime achieved a high degree of security and control, but was flawed as a rehabilitative strategy; essentially, it forced prisoners to become subservient or to rebel. Prisoners were rendered emotionally, psychologically and physically dependent on the system, and were discouraged from taking control or responsibility for themselves.'

9. Differential pay rates for different forms of prisoner employment were seen as unfair and helped cause bullying of poorer prisoners who were given loans they could not repay by richer prisoners (barons) who could receive money from others outside prison. Short-term privileges (e.g. in-cell TV) given as rewards distracted attention from long-term rehabilitation goals, leading to more anxiety about the future after release. Overcrowding was a deprivation issue for de Viggiani⁸, whose evidence supported a 2002 prisons inspectorate report suggesting it had 'discernible damaging effects on safety, respect, purposeful activity and resettlement.'

⁸ De Viggiani N. Unhealthy prisons: Exploring structural determinants of prison health. *Sociology of Health and Illness* 2007;29(1):115-35.

10. Condon reports a semi-structured interview study of 114 prisoners' views of making healthy choices in English prisons.^{9,10} She concludes health promotion models assume autonomy, which is more restricted in prison, meaning making healthy choices is more difficult there for prisoners. Prison discipline in the sense of institutional rigidities, for example lack of choice in the canteen for diabetic people or lack of exercise opportunities for elderly people, may hamper health promotion. Health promotion may focus on, for example, a health behaviour topic such as smoking, or health protection activities such as immunisation, while neglecting others.

Young offenders

11. A 2009 Her Majesty's Inspectorate of Prisons (HMIP) report on standards expected for the treatment of young people in prison has a section on confronting and reporting bullying.¹¹ There is a section on health care which mentions a requirement to hold regular infection control audits, existence of a whole prison approach to health, existence and awareness of communicable disease prevention policy, and evidence of the wide availability of health promotion information. Three hours of physical education (PE) per week, a chaplaincy and individual faith classes are also expected to be available, as is an hour per day of outdoor recreational activities. Behaviour management rewards and sanctions are described but a link between health and good behaviour is not mentioned. There is a catering section but diabetes options are not mentioned. A substance use section mentions prevention of trafficking in drugs or alcohol. A section on post-release pathways includes one for physical and mental health, and one for drugs and alcohol. A children and families pathway includes parenting skills for young people with children of their own.
12. Woodall, from a small focus group and interview-based study in a unit for young offenders aged 18–21, suggests that stress can be a cause of disciplinary issues in prison, and this can be related to telephoning friends and family and to the ending of visiting time.¹² Some prison officers added to stress by treating prisoners in ways experienced as disrespectful, and positive comments were made about the value of female officers, perhaps because they were seen as more sensitive and willing to engage with prisoners. Although counselling was available, a particularly masculine culture among prisoners, valuing the ability to cope with the stresses of incarceration without needing to confide in others (seen as the act of potential self-harmer, taunted as a 'slasher') was a discouragement to take up of counselling.
13. In a study comparing the effects of the introduction of smoking bans at two English young offender units (males age 15–18), the rate of bullying in both units was found to decrease following the introduction of a no-smoking policy.¹³ However, the data was collected by

⁹ Condon L, Hek G, Harris F. Choosing health in prison: prisoners' views on making healthy choices in English prisons. *Health Education Journal*, 2008;67(3):155-66.

¹⁰ Condon L, Hek G, Harris F, Powell J, Kemple T, Price S. Users' views of prison health services: a qualitative study. *Journal of Advanced Nursing* 2007 May;58(3):216-26.

¹¹ Her Majesty's Inspectorate of Prisons. *Expectations: criteria for assessing the treatment and conditions for children and young people held in prison custody*. 2009.

¹² Woodall J. Barriers to positive mental health in a young offenders institution: A qualitative study. *HEALTH EDUC J* 2007;66(2):132-40.

¹³ Lawrence S, Welfare H. The effects of the introduction of the no-smoking policy at HMYOI Warren Hill on bullying behaviour. *International journal of prison health* 2008 Sep;4(3):134-45.

anti-bullying logs, which may not have been consistently completed. Young people's reported perceptions of increases or decreases in bullying were also used, which may have been open to social desirability bias. There was no test of the statistical significance of the fall in bullying. Tobacco formed a currency in the prisons. There was disagreement about whether other items had replaced tobacco as a currency after the smoking ban. Some prisoners were classed as pure bullies, others pure victims, others were bullies/victims, and others were not involved. Each institution had a different profile on this taxonomy. The paper suggests that the bully/victim may be a learned response to communicate to peers that the individual is not a pure victim, and that this feedback circuit may be cut by increasing the prisoners self-confidence so reducing their fear and reducing their aggressive response to bullying.

Women offenders

14. The delivery to girl offenders of communication skills training to defuse potentially violent situations was tested in a comparison of two prospective cohorts with interventions delivered at 15 sites.¹⁴ The intervention group had higher use of the communication skills (measured using validated tools) at six months after delivery of training. Although the communication skills were significantly increased, it was not clear how girls were selected for each intervention.
15. A discussion paper by Smith (2002)¹⁵ specifically considers female prisoners and food, seeing rebellion against both a healthy diet and prison food that is perceived as bad or unhealthy as a way women assert their control over their own bodies in prison. Rebellions may include under- or over-eating, or food as a trigger for fights. The paper is of relevance in that bad food may provoke a reaction that results in a need for disciplinary action.

Drug using offenders

16. Smith (2002)¹⁶ discusses connections between public health issues and prisons practices and culture in the context of the Victoria prison in Australia. Key issues she identifies are that treating illicit drug use as a criminal rather than a health issue that could be treated in the community hampers health promotion by exposing people to brutalising experiences in prison. She notes the tension between the punishment and rehabilitation aims and that although giving more autonomy may result in disciplinary issues in the short term, this was a problem needing to be addressed rather than perpetuating the problems of prisoners in prison. Smith highlights a poor case management system as a crucial area for improvement in the prison.

Summary

17. To summarise, there is currently an ongoing debate about how best health promotion and the traditional prison purpose of the control and punishment of offenders for the protection of society from crime can work together. There is some evidence that to address some

¹⁴ Kelly PJ, Owen SV, Peralez-Dieckmann E, Martinez E. Health interventions with girls in the juvenile justice system. *Womens Health Issues* 2007 Jul;17(4):227-36.

¹⁵ Smith C. Punishment and pleasure: Women, food and the imprisoned body. [References]. *The Sociological Review* 2002 May;Vol.50(2):197-214.

¹⁶ Smith D, Gibson J. Can a prison practise good public health? *Australian Journal of Primary Health* 2002;8(3):81-6.

issues, such as drug use and violence arising from a mental health problem, as matters that are solely for punishment, and that control is counterproductive. On the one hand, drugs may be used as a currency and play their part as prison currency used to support intimidation and bullying. On the other hand, violence may prolong a stay in prison, when the aim is to move people on and prevent reoffending and re-imprisonment. Prisoner reward systems may also be counterproductive and need careful design. Other interventions can be relevant to health promotion in unexpected ways in prison, for example communication skills for defusing violent situations, smoking bans to reduce bullying, and stress reduction methods to reduce bullying. Prison can be disempowering for prisoners through a reduction in their autonomy. Ultimately, this may work against their practising the personal discipline of a healthy lifestyle, so hampering prison health promotion.

What is the evidence that healthy habits in prison will be continued back in the community?

18. Much of the evidence relating to the post-release follow-up of health promotion interventions for prisoners comes from the USA and work with HIV-infected prisoners. The evidence highlighted the importance of strong support systems to help satisfy basic needs eg housing, employment and access to medical and mental health services.^{17,18} There are various examples of case-management where HIV-positive prisoners attend health education groups to reduce higher risk behaviour, in the last few weeks before their release. These programs have shown benefit in reducing the sexual and drug-related risk behaviour in the months following release.¹⁹

19. There were no studies found, discussing the discontinuation of healthy behaviour after admission to prison but consistently reported elements in prison life make this more likely. For example, Douglas et al observed that women reported an increase in smoking and intake of high-carbohydrate 'comfort foods' to help cope with their boredom, aimlessness or stress.²⁰

What evidence is there regarding the types or methods of health promotion that have the most long-reaching effects?

20. The available evidence for this is very limited; however, as Gaiter and Doll reported in 1996, 'successful prevention planning for prison populations requires an understanding not only of the specific risk behaviours but also of the contexts and conditions that sustain them. No standardised format is likely to meet the needs of all risk groups.'²¹ While they specifically referred to HIV prevention, it could be suggested that the same is true for all risk behaviours.

¹⁷ Arriola KR, Briathwaite RL, Holmes N, Fortenberry R. Post-release case management services and health-seeking behaviour among HIV-infected ex-offenders. *Journal of Health Care for the Poor and Underserved* 18 (2007):665-674.

¹⁸ Leukefield C et al. Drug abuse treatment beyond prison walls. *Addiction Science & Clinical Practice*. 2009.

¹⁹ Grinstead O, Zack B, Faigeles B. Reducing post-release risk behaviour among HIV seropositive prison inmates: the health promotion program. *AIDS Education and Prevention*: 2001;13,2.

²⁰ Douglas N, Plugge E, Fitzpatrick R. The impact of imprisonment on health: what do women prisoners say? *J Epidemiol Community Health* 2009;63:749-754.

²¹ Gaiter J, Doll LS (1996). Improving HIV/AIDS prevention in prisons is good public health policy. *American Journal of Public Health*, 86: 1201-1203.

What is the evidence that a holistic/whole prison approach leads to improved health outcomes for prisoners? How is a 'whole prison' healthy approach best delivered?

WHO (2007)²² defines the health promoting prison to include the holistic approach:

'The phrase health promoting prison is used to cover the prisons in which: the risks to health are reduced to a minimum; essential prison duties such as the maintenance of security are undertaken in a caring atmosphere that recognizes the inherent dignity of every prisoner and their human rights; health services are provided to the level and in a professional manner equivalent to what is provided in the country as a whole; and a whole-prison approach to promoting health and welfare is the norm.'

21. According to the Department of Health in England (2002),²³ the health promoting prison aims at:

- building the physical, mental and social health of prisoners (and, where appropriate, staff)
- helping prevent the deterioration of prisoners' health during or because of custody
- helping prisoners adopt healthy behaviours that can be taken back into the community.

22. Although 14 years have passed since the publication of a highly critical review of prison health care in England and Wales by the Chief inspector of Prisons in 1996, papers still appear debating whether public health can be practised in prisons, for example Baybutt 2007.²⁴ However, the assumption now certainly is that it can be, and the whole prison approach is recommended for health promoting prisons, based on the settings approach to health promotion. The whole prison approach is defined by the above paper as including three elements:

- Policies in prisons which promote health (eg a no smoking policy);
- An environment in each prison which is actively supportive of health;
- Prevention, health education and other health promotion initiatives which address assessed health needs within each prison

23. Baybutt notes that all doctors working in prisons in England and Wales are now General Practitioners, mostly working in both the community and the prison, and a restricted medical model of care is no longer accepted. Prison is seen as an opportunity to reach normally hard to reach deprived groups.

24. Examples of the whole prison approach in practice include routine opt-out HIV testing, which increased testing rates compared to testing on request, from 18% to 78%, in one study,²⁵ and in another led to identification of 75 more new HIV+ infections and to 83

²² World Health Organisation. Health in prisons. A WHO guide to the essentials in prison health, Geneva, 2007. http://www.euro.who.int/_data/assets/pdf_file/0009/99018/E90174.pdf.

²³ Department of Health. Health Promoting Prisons: a shared approach, London. 2002.

²⁴ Baybutt M, Hayton P, Dooris M. Prisons in England and Wales: An important public health opportunity? A reader in promoting public health: Challenge and controversy. Thousand Oaks, CA: Sage; 2007. p. 237-45.

²⁵ Liddicoat R, Zheng H, Internicola J, et al. Implementing a routine, voluntary HIV testing program in a Massachusetts county prison. J Urban Health 2006;83:1127-31.

initiations on to anti-retroviral therapy.²⁶ This was discussed in a narrative review by Beckwith (2008)²⁷, who concluded routine opt out HIV testing in prisons should be expanded. A holistic approach integrating addiction harm reduction strategies with HIV prevention strategies can help to improve the prevention of HIV transmission, for example methadone maintenance treatment has been shown to reduce HIV risk behaviours.^{28, 29, 30}

25. Caraher et al (2002)³¹ carried out a multi-method study of health promotion and needs assessment in English and Welsh prisons, which achieved good response rates. The study surveyed 135 prison governors, and carried out 20 semi-structured telephone interviews with a subset of 20 prisons, six case studies of prison health promotion, and additional interviews with health promotion or public health staff. Findings were that the needs assessment process floundered where either public health expertise or prison knowledge were absent, it was then assessment of healthcare rather than health promotion needs and dominated by public health staff with health promotion involvement rare. Thus a holistic approach required involvement of both public health and prison staff. Views of staff and prisoners were rarely built in to these needs assessments; for a whole prison approach clearly they need to be to ensure the acceptability of interventions to these groups, since if they are unacceptable they will fail.

26. Although Caraher found the highest of ten priorities (from questionnaire responses) was given to substance misuse, that rating may have been owing to governors' concern for control rather than health. The next priority was mental health, lowest priorities were healthy eating, physical activity and parenting education. Health promotion was delivered continuously or periodically, and the composition of health promotion groups delivering health promotion was mainly health (nursing) staff rather than prison staff. Caraher suggested health promotion needed to be seen as the responsibility of all staff in the prison, and prisoners needed to participate in needs assessment. So a whole prison approach to both implementation and assessment. Many of these findings were implemented through the 2002 Health promoting prisons strategy in England and Wales, mentioned above.²

27. A recent review of mental health and the criminal justice system in Northern Ireland (2010)³² found that personality disorders existed in 64% of male and 50% of female prisoners. Although offenders with personality disorder came under the definition of mentally disordered, they were not mentally ill, and the report found it was appropriate for them to be tried for their offences, since the disorder was a contributory factor only – not everyone

²⁶ Arriola K, Braithwaite R, Kennedy S, et al. A collaborative effort to enhance HIV/STI screening in five county jails. *Public Health Rep* 2001;116:520-9.

²⁷ Beckwith CG, Zaller ND, Fu JJ, Montague BT, Rich JD. Opportunities to diagnose, treat, and prevent HIV in the criminal justice system. *Journal of Acquired Immune Deficiency Syndromes* 2010;55(SUPPL. 1):S49-S55.

²⁸ Sullivan LE, Metzger DS, Fudala PJ, Fiellin DA. Decreasing international HIV transmission: the role of expanding access to opioid agonist therapies for injection drug users. *Addiction* 2005 Feb;100(2):150-8.

²⁹ Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis. *Addiction* 1998 Apr;93(4):515-32.

³⁰ Gowing L, Farrell M, Bornemann R, Sullivan L, Ali R. Substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Database of Systematic Reviews* 2008;(2):CD004145.

³¹ Caraher M, Dixon P, Carr-Hill R, Hayton P, McGough H, Bird L. Are health-promoting prisons an impossibility? Lessons from England and Wales. *Health Education* 2002;Vol.102(5):219-29.

³² Criminal Justice Inspection Northern Ireland. *Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland*. 2010.

with a personality disorder offenders. There were concerns about the quality of NHS care for mentally disordered offenders, and about the precise responsibilities of the prison service and the NHS. The report therefore recommends implementation of the healthy prison agenda. Good quality mental health care was suggested to be economically beneficial since it reduced reoffending.

28. De Viggiani (2006)³³ in a narrative review argues a whole prison approach is necessary for prisons to meet standards to guarantee safety, provide purposeful activity and effective resettlement and treat prisoners with respect. These are HM Inspectorate of Prisons' (covering England, Wales and Northern Ireland) four tests of a healthy prison. Overcrowding exacerbates problems in the four dimensions, and importation of negative health cultures is increasing as prisons today have permeable boundaries. De Viggiani sees the whole prison approach as a public health prevention model in contrast to a medical model of treatment, and one that could benefit society as a whole by tackling social exclusion, so reducing social inequality which is an acknowledged precursor to criminal behaviour. It is a settings approach, which 'aims to facilitate action on the broad determinants of health rather than solely on management, treatment and prevention of disease.' De Viggiani sees the emphasis on 'physiological and psychiatric health indicators' as merely reinforcing and legitimizing a 'reductionist, pathological approach towards prison health policy and practice.'
29. De Viggiani later carried out primary research investigating such issues in a UK category-C³⁴ adult male training prison that held around 500 sentenced prisoners. The methods were qualitative: participant observation, a group interview and one-to-one, semi-structured interviews with prisoners and prison officers. A valuable feature was the ethnographic approach where the researcher spent about 5 months building up trust by participating in prison activities such as pool, watching football and television and making tea for staff.
30. Key findings were that the Incentives and Earned Privileges Scheme (IEPS), which enabled prisoners to earn privileges through good order and discipline (GOAD), was regarded as disempowering by prisoners. The induction process was stressful and also disempowering. Then the monotony and inactivity of prison life added to that effect. Continued 'divide and rule' policies were perceived as unfair, and resulted in prisoners who complied and were rewarded being regarded as collaborators. That fostered tensions. Differential pay rates, used as part of the reward system, were also regarded as unfair by prisoners. Training was viewed with anxiety about revealing illiteracy and innumeracy. (Showing weakness was against the 'prison code'.) Paternalistic and authoritarian attitudes from prison staff contributed further to disempowerment and reduced self esteem. Overcrowding was important for effects on mental health. The conclusion was that action on the determinants of health needed to be prioritised over promoting healthy lifestyles for example through health education.
31. The Annual Report of HM Chief Inspector of Prisons for England and Wales 2002-2003 {Her Majesty's Inspectorate of Prisons for England and Wales, 2004 56 /id} mentions healthcare

³³ De Viggiani N. A new approach to prison public health? Challenging and advancing the agenda for prison health. *Critical Public Health* 2006;16(4):307-16.

³⁴ Category C is assigned to those who cannot be trusted in open conditions (prisons without walls), but who do not have the resources or will to make a real escape attempt.

and substance abuse, emphasising the importance of detoxification and monitoring, but does not really mention public health. However the report for 2008-09 gives an assessment of each prison on the healthy prison indicators: safety, respect, purposeful activity and resettlement. The indicators are not joined up to an explicit report on public health activity, but do have health implications especially for mental health.

32. The lack of joining up perhaps reflects difficulties in partnership working with complex lines of accountability, and the tension between the need for control and rehabilitation. These were confirmed in a 2005 opinion paper by a medical inspector of England and Wales prisons.³⁵

33. The 2008 report 'delivering every child matters in secure settings' from the national children's bureau³⁶ holistically lists nine entitlements to health:

1. well coordinated, high quality healthcare services that meet assessed individual needs
2. education on healthy eating and a varied, nutritionally balanced diet that meets individual, religious and cultural needs
3. structured physical activity at least twice a week, including team activities and activities in the fresh air
4. an early and ongoing assessment to identify their mental health needs, including risks of selfharm and suicide, and access to comprehensive Child and Adolescent Mental Health Services (CAMHS)
5. an environment that promotes their emotional wellbeing, including positive and caring relationships with staff and a committed relationship with a personal carer
6. a clean, stimulating and comfortable physical environment that promotes their personal hygiene, health and wellbeing
7. high quality sex and relationships education (SRE)
8. effective support for young parents and pregnant young women, including high quality maternity services and interventions to promote positive parenting
9. a comprehensive assessment to identify their needs in relation to substance misuse, and access to a range of high quality education, treatment and support services tailored to their individual needs.

34. With entitlements also in other areas of safety, achievement, making a positive contribution (expressing their views for example) and achieving economic wellbeing this creates a framework relevant to the determinants of health. The publication forms a toolkit for auditing and promoting these entitlements.

³⁵ Lane-Morton T. What health partnerships should seek to provide for offenders. BR J FORENSIC PRACT 2005 Nov;7(4):3-7.

³⁶ Lewis E, Heer B. Delivering Every Child Matters in secure settings: a practical toolkit for improving the health and wellbeing of young people, 2008.

35. A Canadian women's prison was the setting for research in which incarcerated women participated in developing tools and research questions and all later research stages.³⁷ This empowered the female prisoners. A whole prison approach was considered essential to stop TB in prisons in a narrative mini-review by Moller *et al* (2009).³⁸ They otherwise become a 'focus for serious diseases' and also 'receptacles for the mentally ill'.
36. Catrin Smith (2000)³⁹ considered whether healthy prisons were possible bearing in mind the well rehearsed tensions between punishment/control and rehabilitation/health improvement. Although this is a relatively old paper, she makes the useful point that prisons are a disadvantageous environment for good health in themselves, not only because of the importation of the health problems existing outside owing to deprivation which has disproportionately high prevalence in prisoners, but for internal reasons too:
- 'Overcrowding, poor conditions, limited facilities and opportunities, stress, anxiety and the deleterious consequences of liberty loss, increased surveillance and control, all have an impact on health and wellbeing and all represent valid reasons for conducting health promotion in prisons.'
37. Ware 2009⁴⁰ (himself an older ex-prisoner) found an issue where 'older prisoners had received neither health screening nor full medical checks during the duration of their prison sentence unless on demand.'
- 'over two thirds had little or no information about care and support services that could assist them on their release. Twenty-eight per cent of interviewees were considered to have multiple health and social care needs (minimum of three) at the time of release. The majority of these had no settled accommodation and some became homeless within two months, with over half having no access to a GP in their local community. Respondents' social care needs often overrode their health or disability problems, such as finding suitable accommodation. The study highlighted the failure of many local authority social services to come into prison to carry out social care assessments for residents who expected to return to their local communities on release from prison.'
38. This resulted in older prisoners often becoming homeless on release from prison.
39. Whitehead (2006)⁴¹ reviewing the literature from a New Zealand perspective, finds that a single health promotion nurse is unlikely to be the answer to health promotion in prison. They may be called (as in Australia) "correctional/prison mental health nurses", which emphasises a tendency in some to subscribe to the existing correctional ethos and adopt a 'narrow epidemiological definition of need' in their health promotion activities. Whitehead

³⁷ Martin RE, Murphy K, Chan R, Ramsden VR, Granger-Brown A, Macaulay AC, et al. Primary health care: applying the principles within a community-based participatory health research project that began in a Canadian women's prison. *Global health promotion* 2009;16(4):43-53.

³⁸ Moller L, Gatherer A, Dara M. Barriers to implementation of effective tuberculosis control in prisons. *Public Health* 2009;123(6):419-21.

³⁹ Smith C. Healthy prisons a contradiction in terms? *Howard Journal of Criminal Justice* 2000;39(4):November-353.

⁴⁰ Ware S. The development of care services for older people in prison. *Journal of Care Services Management* 2009;3(4):July-September.

⁴¹ Whitehead D. The health promoting prison (HPP) and its imperative for nursing. *International Journal of Nursing Studies* 2006;43(1):123-31.

concludes nursing in prisons needs to operate as a collective effort and in partnership with other key players in a wide ranging collaboration. Reciprocity, where prison staff are also involved in health promotion is helpful, while nurses may 'provide the initial impetus'. Parenting programmes can be considered as follow up services which help to prevent re-offending after release, as can community outreach programmes.

40. In summary, the whole prison approach applies to the way health problems are understood (as interlinked) and to the way needs assessment (including prisoners) and implementation (including staff and prisoners) are carried out. For groups such as mentally disordered offenders who are not mentally ill the whole prison approach can help in deciding responsibilities of the prison service and the NHS. Viggiani persuasively argued that a whole prison approach is necessary for meeting UK standards for healthy prisons, and that action of the determinants of health was more important than education on healthy behaviour for the healthy prison, since like other motivational or controlling prison schemes it could be misinterpreted or lead to counterproductive behaviour by prisoners.
41. There has been work from a UK voluntary body on creating a framework for action or toolkit on the determinants of health in young people's prisons, which may provide pointers for a framework for health promotion in adult prisons. A healthy prison needed to look at features of the prison environment, such as overcrowding generating ill-health – not all ill health was imported to prisons. It was important not to neglect the needs of older prisoners, an increasingly prevalent group, and finally follow up services connecting the prison health promotion effort to the wider community for ex prisoners and their families were part of a whole prison approach to prevent re-offending.

What risk factors contribute to poor health in prisons?

42. Poor health, especially that commencing in prison and continuing after leaving prison is an important issue for both the health promotion and control and security agendas in society, since various elements of ill health are associated with being a prisoner.⁴² Evidence for simple causal links is debatable as multiple causal factors and causal directions are likely to be involved. It is however possible that if prisons generate poor health they may be increasing, rather than reducing, crime as well as ill health.

In Prison

43. The reviews of evidence on individual health promotion topics in the current report suggest prisoners' health is at greater risk from alcohol consumption, drug use, blood-borne virus (BBV) infection, smoking, social deprivation, mental health, unsafe sex, unhealthy diet, bad dental hygiene, and low levels of physical activity.⁴²

⁴² Graham L. Prison Health in Scotland. A Healthcare Needs assessment, Edinburgh, Scottish Government; 2007. <http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf>.

44. However, de Souza (2005),⁴³ using a stratified random sample, recorded a high prevalence of CV risk factors (compared to the general Australian population) in the New South Wales Prisoner population in 1996 and 2001, particularly in younger prisoners. Although hypertension, hypercholesterolaemia and smoking were lower in 2001, smoking was still very high at both times. Age and sex adjusted prevalence was no different except for a higher prisoner Standardised Morbidity Ratio (SMR) for angina than the Australian population.
45. De Viggiani's qualitative paper,⁴⁴ suggested the prison regime itself had a negative effect on the kinds of attitude that might be helpful to a person in taking care of his or her own health:
- 'Thus, while the prison was highly effective in rendering prisoners subservient to and dependent upon the regime, through this very process it fostered idleness and apathy, distracting prisoners from the important goal of rehabilitation (through empowerment, personal responsibility and autonomy) towards short-term privileges...'
46. Boredom, victimisation by prison officers, overcrowding, were all risk factors for ill health and mental ill-being in prison.
47. A study of risk factors in women prisoners for CVD⁴⁵ found higher levels in the prison population than for in women in the general population. Diet and exercise and smoking were all more risky for imprisoned women. They tended to deteriorate after one month in prison. Although the proportion of imprisoned women who were obese was 40% compared to 56% in the general population, the proportion obese increased after one month in prison, and the mean weight increased by 1.5Kg (1.0-2.0, $p < 0.001$). There were no statistically significant changes in physical activity levels or blood pressure after one month. Recommendations included a whole prison approach to address the multiple causality involved in CVD risk.
48. A cross sectional survey of Irish prisons⁴⁶ identified verbal abuse by prison officers as independently predictive of poor prisoner health in multiple logistic regression, although small numbers were involved. Lynch (2007)⁴⁷ in a discussion of two previous studies mentions the need to better understand the association between brain injury and 'abhorrent or unacceptable behaviour' in Australian young peoples' prisons. She also highlights the value of opportunistic interventions such as Pap smears, screening for

⁴³ D'Souza RM, Butler T, Petrovsky N. Assessment of cardiovascular disease risk factors and diabetes mellitus in Australian prisons: is the prisoner population unhealthier than the rest of the Australian population? *Australian & New Zealand Journal of Public Health* 2005 Aug;29(4):318-23.

⁴⁴ De Viggiani N. Unhealthy prisons: Exploring structural determinants of prison health. *Sociology of Health and Illness* 2007;29(1):115-35.

⁴⁵ Plugge EH, Foster CE, Yudkin PL, Douglas N. Cardiovascular disease risk factors and women prisoners in the UK: the impact of imprisonment. *Health Promotion International* 2009 Dec;24(4):334-43.

⁴⁶ Hannon F, Friel S, Kelleher CC. The relative influence of socio-demographic, lifestyle, environmental factors and co-morbidity on self rated health of the Irish prisoner population. *Irish Medical Journal* 2007 Sep;100(8):suppl-61.

⁴⁷ Lynch C, Matthews R, Rosina R. Health as a mediator of change in the trajectory of young people in contact with the criminal justice system. *International Journal of Adolescent Medicine & Health* 2007 Jul;19(3):269-76.

infectious diseases, management of chronic diseases and mental health and drug dependence interventions, which she states will lead to improved criminal justice outcomes.

49. Murdoch *et al* (2008) in a cross sectional interview-based study looking at depression in life sentence prisoners aged over 55, found no correlation between sentence served, or left to serve, or other prison related variables and geriatric depression score (GDS). In assessment of covariates using multiple regression, age was modestly positively related to depression score (standardised beta = 0.19). A number of health related variables were positively related to GDS, including chronic illness (hypercholesterolaemia, ischaemic heart disease, hypertension, illnesses in the past 12 months) and taking more than four prescribed medications. Taking these five together to create an ill health index, scoring 1 to 5, the index was statistically significantly and positively related to depression. This was independent of age and length of sentence. There was no relationship between smoking status, quality of vision or hearing and GDS scores, and although restricted mobility was related to GDS, it was confounded by age. Those who were satisfied with their healthcare were significantly less depressed ($p < 0.02$). Prisoners with educational qualifications had less depression than others ($p < 0.003$) but that was mediated by their also having fewer health problems on the ill-health index ($p < 0.006$).

After leaving Prison

50. A study by Bowser *et al*⁴⁸ evaluated a post-release harm reduction programme for drug users who were ex-offenders. Although this paper is not specifically about risk factors for poor health after leaving prison, it found this intervention had a benefit for this risk group. However there was no comparison group who did not receive the intervention, it was a single group pre–post study. It was not an intention to treat analysis. The comparison made was between those who started the program but did not complete it and those who completed the programme. Completers had better six and 12 month outcomes for alcohol use and drug use (days per month) though not at statistically significant levels. Completers did however have significantly fewer days in jail, but this was an artefact since returning to jail caused non-completion rather than the other way around. In view of these methodological difficulties, the study was inconclusive.
51. Deprivation level was implicitly an important factor in poor health after leaving prison in de Viggiani's qualitative paper,⁴⁹ since deprivation and a family history and culture of crime affected take up of employment and training opportunities. This study was set in a training prison:

'Those prisoners who were at greatest risk of re-offending were least likely to benefit from the employment, training and offending behaviour programmes on offer.'

⁴⁸ Bowser BP, Jenkins-Barnes T, Ilard-Smith C, Lockett G. Harm reduction for drug abusing ex-offenders: Outcome of the California prevention and education project more project. *Journal of Evidence-Based Social Work* 2010;7(1-2):15-29.

⁴⁹ De Viggiani N. Unhealthy prisons: Exploring structural determinants of prison health. *Sociology of Health and Illness* 2007;29(1):115-35.

52. Smoking bans in prison are common in the US. A small study⁸ found of 33 (67% of participants) who wanted to quit or were uncertain 82% were still abstinent from tobacco one month post discharge. This was a small study and the study sample was already well disposed to quitting.
53. Beckwith (2008)⁵⁰ identified concerns about continuing treatment for people identified as HIV+ after they leave prison, since they may have limited access to health services in the community, concluding strategies are needed to improve linkages to care outside prison.

Summary

54. In summary, although risk factors for poor health in prison were higher than in wider society, they varied in importance, and crude prevalence was affected by demographic mix. For example CV risk factor prevalence was higher in Australian prisons but only angina was higher after adjustment for age and sex. Prison specific issues included boredom, overcrowding, lack of autonomy, lack of exercise, verbal abuse, obesity in women. Bad physical health was associated with depression. After leaving prison interventions were most successful with groups that wanted to change and so were already at least risk of re-offending (smoking cessation, alcohol and drug use reduction, employment and training programmes). There remained a hard core that were not being reached, not perhaps because they did not want to change but because they had written themselves off as members of the legitimate world, seeing a criminal career as the only (or best?) option.
55. The latest prisoner survey⁵¹ in Scotland identifies evidence of individual risk factors affecting health which present key health improvement opportunities within this unique community. For example:
 - 50% of prisoners surveyed stated that they were drunk at the time of their offence and 38% report that their drinking affected their relationship with their family. This is in contrast to 14% of men and 9% of women in the Scottish population saying they had an alcohol problem;i
 - 76% of Scottish prisoners report being smokers compared to the national average of approximately 24%.ii However 56% of those surveyed stated that they wished to give up;
 - Prisoners surveyed reported 'feeling interested in people', 'feeling loved' and 'feeling close to other people' (57%, 43%, 56%) only 'some of the time' or 'rarely'; and
 - 44% of surveyed prisoners reported being under the influence of illicit drugs at the time of their offence and 39% reported that drug use was a problem for them on the outside.

⁵⁰ Beckwith CG, Zaller ND, Fu JJ, Montague BT, Rich JD. Opportunities to diagnose, treat, and prevent HIV in the criminal justice system. *Journal of Acquired Immune Deficiency Syndromes* 2010;55(SUPPL. 1):S49-S55.

⁵¹ Prisoner Survey 2011. Scottish Prison Service. Available at: <http://www.sps.gov.uk/MultimediaGallery/e7698343-107e-48c9-90ce-80db7698b5b3.pdf>

Reduce smoking

Policy context

56. *A Breath Of Fresh Air For Scotland Improving Scotland's Health: The Challenge Tobacco Control Action Plan* (Scottish Executive, 2004) brought fundamental change to the smoking culture within Scotland. The policy was radical for its time in reviewing smoking in public places (with the exception of mental health unit accommodation for patients and prisoners cells) while ensuring NHS smoking cessation support would be available for smokers who wished to stop smoking.
57. *Towards a future without tobacco: The Report of The Smoking Prevention Working Group* (Scottish Government, 2006) built on the foundation of the *Breath of fresh Air paper* and identified target groups for tobacco control measures and smoking cessation support including young people and pregnant women.

Literature: Prison smoking statistics and cultural issues

58. The proportion of prisoners who smoke is very high compared to the national average in all the studies reviewed. An example of this is shown in a study within 2 women's prisons in England where the proportion of imprisoned women who smoked was 85.3% as compared to the national average for adult women in England of 24% at that time (Plugge, Foster et al, 2009).⁵²
59. A Polish study of prisoners attitudes to smoking and smoking cessation (Sieminska, Jassem and Konopa, 2006)⁵³ showed that the level of educational attainment, psychosocial factors, attitudes towards health and lifestyle and alcohol and substance abuse were different to other groups. This is consistent with the findings of the other Australian and English research papers reviewed.
60. Tobacco is integral to the culture of prison life. Tobacco is utilised not only as a tool to manage stress and boredom as well as relieving tension for prisoners. A qualitative study in a maximum security prison in new South Wales (Richmond, Butler et al, 2009)⁵⁴ identified that for prisoners who were trying to stop smoking, 'lockdowns' are a distinct trigger to returning to smoking. While the study is a qualitative small study of seven focus groups, the findings provide a real insight into the practical prison culture issues which can provide challenges to prisoners wishing to stop smoking while in prison.

⁵² Plugge E, Foster C, Yudkin P, Douglas N. Cardiovascular disease risk factors and women prisoners in the UK: the impact of imprisonment. *Health Promot. Int.* (2009) 24 (4): 334-343.

⁵³ Sieminska A, Jassem E, Konopa K. Prisoners' attitudes towards cigarette smoking and smoking cessation: a questionnaire study in Poland. *BMC Public Health*.2006;6:181.

⁵⁴ Richmond R, Butler T, Wilhelm K et al. Tobacco in prisons: a focus group study. *Tob Control* 2009;18:176-182 doi:10.1136/tc.2008.

61. A number of the papers provided the view that smoking cessation was not considered a priority by prison authorities with most attention directed at other alcohol and drug problems.

Health improvement interventions

62. Strategies which prisoners acknowledged as helpful in trying to stop smoking were support from family members. This was a consistent finding in all the literature reviewed. The Polish study reviewed identified that the most important trigger for the prisoners surveyed to stop smoking was anxiety about their health, but this was not a finding in the other papers. Potentially, there is an opportunity to identify the triggers for smokers in this unique community and to develop interventions which utilise these triggers to best effect while realising that, as an addiction, it may take the smoker a number of attempts to stop smoking before they are successful.
63. The literature reviewed which addresses the potential support prisoners could receive to stop smoking by using nicotine patches and other pharmacotherapies was Australian. In Australian prisons, prisoners have to pay for nicotine patches and pharmacotherapies, thus prisoners saw these treatments as less effective as they were too expensive.
64. One barrier to being able to stop smoking was seen as the reality of sharing a cell with another smoker and the prisoners in the study suggested the potential of designated smoke free cells for those who wished to try to stop smoking.
65. All the papers reviewed identified the significant potential of smoking cessation plans with clear goals for prisoners. Other strategies which prisoners acknowledged as helpful in trying to stop smoking were support from family members. In the study of prisoners in New South Wales⁵⁵, the men in particular noted the importance of physical activity to replace smoking behaviour. A number of the papers provided the view that smoking cessation was not considered a priority by prison authorities with most attention directed at other alcohol and drug problems.
66. Scottish Prisons policy on tobacco control allows prisoners to smoke in their own cells as this is considered to be their private space. While there needs to be genuine consideration given to prisoners' human rights and their abilities to and coping mechanisms to manage stress, tension and boredom, it could be argued that implementing smoking bans in prisons is a lost public health opportunity, especially given the high levels of smokers within this unique community. Plugge et al, 2009⁵⁶ highlighted that in US prisons where smoking bans have been implemented and from limited experience of smoking bans in English young offenders institutes, there have not been overwhelming issues to deal with for either the prisoners or prison staff.

⁵⁵ Richmond R, Butler T, Wilhelm K et al. Tobacco in prisons: a focus group study. *Tob Control* 2009;**18**:176-182 doi:10.1136/tc.2008.

⁵⁶ Plugge E, Foster C, Yudkin P, Douglas N. Cardiovascular disease risk factors and women prisoners in the UK: the impact of imprisonment. *Health Promot. Int.* (2009) 24 (4): 334-343.

Reduce harmful use of alcohol

Key policy documents for reducing the harmful use of alcohol in Scottish Prisons:

67. The Scottish alcohol strategy (2009)⁵⁷ has a focus on outcomes. The views of prisoners were sought through the Scottish prison service in the formulation of the strategy. The priority is stated as:

‘Work with partners to encourage the development of integrated care pathways for offenders and information sharing to ensure they receive continuity of alcohol support and treatment both in custody and in the community.’

68. The strategy also stated its intention to conduct research on the effect of brief alcohol interventions with prisoners.

69. A UK report from the Centre for Mental Health (2010)⁵⁸ looked at securing employment for offenders with alcohol problems. It noted funding was precarious for offender-specific alcohol services, and alcohol problems did not have equivalent policy status to drug problems. The report suggests building on existing frameworks, and improving the evidence base through mandatory collection of Alcohol Use Disorders Identification Test (AUDIT) scores for all offenders entering the criminal justice system and the monitoring of interventions using standardised tools.

70. The Scottish Prison Service drug misuse strategy agreed with the UK centre for mental health that there was a lack of attention to alcohol problems and mental health problems and how these may be further connected to illicit drug use.⁵⁹

71. The England and Wales prison service alcohol misuse strategy (2004) covers information, treatment and throughcare.⁶⁰ It includes the introduction of alcohol testing. The SPS Strategy Framework For The Management Of Substance Misuse In Custody⁶¹ includes alcohol. It aims to work with partners to develop integrated care pathways for prisoners with alcohol problems, supported by information protocols. Wrap-a-round care and through care are the stated methods for this.

⁵⁷ Scottish Government. *Changing Scotland's Relationship with Alcohol: A Framework for Action*. 2009.

⁵⁸ Centre for Mental Health. *Beyond the gate: Securing employment for offenders with mental health problems*, 2010

⁵⁹ Shewan D, Marshall L, Wilson G, Vojt G, Galloway J, Marley C. SPS Strategy on the Management of Drug Misuse: Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention, Edinburgh, Department of Psychology, Glasgow Caledonian University, and Scottish Prison Service; 2006. <http://www.sps.gov.uk/MultimediaGallery/a8143eae-9f0a-4ac6-a32f-74722f5ffa11.doc>.

⁶⁰ Wrench P. *Addressing Alcohol Misuse: A Prison Service Alcohol Strategy For Prisoners*, 2004.

http://www.hmprisonservice.gov.uk/assets/documents/1000082AAddressing_Alcohol_Misuse.doc.

⁶¹ Scottish Prison Service. *Strategy Framework For The Management Of Substance Misuse In Custody*, Edinburgh, 2010.

72. The Scottish Prison survey 2009 states:

‘Half of those who completed a questionnaire (50%) reported being drunk at the time of their offence, an increase of 10% on 2005 figures of 40%. A quarter (24%) reported that drinking affected their ability to hold down a job and over one third of prisoners (38%) noted that their drinking affected their relationship with their family.’

73. Graham (2007)⁶² reports that 41% of male and 36% of female prisoners had an alcohol problem in 2006, compared to 13% of men and 7% of women in the Scottish population.

74. The effectiveness of interventions for alcohol problems in community primary care was reviewed for Scotland by SIGN in 2003,⁶³ which recommended brief interventions for hazardous and harmful drinkers identified using clinical interviews with GP and the FAST⁶⁴ or CAGE⁶⁵ screening tools with consumption questions. These can prevent progression to alcohol dependence. Interventions for Alcohol Dependence were reviewed by the Health Technology Board for Scotland in 2004,⁶⁶ which recommended coping skills training and other cognitive interventions with pharmaceutical interventions as adjuncts. The impact of alcohol on mental health is considerable and the scale of its impact continues to be poorly understood. (CMO report 2009).⁶⁷

Literature identified

75. Using a purposive US sample of 60 HIV positive prisoners incarcerated for 2 years or less, and weighted to include 40% women, Harzke (2006)⁶⁸ studied utilisation of primary health services after release. The sample was predominantly African American and heterosexual. Harzke et al found that no use of alcohol since release and taking HAART therapy at the time of release predicted having utilised primary health care at a post-release interview 7-21 days after release for HIV positive prisoners in US prisons. Living in the same place as before incarceration and in comfortable circumstances also predicted utilisation. While this does not tell us the direction of causality it is an interesting association. Those in care at time of release had higher rates of being in the same accommodation, being in comfortable accommodation, no alcohol use since release and taking their medication treatment for their HIV at the time of release.

⁶² Graham L. Prison Health in Scotland. A Healthcare Needs assessment, Edinburgh, Scottish Government; 2007.

<http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf>.

⁶³ SIGN. The management of harmful drinking and alcohol dependence in primary care, Edinburgh, Scottish Intercollegiate Guidelines network; 2003. <http://www.sign.ac.uk/guidelines/fulltext/74/index.html>.

⁶⁴ Fast Alcohol Screening Test

⁶⁵ Acronym from subjects of questions: Cut down, Annoyed, Guilty, Eye opener

⁶⁶ Slattery J, Chick J, Cochrane M, Craig J, Godfrey C, Kohli H, et al. Health Technology Assessment Report 3: Prevention of relapse in alcohol dependence, Edinburgh, Scottish Government; 2004.

<http://www.nhshealthquality.org/nhsqis/files/Health%20Technology%20Assessment%20Report%20Full%20version.pdf>.

⁶⁷ Burns H. Annual Report of the Chief Medical Officer, Edinburgh, Scottish Government; 2009.

<http://www.scotland.gov.uk/Publications/2009/12/16103619/3>.

⁶⁸ Harzke AJ, Ross MW, Scott DP. Predictors of Post-Release Primary Care Utilization among HIV-Positive Prison Inmates: A Pilot Study. *AIDS Care* 2006 May 18;no. 4(pp. 290-301).

76. Condon 2008⁶⁹ in a qualitative study in prison in the north and south of England including women's, men's and young offenders' institutions carried out in-depth semi-structured interviews with 111 prisoners in 12 prisons. She found that alcohol was regarded as a less urgent issue than drugs by prisoners, but was mentioned frequently and seen as a health issue that was not sufficiently targeted with help for alcohol addiction in prison lacking.
77. The Care Quality Commission (2010)⁷⁰ reported the results of their thematic inspection of youth alcohol misuse and offending, in 13 youth offending teams in England and Wales. They aimed to discover whether these were sufficiently engaged and involved in efforts to reduce the impact of alcohol misuse by children and young people who offend. The findings were that assessing alcohol-related needs was inconsistent across England and Wales, so that needs remained unmet. Linking alcohol to offending behaviour was sometimes missing, and assessments were variable in quality and comprehensiveness, the more comprehensive holistic assessments better identified alcohol related needs. Assessments were not reviewed thoroughly enough during interventions, and once referred to a health specialist, although good screening tools were used, there was inconsistency in which tools were used. Dual diagnosis pathways were underdeveloped. There was insufficient representation of alcohol issues on management boards. The report recommends nationally validated holistic assessments linked to all offending behaviour, evaluation of the outcome of interventions, and prioritisation at strategic level.
78. A recent needs assessment for alcohol problems among Scottish prisoners⁷¹ concluded that many prisoners who could benefit from interventions to address alcohol consumption and alcohol-related harm were being missed. They recommended the planning and development of tiered interventions based on detection with a validated screening tool and subsequent comprehensive specialist assessment when appropriate. Integrated alcohol care pathways are an important part of the process.

Summary

79. In summary, alcohol policy in relation to prisons seeks to ensure continuity of care after release and is seen as a potential opportunity for brief interventions. Integrated alcohol care pathways are key. To identify potential alcohol problems, a validated screening tool and subsequent assessment where appropriate, should be introduced. Alcohol problems for prisoners need to be understood in connection to the offending behaviours, employment, and mental health, and that implies a holistic of whole prison approach.

⁶⁹ Condon L, Hek G, Harris F. Choosing health in prison: prisoners' views on making healthy choices in English prisons. *Health Education Journal*, 2008;67(3):155-66.

⁷⁰ Care Quality Commission . *Message in a bottle: a joint inspection of youth alcohol misuse and offending*. 2010.

⁷¹ Parkes T, MacAskill S, Brooks O *et al*. *Prison health needs assessment for alcohol problems*. NHS Health Scotland. 2010.

Reduce harmful use of illicit drugs

Key policy

80. A 2006 Scottish Prison service strategy, based on very thorough and high quality multi-method research, focussed on the management of drug misuse alone.⁷² It states:

‘In Scotland, the most recent figures show that 82% of the prisoner population had used an illegal drug in the twelve months prior to imprisonment, of whom 56% reported having used heroin. Overall, 27% of prisoners with a history of drug use in Scotland in 2004 reported having been in drug treatment prior to imprisonment.’

81. The 2011 Scottish Prison Survey⁷³ does not report equivalent figures, but states:

‘Just under half of respondents (44%) reported being under the influence of drugs at the time of their offence and 39% stated their drug use was a problem for them on the outside. One fifth of prisoners (18%) reported that they committed their offence to get money for drugs and one quarter (23%) were receiving treatment for drug use before they were imprisoned.’

82. Drug use also continues in prison, 20% of prisoners reported drug use in the past month in the 2001 survey. The most common drugs were cannabis (75%), cocaine (65%), benzodiazepines (54%) and heroin (41%). Graham (2007)⁷⁴ states one out of two Scottish prisoners has a recorded history of drug dependence in the community, which she says is likely to be an underestimate owing to reporting issues in G-PASS.

83. The Scottish drugs strategy (2008)⁷⁵ states an intention to improve treatment for drug problems within prisons, suggesting a new approach is needed maximising recovery as compared to punishment. A range of security measures has been developed to reduce the supply of drugs into prisons, and punitive mandatory drug testing has been found ineffective and stopped, being replaced by voluntary testing and testing with a clear purpose (annual and liberation sampling) as part of a therapeutic approach. Mandatory testing was thought to have promoted use of heroin (detectable for a few days after use) instead of cannabis (detectable weeks after use).⁷⁶ Detoxification and substitute prescribing are provided if

⁷² Shewan D, Marshall L, Wilson G, Vojt G, Galloway J, Marley C. SPS Strategy on the Management of Drug Misuse: Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention, Edinburgh, Department of Psychology, Glasgow Caledonian University, and Scottish Prison Service; 2006. <http://www.sps.gov.uk/MultimediaGallery/a8143eae-9f0a-4ac6-a32f-74722f5ffa11.doc>.

⁷³ Scottish Prison Service. Prisoner Survey 2011

⁷⁴ Graham L. Prison Health in Scotland. A Healthcare Needs assessment, Edinburgh, Scottish Government; 2007. <http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf>.

⁷⁵ Scottish Government. The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, 2008. <http://www.scotland.gov.uk/Publications/2008/05/22161610/12>.

⁷⁶ Shewan D, Marshall L, Wilson G, Vojt G, Galloway J, Marley C. SPS Strategy on the Management of Drug Misuse: Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention, Edinburgh, Department of Psychology,

appropriate on initial assessment on entry. Prisoners are given an integrated care plan addressing wider needs. Integrated working with local councils, families etc. aims to allow continuity of care. Information sharing (e.g. about substitute prescribing and voluntary through care for those not subject to statutory arrangements (from the Throughcare Addiction Service) support that. There is an issue for short stay prisoners (less than 1 month) where there is not enough time to carry out the above model addressing their wider needs.

84. The Scottish Prison Service *Strategy Framework for the Management Of Substance Misuse In Custody* (2010)⁷⁷ is recovery focussed, aiming to reduce drug-related deaths and to reduce re-offending. Specific intended outcomes are given:

- Achievement of Key Performance Indicator to evidence a reduction in the number of prisoners misusing drugs;
- Work with partners to develop integrated care pathways for prisoners with alcohol problems, supported by information protocols;
- Contribution towards national datasets to inform wider evidence base and improve outcome data;
- Reduced prevalence of smoking among the prisoner population;
- Increase in the numbers of prisoners being initiated on Hepatitis C treatment;
- Increase in the number of prisoners attending community appointments following release from prison;
- Reduced the number of Drug-Related Deaths soon after release from prison;
- Contribution towards achieving the national indicator to decrease the estimated number of problem drug users in Scotland; and
- Contribution towards achieving the national indicator in reducing the overall re-conviction rates as outlined in the National Performance Framework

85. Stopping drugs getting into prison can be regarded as a form of prevention, which may be appropriate in the prison context, though criticised in the wider society for reasons similar to the eventual failure of alcohol prohibition in 1920's America, i.e. encouragement of the link between supply and crime. There is a 2008 UK strategy on the disruption of supply of illicit drugs in prisons, which recommends a number of measures, including blocking mobile phones, high grade searching from the installation of a BOSS chair in all prisons, and better intelligence. There are cost implications to these.⁷⁸

Literature identified

86. Galea and Vlahov (2002)⁷⁹ review the US evidence on the adverse health consequences of low socioeconomic status, homelessness, and incarceration among drug users. This was a narrative review with no methodology given. Injecting drug users were found in this review

Glasgow Caledonian University, and Scottish Prison Service; 2006. <http://www.sps.gov.uk/MultimediaGallery/a8143eae-9f0a-4ac6-a32f-74722f5ffa11.doc>.

⁷⁷ Scottish Prison Service. *Strategy Framework For The Management Of Substance Misuse In Custody*, Edinburgh, Scottish Prison Service; 2010.

⁷⁸ Blakey D. *Disrupting the supply of illicit drugs into prisons: A report for the Director General of National Offender Management Service*, UK government; 2008. <http://www.justice.gov.uk/publications/docs/blakey-report-disrupting.pdf>.

⁷⁹ Galea S, Vlahov D. Social determinants and the health of drug users: Socioeconomic status, homelessness, and incarceration. *Public Health Reports* 2002;117(SUPPL. 1):S135-S145.

to be 20 times more prevalent in prison than in the community. IDU status was associated with risky sex, and previous incarceration was associated with being HIV positive in current prisoners. Homelessness and mental illness increased the likelihood of high risk behaviour. The conclusion is that interventions to reduce drug use must address socio-economic circumstances (social factors) that exacerbate the consequences of drug use. This was particularly important on release from prison, at which time Galea noted evidence of an increased mortality rate (four times the age adjusted rate in the general population) within one year of release.⁸⁰ There was other evidence of a particularly immediate effect, a seven-fold increase in deaths from overdoses within two weeks of release compared to the next 10 weeks, for former prisoners who had been IDUs.⁸¹

87. Michel (2008)⁸² found individuals in French prisons may already be on substitution treatment on entry to prison. At prison entry, 1.5% in 2003 reported being on methadone treatment, while for buprenorphine this figure was 6.0% in 2003. Michel found a lower proportion of HIV positive people were on HAART in prison than in society at large (73% vs 88% in 2000), but when adjusted for severity this difference disappeared.
88. The 2006 strategy research⁸³ found covert drug use in groups was seen by prisoners as less likely to be discovered, but was also more difficult to break away from drug use in the group than as a lone user. Assessment for drug use on entry was reported as rushed and less likely to result in full disclosure (could be either under or over reported) if carried out by a uniformed officer. The time lag to subsequent interventions was seen as too long. Substitute prescribing of methadone needed to be secure, with a clear policy for reduction in order for prisoners not to feel anxiety and to reduce the likelihood of their topping up on illegal drugs. Some prisoners felt stigmatised by receiving methadone (in the eyes of prison officers). Cognitive distraction helped cessation of drug use, boredom threatened it. Family visits, especially for female prisoners to see their children, gave motivation to stop. Residential prison staff were considered well place for training to raise conversations with prisoners about tackling their drug use, though prison staff felt stopping was an objective to be achieved perhaps over a number of short sentences, not just one.

Summary

89. In summary reliable non-stigmatising substitute prescribing with a clear aim and plan for reduction would help prevent injecting and topping up, and is essential if supply disruption and reduction is tried since that could have counterproductive consequences if tried alone, especially as it is unlikely ever to be wholly successful. Prison residential officer addictions education would help them to engage more positively with prisoners about reducing their

⁸⁰ Harding-Pink D. Mortality following release from prison. *Med Sci Law* 1990;30(1):12-6.

⁸¹ Byrne A, Dolan K: Methadone treatment is widely accepted in prisons in New South Wales. *Bmj* 1998; 316(7146): 1744-5.

⁸² Michel L, Carrieri MP, Wodak A. Harm reduction and equity of access to care for French prisoners: A review. *Harm Reduction Journal* 2008;(5):1-11. <http://www.harmreductionjournal.com/content/5/1/17>.

⁸³ Shewan D, Marshall L, Wilson G, Vojt G, Galloway J, Marley C. SPS Strategy on the Management of Drug Misuse: Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention, Edinburgh, Department of Psychology, Glasgow Caledonian University, and Scottish Prison Service; 2006. <http://www.sps.gov.uk/MultimediaGallery/a8143eae-9f0a-4ac6-a32f-74722f5ffa11.doc>.

drug use. As with alcohol a holistic through care approach involving families (where helpful) and addictions, mental health, housing, education and employment services is needed to break the cycle of drug use, mental health problems, worklessness, homelessness and imprisonment.

Improve mental wellbeing

Policy context

90. Scottish Government's latest policy and action plan, 'Towards a Mentally Flourishing Scotland'⁸⁴ outlines how it will improve mental wellbeing and mental illness through the Government's provision of services but also by working through social policy and health improvement activity. It describes how it is based on a social approach which 'recognises that our mental state is shaped by our social, economic, physical, and cultural environment, including people's personal strengths and vulnerabilities, their lifestyles and health-related behaviours, and economic, social and environmental factors'. It emphasises the importance of dealing with improving people's sense of individual mental wellbeing as well as tackling mental health problems or illness.

91. The policy has six strategic priorities:

- Mentally Healthy Infants, Children and Young People
- Mentally Healthy Later Life
- Mentally Healthy Communities
- Mentally Healthy Employment and Working Life
- Reducing the Prevalence of Suicide, Self-harm and Common Mental Health Problems
- Improving the Quality of Life of those experiencing Mental Health Problems and Mental Illness

92. The policy does not specifically refer to any particular group in society but takes a population-wide approach. However, the priorities most relevant to prisoners include reducing the prevalence of suicide and self-harm which builds on an earlier policy addressing suicide and self-harm, 'Choose Life'⁸⁵. 'Choose Life' was refreshed by the Scottish Government in 2010.⁸⁶ In addition, if one is taking a 'whole prison approach', one could apply the spirit of the strategic priority, 'mentally healthy communities', which describes:

'Good mental wellbeing and reduced incidence of mental health problems is important for the healthy functioning of communities. They affect behaviour, social cohesion, social inclusion, crime and prosperity. Similarly, the quality of the physical environment, proper access to nature and green space and access to cultural

⁸⁴ Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011. Scottish Government. 2009. Available at: <http://www.scotland.gov.uk/Resource/Doc/271822/0081031.pdf>

⁸⁵ Choose Life: A national strategy and action plan to prevent suicide in Scotland. Scottish Executive. 2002. Available at: http://www.chooselife.net/web/FILES/Choose_Life.pdf

⁸⁶ Scottish Government. Choose Life: A national strategy and action plan to prevent suicide in Scotland. 2010. Available at: www.scotland.gov.uk/Publications/2010/10/26112102/0

experiences have an important role to play in shaping the mental state of individuals.⁸⁷

93. The Scottish Prison Service are in the process of developing a new strategy for mental health which builds on the positive work delivered since the launch of *Positive Mental Health*⁸⁸, continuing to incorporate some of its aims and practices, such as the strong ethos of care and opportunity across prisons, the role and function of establishment Multi-Disciplinary Mental Teams and mental health awareness training for staff. It requires implementation of *Taking Steps*⁸⁹ and the *SPS Mental Health Training Strategy (2010)*⁹⁰. Adherence to these documents will improve awareness of mental health needs within prison and the confidence of staff to address mental health needs, broaden clinical and practice skills, further integrate services and partnerships, and provide a means for tracking and monitoring the quality of individualised care delivery.
94. NHS Health Scotland has also developed a logic model⁹¹ which identifies the key outcomes for mental health improvement and specifies local activities which could be undertaken to achieve them.

Literature

95. In 2009, Lord Bradley published his review of people with mental health problems and learning disabilities in the criminal justice system.⁹² Among the various recommendations made by the Bradley Report, it highlighted the importance of tackling mental health problems in tandem with any associated alcohol or substance misuse problems: *'Throughout the course of this review it has become apparent that the issue of dual diagnosis (mental health problems combined with drug and/or alcohol problems) is a vital component of addressing the issue of mental health and criminal justice.'*
96. A recent study looking at prison mental health in-reach services⁹³ suggested that dual diagnosis should be regarded as the norm, rather than the exception. Another study⁹⁴ showed the following:
- 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems; and
 - 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year.

⁸⁷ Scottish Government. *Towards a Mentally Flourishing Scotland (Page 25)*
<http://www.scotland.gov.uk/Publications/2009/05/06154655/0>

⁸⁸ Scottish Prison Service. *Positive Mental Health*. 2002.

⁸⁹ Scottish Public Health Network/SPS. *Taking Steps: A pathway for supporting prisoners experiencing emotional distress or mental health problems* User Guide and Workbook (2009)

⁹⁰ Scottish Prison Service. *Mental Health Training Strategy* (2010).

⁹¹ NHS Health Scotland. Outcomes framework for implementing Scotland's mental health improvement strategy. Sep 2010. Available at: <http://www.healthscotland.com/uploads/documents/13716-Outcomes%20Framework%20for%20MHI%20September%202010.pdf>

⁹² Bradley (2009) Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System. London: House of Lords.

⁹³ Shaw J et al, 2008. A national evaluation of prison mental health in-reach services.

⁹⁴ Weaver T et al, 2003. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *The British Journal of Psychiatry*, Vol 183, pp 304–313.

97. It commented that despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol.
98. The WHO's Mental Health Promotion in Prisons⁹⁵ consensus statement highlighted the importance of good mental health because *'imprisonment had adverse effects on the mental health of a significant number of prisoners, and the prevalence of mental ill health in all prisons was very high. In addition, staff in prisons dealing with disturbed or otherwise difficult prisoners could experience workplace-induced stress, with consequent implications for their mental and physical wellbeing and for the good management of prisons.'*
99. It describes mental health as a 'positive sense of wellbeing, from which springs the emotional and spiritual resilience which is important for personal fulfilment and which enables us to survive pain, disappointment and sadness. It requires an underlying belief in our own and others' dignity and worth. While it may be difficult to contemplate the existence of positive mental health among prisoners, prison should provide an opportunity for prisoners to be helped towards a sense of the opportunities available to them for personal development, without harming themselves or others.'
100. The Statement recommends practical ways of enhancing the individual's emotional resilience and the strength of the community, which have been shown to be effective. (Many of these benefit those already suffering from severe mental disorders as well as those without mental disorders.) These include:
- regular physical exercise
 - regular participation in education, work or training
 - access to the arts
 - anti-bullying strategies
 - prevention of depression:
 - cognitive/behavioural procedures
 - spiritual reflection, which could include meditation or yoga
 - the acquisition of skills
 - utilising prisoners' resources, for example for peer support.
101. The outdoor environment is now seen as a key setting for the promotion of good mental health and wellbeing. Recent research on green space and general health has shown a positive association, although the exact mechanisms which generate these positive effects are not entirely clear at present (Croucher, 2007).⁹⁶
102. In a qualitative evaluation of art therapy, Argyle et al (2005)⁹⁷ found that 'arts in health' provision in a community setting can offer positive health benefits and aid health promotion without the need for specialist 'art therapists'. Art can help increase communication, self-understanding and wellbeing, alleviate stress and anxiety.⁹⁸ They found that the very process of creating art – for example, through painting, photography or music – rather than its

⁹⁵ World Health Organisation. Mental Health Promotion in Prisons. London: WHO, 1998.

⁹⁶ Croucher, K., Myers, L. and Bretherton, J. (2007) The links between greenspace and health: a critical literature review, University of York, 2007.

⁹⁷ Argyle E, Bolton G. Art in the community for potentially vulnerable mental health groups. Health Education. Vol 105, 2005. pp340-354.

⁹⁸ Staricoff R (2004). Arts in Health: A Review of the Medical Literature. Arts Council England, London.

therapeutic interpretation (which requires a specialist art therapist) was what made the art successful. 'In medicine and healthcare, 'people become patients' [and in the prison service, 'prisoners']; in arts in health projects, people become artists. Participants make their own choices and remain in control of their activity and level of psychological and social involvement.'⁹⁹

103. In a qualitative study specifically examining the barriers to positive mental health in young offenders, Woodall (2007) highlights that family and significant others should be viewed as buffers for reducing stress and as part of the rehabilitative process and as a result, for many, the time after a visit was a particular low point in the regime. As such, post-visit support was recommended.¹⁰⁰ In addition, Woodall recommended that it may be constructive to consider how the self-help ethos of a YOI could be developed to enhance more mutual support and a greater sense of community. The experience of conducting his research would suggest that prisoners have a desire to talk about their experiences are able to make constructive suggestions about how best to change prison life for future prisoners.

Increase uptake of healthy eating

Policy

104. Policy regarding nutrition and food standards in major institutions, such as hospitals and prisons, is provided by the Food Standards Agency (Scotland) and Scottish Government.
105. Specifically, draft guidance for Scottish prisons was issued by the Food Standards Agency (Scotland) in 2007.¹⁰¹ The guidance contains information such as the percentage energy provision from total fats, saturated fatty acids, carbohydrates and non milk extrinsic sugars, which is regarded as best practice. Standardised SPS recipes were introduced during May 2010. These recipes are currently being nutritionally analysed for 14 nutrients and are provided with a colour code (similar to the FSA labelling- red, amber and green) to support menu planning. Research will be conducted by the FSA (Scotland) to nutritionally analyse a three week menu cycle which has achieved the Healthy Living Award.
106. Guidance regarding the amount of fresh produce is available from the FSA (Scotland) and also the SPS Caterers Handbook. Nine prisons have already achieved the Healthy Living Award with the remainder working towards it. This requires 50% of the food to be prepared on site. A variety of fresh, frozen, dried and tinned fruit and vegetables are incorporated in recipes and as menu options. The uptake of fresh fruit from the menus has been disappointing and as such, some sites will send the fresh fruit directly to the residential areas, to allow free access throughout the day.

Literature

107. For the general population, a healthy diet brings benefits such as reduced risk in for example, cardiovascular disease and cancer. Among some people, there is also evidence that a poor diet, is associated with antisocial behaviour which may have additional implications for health promotion in the criminal justice setting. Gesch et al (2002) looked at the impact

⁹⁹ Smith R (2002). Spend (slightly) less on health and more on the arts. *BMJ* Vol 325. pp1423-3.

¹⁰⁰ Woodall J. Barriers to positive mental health in a Young Offenders Institution: A qualitative study. *Health Education Journal* 2007 66:132.

¹⁰¹ Nutrient and food standards for the Scottish Prison Service. Scottish Government. Jan 2007. (In draft)

of specific diet supplementation in the form of a physiological dosage of vitamins, minerals and essential fatty acids on young adult prisoners in the UK. An experimental, placebo-controlled double-blind methodology was used to show that supplementing prisoners' diets (on average for approximately 4 months) caused a reduction in antisocial behaviour to a remarkable degree.¹⁰²

108. There was little literature found describing how healthy eating is implemented in prisons. Condon et al (2008) explored the views of prisoners in England into making healthy choices which included their attitudes to healthy eating. She found a variety of attitudes to nutrition in prison, ranging from those who had come from a chaotic background finding that at least prison food was regular and available through to those who had preferred healthy food choices before prison, struggling to maintain their healthier options such as low-fat, high fibre or low sugar foods. Older prisoners in particular were concerned about the long-term effects of poor diet upon health when they were unable to access healthy foods in prison. The 'Canteen' – comprising purchases of fizzy drinks, crisps and chocolate bars – was very popular, although this had to be weighed against the purchase of phone credit or tobacco. In contrast, where prisoners were committed to activities such as body building (mainly among young offenders and young male prisoners), vitamin tablets and protein drinks were preferentially purchased.¹⁰³
109. In a qualitative study, involving in-depth group and one-to-one interviews with women prisoners, Smith (2002) concluded that food assumes enormous importance in prison; for many prisoners, it conditions their life in custody. The findings indicated that, where control is taken away from the individual, 'food is experienced not only as part of the disciplinary machinery but also as a powerful source of pleasure, resistance and rebellion'. As such, it has implications for health promotion within the prison setting.¹⁰⁴ Smith found that most women prisoners know what constitutes a healthy diet and which types of food are 'good for you' yet despite their health beliefs they continue to eat in what could be considered an 'unhealthy way'. However, in the prison setting, where personal autonomy is significantly challenged, women prisoners reported that their food and diet practices allowed them a viable sense of self-control – a means of 'psychic survival'.¹⁰⁵ Smith warns that, 'health promotion ... could constitute an effective strategy for enhancing the health of women prisoners. However, the reality remains largely individualistic, behaviourist and victim-blaming, evidenced most clearly by the emphasis on personal lifestyle change.'¹⁰⁶
110. Smith's conclusion for health promotion is that it needs to 'recognise the importance of the total social environment in which health behaviour is entrenched and to challenge the ...

¹⁰² Gesch CB, Hammond SM, Hampson SE, Eves A, Crowder MJ. Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners. Randomised placebo controlled trial. *British Journal of Psychiatry*, 2002;181:22-28.

¹⁰³ Condon L, Hek G, Harris F. Choosing health in prison: Prisoners' views on making healthy choices in English prisons. *Health Education Journal* 2008 67:155.

¹⁰⁴ Smith C. Punishment and pleasure: women, food and the imprisoned body. *The Sociological Review* 2002. Vol 50 pp 197-214.

¹⁰⁵ Graham H. (1998) Health at risk: poverty and national health strategies. In Doyal L (ed) *Women and Health Services*, Buckingham: Open University Press.

¹⁰⁶ Smith C. Punishment and pleasure: women, food and the imprisoned body. *The Sociological Review* 2002. Vol 50 pp 197-214.

causes of health exclusion rather than focusing on individual resolutions, with their moral emphasis on personal behaviour.’

Encourage better oral health

111. In 2005, the Dental Action Plan¹⁰⁷ set out the commitment of the Scottish Executive to ensure that vulnerable adults have access to preventative dental programmes, which would assist them in maintaining good oral health. Equally Well, the Ministerial Taskforce on Health Inequalities has identified the need for specific personalised oral health programmes to help address health inequalities.¹⁰⁸ Most recently, a Dental Priority Groups Strategy has been drafted (which includes a framework for improving oral health of prisoners) and is awaiting ministerial approval.
112. The Scottish Prisons Dental Health Survey¹⁰⁹ reported that levels of oral disease among the prisoner population in Scotland were much higher those seen in UK adults living in the community. For example, prisoners had significantly more decayed teeth, fewer filled teeth (related to lower access to dental care) and fewer standing teeth than the general population. In addition, the prison population may be at higher risk of oral cancer, with more lifetime exposure to known risk factors such as smoking and alcohol consumption.
113. Good oral health contributes to health and wellbeing throughout life by facilitating nutrition, improving facial appearance, which can help self-esteem, reducing dental pain and infection. Regular examination by a dental professional will aid early detection of oral cancer, which improves the likelihood of simplified treatment and improved survival from the disease.
114. Current provision of dental care in the Scottish Prison Service focuses on ‘fire-fighting’. The service is directed at pain relief and emergency care and routine dental treatment with very limited time available for prevention of disease within the dental surgery setting.¹¹⁰
115. However, despite the constraints, there are examples of good practice of oral health promotion within Scottish prisons. For example, within HMP Shotts, the Oral Health Promotion Pilot and within HMP Cornton Vale, NHS Forth Valley has been particularly active.¹¹¹

¹⁰⁷ An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland. 2005. Available at: <http://www.scotland.gov.uk/Resource/Doc/37428/0012526.pdf>

¹⁰⁸ Equally Well. Report of the ministerial taskforce on health inequalities. 2008. Available at: <http://www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf>

¹⁰⁹ Jones C, McCann M, Nugent Z. Scottish Prisons’ Dental Health Survey. 2002. Available at: <http://www.scotland.gov.uk/Resource/Doc/47210/0013527.pdf>

¹¹⁰ McCann M. Draft Dental Priority Groups Strategy. Scottish Government. 2011. (Awaiting publication)

¹¹¹ Report on the Prison Oral Health Promotion Programme in Forth Valley. NHS Forth Valley. 2009.

Prison Oral Health Promotion Programme in Forth Valley: Cornton Vale¹¹²

<p>The project at Cornton Vale takes a ‘whole prison’ approach to improving oral health in prison.</p> <p>Leadership:</p> <p>Dedicated oral health promoter involvement Senior prison staff commitment to the programme</p> <p>Improving the environment: plumbed-in drinking water across the prison</p> <p>Helping prisoners to make healthy choices:</p> <p>Increased number of sugar-free products on canteen sheet Increased access to fresh fruit through the launch of the Rainbow bags Affordable artificial sweetener and sugar-free drinks on canteen sheet</p> <p>The right information:</p> <p>Decorative posters promoting fruit and vegetables throughout the prison Oral health promotion induction, work parties and within the smoking cessation course Oral health promotion training session with prison staff Distribution of an oral health pack, containing a toothbrush and fluoride toothpaste</p>
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116. A review of the literature and information from prison health promotion pilots ongoing across Scotland suggest that the following measures are effective in improving the oral health of prisoners. It is expected that any future strategy will take account of this information:
- All prisoners should be offered a basic assessment of oral health at induction.
 - A basic care plan should be developed, based on prisoner needs, and appropriate to likely remand period or sentence length.
 - Prisoners should have the opportunity to brush twice daily with a fluoride toothpaste containing at least 1,350 ppm fluoride.
 - The Scottish Prison Service should work closely with NHS Boards to ensure that basic prison issue toothbrushes are of a standard that reflects standards applicable in national dental programmes across Scotland.
 - Interdental cleaning aids should be available to supplement toothbrushing, in keeping with the need for safety and security.
 - Drinking water should be freely available to reduce the consumption of sugared drinks.
 - Fresh fruit and vegetables should be available as a choice at mealtimes and through the canteen system offered as an alternative to sugary snacks.
 - Canteen sheets should offer a range of sugar-free products, including sugar substitutes.
 - In all NHS Boards with a prison facility, the Board should ensure that an oral health educator takes a lead role in promoting oral health messages across the whole prison, working directly with prison health promotion committees to embed oral health improvement messages throughout the prison.

^{112 112} McCann M. Draft Dental Priority Groups Strategy. Scottish Government. 2011. (Awaiting publication)

- The Scottish Prison Service should ensure that dieticians work with prison catering managers to reduce progressively the sugar content of prison meals and to ensure the daily inclusion of fresh fruit and vegetables on prison menus.
- Educational resources promoting key oral health messages should be developed for prisoners, taking account of their needs.
- Prison officer training should include a module on oral health.
- Training should be provided to prisoners wishing to become oral health champions within Scottish prisons.
- NHS Boards should provide strategic support to prisons to ensure that oral health improvement becomes integrated into Scottish prisons.
- Each prison dental team should have access to NHS Board health promotion services and resources.
- Chairside oral health promotion activity should be specified routinely as part of the job profile and contracts of those providing prison dental services.
- Prisons should work closely with NHS Boards to raise awareness of local arrangements for throughcare for those leaving prison.

117. Additional ideas on oral health promotion tips¹¹³ (not mentioned above in Draft Dental Priorities Strategy):

- Using visual aids such as videos that are purposely designed for prisoners.
- Linking oral health to smoking cessation advice and alcohol.
- Ensuring health promotion information is available in an appropriate range of languages.
- Paying prisoners to attend oral health promotion sessions or ensuring these do not clash with paid work.

Increase safer sex

118. Buston and Wight suggest that the Young Offender Institution as a site for sexual health promotion may have strong potential that is currently under-utilised.¹¹⁴

Key policy documents for health promotion to increase safer sex in Scottish prisons

119. The Strategy and Action Plan for Improving Sexual Health in Scotland¹¹⁵ was published in 2005. For prisons, it mentions the need to 'tackle the incidence of sexually transmitted infections among high risk or socially excluded groups and those in prisons' (see p. 7). It states that the:

'Scottish Prison Service will sustain its commitment to health improvement and harm reduction enabling the availability of condoms for males and dental dams for females throughout the course of their detention in young offender institutions and adult prisons.'

¹¹³ Harvey S et al. Reforming prison dental services in England – a guide to good practice. Department of Health 2005.

¹¹⁴ Buston K, Wight D. (2010). Young male offenders reported STI testing behaviour: findings from a qualitative study. The Journal of family Planning and Reproductive Care, 36, 7-11.

¹¹⁵ Scottish Executive HD. Respect and responsibility: strategy and action plan for improving sexual health, 2005.

120. Graham (2007),¹¹⁶ in a report commissioned to inform SPS health policy, used chlamydia infection as an indicator of sexual health.

Literature identified

121. Castrucci (2002)¹¹⁷ in an interview study (retrospective survey design) of 210 incarcerated adolescents in North Carolina, US, found that:
- ‘Given strong associations between risky sexual behaviour and substance use, interventions should be more multi-problem-focused. Health interventions should attempt to address common causes of both behaviours. Effective interventions will be those that can successfully demonstrate effects on outcomes that measure both the intervention effects on substance use and risky sexual behaviours.’
122. An example of the above was that inconsistent condom use and sex with multiple partners was associated with substance misuse.
123. Hilton (2001)¹¹⁸ in a review of the literature on harm reduction strategies between 1990 and 2000 (no methodology given) found harm reduction activities were politically difficult to implement in Canadian prisons as they were seen to encourage illegal behaviour, such as drug use and sex. Among the 25 French prisons evaluated in the ORS-PACA study,¹¹⁹ 23. 34% of inmates believed that condoms were not available in prisons, and 29% reported that they needed to ask doctors or nurses to obtain them. Rotilly (2000)¹²⁰ reports that 8% of French prisoners had heterosexual sex in prison and 1% homosexual. Only 20% of those having homosexual sex reported condom use. A review carried out for French prisons for HIV, HBV and HCV in 2007 for the 15 years up to 2006 (Michel 2008)⁷ suggests this implies a need for more education about unsafe sexual practices.
124. Tang (2003)¹²¹ discusses service provision in sexual health to young offenders in English institutions. Tang recommends that adolescent sexual health clinics be set up immediately in all YOI run by specialists with GUM training.
125. Delivery of health promotion interventions in sexual health to young men has to be gradual and giving them a leaflet alone does not work according to a news report/qualitative project from the North West UK by Eaton 1994.¹²² Buston (2010)¹²³ in a qualitative study using interviews with 40 young men aged 16–20 in a Scottish YOI found:

¹¹⁶ Graham L. Prison Health in Scotland. A Healthcare Needs assessment, Edinburgh, Scottish Government; 2007. <http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf>.

¹¹⁷ Castrucci BC, Martin SL. The association between substance use and risky sexual behaviors among incarcerated adolescents. *Maternal and child health journal* 2002;6(1):43-7.

¹¹⁸ Hilton BA, Thompson R, Moore-Dempsey L, Janzen RG. Harm reduction theories and strategies for control of human immunodeficiency virus: a review of the literature. *Journal of Advanced Nursing* 2001;33(3):357-70.

¹¹⁹ Rotilly M. Réduction des risques de l'infection à VIH et des hépatites en milieu carcéral : prévalences des pratiques à risques et analyse des contraintes et de la faisabilité des programmes de réduction des risques en milieu carcéral, ORS PACA; 1998.

¹²⁰ Michel L, Carrieri MP, Wodak A. Harm reduction and equity of access to care for French prisoners: A review. *Harm Reduction Journal* 2008;(5):1-11. <http://www.harmreductionjournal.com/content/5/1/17>.

¹²¹ Tang A. Exclusively young offenders: Providing dedicated adolescent sexual clinics in English young offender institutions. [References]. *International Journal of STD & AIDS* 2003 May;Vol.14(5):293-7.

¹²² Eaton L. Health and young offenders. *Nursing Times* 1994;90(24):32-3.

'The main reason given [for not feeling ready to be a father] was being unable to fulfil what they regarded as the key role of financial provider. Most of the men had given little or no thought to the possibility of a sexual partner becoming pregnant. Contraceptive use was high, however, among the minority who reported thinking about this possibility.'

Summary

126. In summary, there is evidence that unsafe sex, resulting in sexually transmitted infections, is a big issue in the Scottish prison population. However, some of this will result from risk behaviour before prison. Condom distribution is unlikely to be sufficient, education about the need for consistent use in many forms of sexual activity is required. The priority target group is young people, and avoidance of stigma (including education of prison officers) and widespread information about condom availability are required. In addition, prison sexual health clinics for young people are required to reduce the pool of already existing infection and prevent further transmission.

Reduce transmission of blood-borne viruses

Key policy documents for BBV health promotion in Scottish prisons

127. The Hepatitis C Action Plan for Scotland¹²⁴ states of an estimated 38,000 persons living in Scotland chronically infected with Hepatitis C, 14,500 had been diagnosed, 8,000 had ever attended specialist clinical services, and 90% of those infected have been involved in drug injecting at some time. Most recent information on prison prevalence dates from the mid-1990s and suggests 24% of the prison population tests Hepatitis C positive (antibodies present). The strategy includes prisons under all key aspects. It emphasises the crucial role of the voluntary and local authority sectors in providing education, training and social support services. Since 95% of GPs did not diagnose a single case in 2006, another setting for identification may improve public health. Prisons are such an opportunity. One stated action was to pilot an in-prison needle/syringe exchange initiative as one of a range of harm reduction measures to reduce the transmission of Hepatitis C. Hepatitis C guidance and education material for young people was also to be distributed to relevant institutions including YOI. For Scottish prisons, Graham (2007)¹²⁵ reports estimates of:

'... the overall prevalence of Hepatitis C in the prison population to be 16–20% (45–54% in current or previous Intravenous Drug Users (IDUs) and 4% in non-IDUs). Extrapolating these estimates to the age and sex structure of the Scottish prison population gives overall numbers of 9,551.'

¹²³ Buston KM. Experiences of, and attitudes towards, pregnancy and fatherhood among incarcerated young male offenders: Findings from a qualitative study. *Social Science & Medicine* 2010 Dec;71(12):2212-8.

<http://www.sciencedirect.com/science/article/B6VBF-51921B2-4/2/51d5ac6d82244e8ee277655e72ce11ce>.

¹²⁴ Scottish Government. Hepatitis C Action Plan for Scotland Phase II: May 2008 – March 2011, Edinburgh, 2010. <http://www.scotland.gov.uk/Resource/Doc/222750/0059978.pdf>.

¹²⁵ Graham L. Prison Health in Scotland. A Healthcare Needs assessment, Edinburgh, Scottish Government; 2007. <http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf>.

128. Scottish policy on sexual health¹²⁶ does not cover the blood borne viruses associated with sexual transmission in any depth, though it does mention the HIV health promotion strategy, and offering HIV testing at GUM clinics. Graham (2007)¹²⁷ states that of 19 HIV positive prisoners in 2006, seven were on HAART treatment.

129. The SPS covers BBV in its framework for the management of substance misuse:¹²⁸

'SPS will ensure that a range of Blood Borne Virus prevention, treatment, care and support services will be available by:

- offering immunisation against Hepatitis A and B to all prisoners on admission and ensuring any course of treatment will continue throughout their sentence and after release
- providing prisoners with information at induction on how to access blood borne virus services and highlight associated risk behaviours
- providing blood borne virus services in accordance with Health Care Standards and the National Memorandum of Understanding/Service Level Agreements between SPS and NHS Boards
- offering a range of harm reduction measures to reduce the transmission of blood borne viruses.'

Literature found

130. The Scottish prison survey (2011)¹²⁹ reported (regarding prisoners):

'One third had been tested for Hepatitis C (34%) before coming into prison and one in ten (10%) thought that they could be Hepatitis C positive.'

131. Although 48% of prisoners had been tested for Hep C while in prison, 85% said they would agree to a test. Again, from the SPS survey 2011, 1% of prisoners had injected drugs in the past month and 69% of these had shared needles (40). The 2006 strategy research¹³⁰ found explanations for continued injecting mainly focused on a user's access to heroin being limited, and injecting being a more efficient way of using the drug in prison.

132. A review of the literature on harm reduction strategies was carried out for French prisons for HIV, HBV and HCV in 2007 for the 15 years up to 2006 (Michel 2008).¹³¹ Study selection criteria are given. The review covered access to harm reduction measures and care.

¹²⁶ Scottish Executive Health Department. Respect and responsibility: strategy and action plan for improving sexual health, 2005.

¹²⁷ Graham L. Prison Health in Scotland. A Healthcare Needs assessment, Edinburgh, Scottish Government; 2007.

<http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf>.

¹²⁸ Scottish Prison Service. Strategy Framework For The Management Of Substance Misuse In Custody, Edinburgh, Scottish Prison Service; 2010.

¹²⁹ Scottish Prison Service. Prisoner Survey 2011

¹³⁰ Shewan D, Marshall L, Wilson G, Vojt G, Galloway J, Marley C. SPS Strategy on the Management of Drug Misuse: Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention, Edinburgh, Department of Psychology, Glasgow Caledonian University, and Scottish Prison Service; 2006. <http://www.sps.gov.uk/MultimediaGallery/a8143eae-9f0a-4ac6-a32f-74722f5ffa11.doc>.

¹³¹ Michel L, Carrieri MP, Wodak A. Harm reduction and equity of access to care for French prisoners: A review. Harm Reduction Journal 2008;(5):1-11. <http://www.harmreductionjournal.com/content/5/1/17>.

Treatment and care are also prevention strategies in HIV, as in any infectious disease where treatment reduces infectivity, and Michel emphasises this in connection with prison health, highlighting how the latter is now seen not only as an important issue in its own right, but also as a public health concern for the wider society. Michel (2008)¹³² found although bleach was distributed to drug injectors inexpensively for cleaning their needles, only 59% used it.

133. An Australian study (Dyer 2009)¹³³ involving interviews with 23 health professionals involved with provision of Hepatitis C support or education services to prisoners found provision of hepatitis C education and support services varied considerably between prisons and across states. Interviewees identified successful services and barriers to improvement, including limited time, insufficient funding and frequent personnel changes. The study recommended external provision of the service.

134. Using custody facility admission records, Bartlett (2008)¹³⁴ found incomplete immunisation rates in young people admitted to correctional institutions in Canada. The recommendation was for greater emphasis on completing immunisations, with prison an implicit opportunity for that. A similar finding, also recommending on-going monitoring of prisoner immunisation records, using a cross-sectional audit of all prisoner health records, was made by Gilles 2008¹³⁵ for prisons in Western Australia.

135. Reducing post-release risk behaviour is an issue for people testing positive for hepatitis or HIV. Grinstead (2001)¹³⁶ reported that an eight session pre-release educational intervention to decrease risk behaviour was feasible and that compared with men who signed up for it but could not attend, participants reported lower levels of sex or drug-related risky behaviour and more use of community resources. However, there may have been selection bias, in that those who did not attend were more or less inclined to risk behaviour.

136. A prison health group education program focusing on hepatitis and STDs was evaluated by Lehma (2001)¹³⁷ and found to be an excellent way to change participants knowledge and self-efficacy in a women's prison in southern US. Participants were self-selected. Leukefeld (2002)¹³⁸ from a descriptive survey of health problems in incarcerated drug abusers in US prisons also supported the value of behavioural health interventions in HIV+ people in prison, and focused on HIV+ risk reduction. Leukefeld suggested external behavioural health providers could provide targeted healthy interventions in prison. Similar support to the

¹³² Michel L, Carrieri MP, Wodak A. Harm reduction and equity of access to care for French prisoners: A review. *Harm Reduction Journal* 2008;(5):1-11. <http://www.harmreductionjournal.com/content/5/1/17>.

¹³³ Dyer J, Tolliday L. Hepatitis C education and support in Australian prisons: Preliminary findings of a nationwide survey. *Health Promotion Journal of Australia* 2009 Apr 20;no. 1(pp. 37-41).

¹³⁴ Bartlett L, Kanellos-Sutton M, van WR. Immunization Rates in a Canadian Juvenile Corrections Facility. *Journal of Adolescent Health* 2008;43(6):609-11.

¹³⁵ Gilles M, Swingler E, Craven C, Larson A. Prison health and public health responses at a regional prison in Western Australia. *Australian & New Zealand Journal of Public Health* 2008 Dec;32(6):549-53.

¹³⁶ Grinstead O, Zack B, Faigeles B. Reducing postrelease risk behavior among HIV seropositive prison inmates: The health promotion program. *AIDS Education and Prevention* 2001;13(2):109-19.

¹³⁷ Lehma C. Description and evaluation of a health education program for women offenders. *The ABNF journal: official journal of the Association of Black Nursing Faculty in Higher Education, Inc* 2001;12(6):124-9.

¹³⁸ Leukefeld CG, Staton M, Hiller ML, Logan TK, Warner B, Shaw K, et al. A descriptive profile of health problems, health services utilization, and HIV serostatus among incarcerated male drug abusers. *The Journal of Behavioral Health Services & Research* 2002 May;Vol.29(2):167-75.

wider public health value of prevention activity in prisons has come from government sources in the US (Rapposelli, 2002).¹³⁹

137. The jailbreak health project in NSW using a weekly radio programme (Minc, 2007)¹⁴⁰ successfully provided information on BBV transmission (especially Hepatitis C). Focus group feedback suggested prisoners valued the programme as relevant and useful. The programme created a culture in Australian prisons of 'looking after your mates'. Focus groups informed content and broadcasting times. Some staff felt the programme encouraged unsafe/illegal practices and refused permission to broadcast from inside the prison. It may not be surprising if a consequent perception of subversiveness increased its appeal to prisoners.
138. Zack (2004) reported a study of a Californian intervention that reduced post-release risk behaviour in HIV+ former inmates in regard to transmission of BBVs. The intervention topics were informed by prisoners' wants and consisted of teaching sessions run by a local AIDS project for pre-release prisoners. There were 12,000 participants in the first year. By demand from participants, this was followed by work setting up HIV orientation classes for new inmates and inmate peer education for new inmates. A pre-release health promotion intervention for HIV positive prisoners was then instituted to reduce risk of transmission after release. The programme was subsequently expanded to include other sexually transmitted diseases, tuberculosis and hepatitis, and other institutions as well. Evaluation used pre- and post-intervention interviews, and telephone interviews post-release. There was a comparison group but allocation to intervention and control groups was not random. Dropouts were not compared between intervention and control groups (therefore not an intention to treat analysis). Men in the intervention group reported greater involvement with community services and reduced sexual or drug-related risk behaviour (19% of the intervention group had injected heroin since release, compared to 30% of the control group).

Summary

139. In summary, Hepatitis C infection is widespread in Scotland. Prisons may be a setting for transmission through the sharing of needles by a small proportion of drug users who inject. However, prisoners welcome Hep C testing and learning more about Hep C. Efforts to prevent drugs entering prison unless 100% successful may encourage injecting as a more efficient method of administration from the injector's perspective. Harm reduction through improving the safety of drug paraphernalia may not be very effective alone, but information initiatives informed by prisoners expressed information needs reduced risky behaviour. Immunisation rates in prisoners may be low (important for Hep A and B). A holistic healthy or whole prison approach in collaboration with social work agencies is important to reduce risk-taking behaviour post-release.

¹³⁹ Rapposelli KK, Kennedy MG, Miles JR, Tinsley MJ, Rauch KJ, Austin L, et al. HIV/AIDS in correctional settings: a salient priority for the CDC and HRSA. *AIDS Education & Prevention* 2002 Oct;14(5:Suppl B):Suppl-13.

¹⁴⁰ Minc A, Butler T, Gahan G. The Jailbreak Health Project--incorporating a unique radio programme for prisoners. *International Journal of Drug Policy* 2007 Oct;18(5):444-6.

Increase physical activity

140. Physical activity has multiple beneficial effects both to prevent and manage the effects of chronic disease, frequently associated with muscle wasting such as cardiopulmonary disease, metabolic syndrome-related disorders (such as diabetes), depression or cancer.¹⁴¹ It also improves functional capacity, wellbeing and quality of life.¹⁴²
141. Physical activity has an important role to play in making the Scottish population healthier. Raising levels of physical activity is of relevance to a number of national outcomes, indicators and targets outlined in the Scottish Government's National Performance Framework.¹⁴³ The Scottish Government's physical activity strategy Let's make Scotland more Active (2003)¹⁴⁴ set minimum recommended levels of physical activity for children and adults, and targets for achievement by 2022. Research has also found general inequalities in health related to income levels, with higher clusters of ill health within disadvantaged or deprived communities (Pickett and Pearl, 2001).¹⁴⁵
142. Although current guidelines recommend that healthy levels of activity are 30 minutes per day for adults and 1 hour per day for children and young people, there are concerns that these levels are not being met by large numbers of people in Scotland and that greater numbers of sedentary people are found in the lower socio-economic groups.
143. Exercise referral schemes (ERS) aim to increase participation in physical activity and, more specifically, aim to treat or prevent ill health in individuals who have, or are at risk of, ill health by encouraging participation in physical activity for the improvement of health and wellbeing. The majority of schemes offer activity to 'at risk' groups of people as well as the general population via primary care professionals and local service providers. Most schemes also promote the benefits of a healthy lifestyle and encourage long-term adherence to physical activity. However, evaluation of various schemes have produced equivocal results regarding the effectiveness of ERS over the long term. ERS appear to have better results over the short term (less than 12 weeks).¹⁴⁶ Across Scotland, only 70% of GP practices actually have access to ERS.
144. Condon *et al*¹⁴⁷ state that many prisoners, especially young men, described themselves as taking more exercise in prison than outside prison, often because imprisonment was the only time they were not using drugs. Many prisoners regarded the gym as a coping strategy. However, access to the gym for some prisoners was constrained due to security, particularly in high-security prisons. There was also, for some, a perception, that access to the gym was

¹⁴¹ Pedersen B, Saltin B. Evidence for prescribing exercise as therapy in chronic disease. *Scand J Med Sci Sports* 2006;16(Suppl 1):3-63.

¹⁴² Perez-Moreno F, Camara-Sanchez M, Tremblay J, Riera-Rubio V, Gil-Paisan L, Lucia A. Benefits of exercise training in Spanish prison inmates. *Int J Sports Med* 2007;28:1-7.

¹⁴³ Scottish Government. National Performance Framework. Available at: <http://www.scotland.gov.uk/Publications/2007/11/13092240/9>

¹⁴⁴ Scottish Government. Let's make Scotland more active. Available at: <http://www.scotland.gov.uk/Resource/Doc/47032/0017726.pdf>

¹⁴⁵ Pickett K, Pearl M. 2001. Multilevel analyses of neighbourhood socioeconomic context and health outcomes: a critical review. *Journal of Epidemiology and Community Health* 55: 111-122.

¹⁴⁶ Jepson R, Robertson R, Doi L. Audit of Exercise Referral Scheme in Scotland March 2010. University of Stirling.

¹⁴⁷ Condon L, Hek G, Harris F. Choosing health in prison: Prisoners' views on making healthy choices in English prisons. *Health Education Journal* 2008 67:155.

granted on a more arbitrary basis, which struck some as unfair. Additionally, prisoners who were less fit, for example due to older age or chronic illness reported being more likely to engage with gym fitness if it were available, for example, as 'remedial gym'. There were reports that some members of staff also felt more comfortable with this arrangement as there was reportedly a 'fear of litigation' in the event that an older prisoner collapsed in the gym.

145. 'The promotion of physical activity in secure accommodation'¹⁴⁸ outlines the importance of physical activity in prisons – both as a means of improving mental and physical health and in the wider context of social inclusion and re-offending. For example, Houchin (2005) notes 'physical education instructors report some success in engaging those in secure accommodation successfully in sporting activities that give them access on release to networks that may support their transition to legitimate and rewarding lifestyles.'¹⁴⁹ Research suggests key factors that maximise levels of participation:¹⁵⁰
- The context of physical activity promotion, i.e. within a prison setting
 - The range of activities offered
 - The extent to which equality of access for all groups is pursued
 - The extent and quality of physical activity-related facilities
 - The nature and quality of instructors/facilitators
 - The timing of activities
146. In addition, the promotion of physical activity in secure accommodation highlights the general recommendations from a 'settings approach' that are relevant to prisons as well as specific guidance for implementing successful change.¹⁵¹ For example, any interventions introduced need to be about more than just health improvement – they need to help the organisation's other strategic aims such as education or community re-integration. Physical activity can encompass specific exercises and sports but also be part of 'active living' such as walking or gardening.

Improve parenting

147. The literature regarding offenders and parenting skills was limited. Houghugh (1998)¹⁵² suggests that parenting may be the most important public health issue facing society and that the quality and style of parents' care of their children is widely accepted as central to understanding a variety of health outcomes. 'Good (enough) parenting', by both the mother and father, is currently seen as a solution to many of the ills of society.¹⁵³
148. There is growing evidence of the positive influence of the father's engagement (defined as 'direct contact', such as play, reading, outings or care-giving activities') on offspring' social,

¹⁴⁸ The promotion of physical activity in secure accommodation. Physical Activity and Health Alliance. (2007) Available at: <http://www.healthscotland.com/uploads/documents/5562-6.pdf>

¹⁴⁹ Houchin R. (2005) Social Exclusion and Imprisonment in Scotland: A report. Scottish Prison Service, Glasgow.

¹⁵⁰ The National Audit Office (2006) Serving Time: Prisoner diet and exercise. NAO, London. Available at: http://www.nao.org.uk/publications/0506/prisoner_diet_and_exercise.aspx

¹⁵¹ Chu C et al (2000) Health-promoting workplaces. Health Promotion International Vol 15(2);155-167.

¹⁵² Houghugh M. The importance of parenting in child health. *BMJ* 316 : 1545 (Published 23 May 1998)

¹⁵³ Social Exclusion Unit. (2005) Transitions: Young adults with complex needs. London: Office of the Deputy Prime Minister.

behavioural and psychological outcomes.¹⁵⁴ The authors also concluded that fathers' engagement reduces the frequency of behavioural problems in boys and decreases criminality and economic disadvantage in low socio-economic status families. Although prisons do not routinely collect data on the fatherhood status, it has been estimated that at least one in four incarcerated young offenders is a father.¹⁵⁵

149. Salmon (2005) estimated that 45% of prisoners lose contact with their families while imprisoned and 22% of married prisoners experience a breakdown in that marriage due to imprisonment.¹⁵⁶ Prisoners who are able to keep meaningful contact with their families are almost six times less likely to re-offend (Holt and Miller, 1972) due to improved resettlement on release.¹⁵⁷ There is weighty literature on desistance from re-offending that points to the protective quality of 'social bonds', including those arising from the offender valuing, and being valued as, being part of a family unit.¹⁵⁸

150. One of the recommendations in Scottish Government's 'Equally Well' strategy for tackling health inequalities is:

'The Scottish Prison Service should offer family and relationships support from the date of entry to prison. 51% of men and women in prison had dependent children and approximately 15,500 children in Scotland lose a parent to prison every year. The health, social and educational prospects of these children are affected in turn by their parent's health and wellbeing.'¹⁵⁹

151. The Equally Well Implementation Plan identifies Early Years and Mental Health and Wellbeing as two of the key areas for reducing inequalities in Scottish society. There is evidence that emotional and behavioural problems in childhood are associated with increased likelihood of offending behaviour in adulthood.¹⁶⁰ There is also evidence that links parental incarceration with offending behaviour among boys, although it is unclear whether this is a causal relationship or a correlation indicative of other related factors such as stigma or reduced family income.¹⁶¹ There is good evidence that early years interventions yield the greatest return for the resource outlaid.¹⁶² Although the opportunity for early years intervention has been missed for current offenders, it points the way for reducing offending behaviour in the future and also the potential importance of promoting parenting programmes among the prisoner population.

¹⁵⁴ Sarkadi A, Kristiansson R, Oberklaid F, Bremberg S. (2007) Father's involvement and children's developmental outcomes: a systematic review of longitudinal studies. *Acta Paediatrica*, 97, 153-158.

¹⁵⁵ MacMillan C. (2005). Public health initiative at a young offenders institute. *Community Practitioner*, 78, 397-399.

¹⁵⁶ Salmon S (2005). Prisoners' children matter. *Prison Service Journal*. 159;16-19.

¹⁵⁷ Holt N, Miller D (1972). Explorations in inmate-family relationships. California: Department of Corrections.

¹⁵⁸ Farrall S. (2002). Rethinking what works with offenders: Probation, social context and desistance from crime. Cullompton: Willan.

¹⁵⁹ Equally Well. Report of the ministerial taskforce on health inequalities. 2008. Available at:

<http://www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf>

¹⁶⁰ Barlow J, Parsons J. Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. *Cochrane Database of Systematic Reviews Issue 2*, 2003.

¹⁶¹ Murray J, Farrington DP. Parental imprisonment: effects on boys' antisocial behaviour and delinquency through the life-course. *Journal of Child Psychology and Psychiatry* 46:1269-1278, 2005.

¹⁶² Sinclair, A. 0-5: How Small Children Make a Big Difference. The Work Foundation, 2007

152. An evaluation of the Jigsaw Visitors Centre at HMP Leeds, which upgraded the traditional visitors centre with a healthy living centre, saw improvements in the 'quality' of visits to prisoners as perceived by all key stakeholders.
153. Given the considerable costs of crime attributable to conduct disorders (Sainsbury Centre, 2009b)¹⁶³, and the links made between mothers with borderline personality disorder, incarceration and intergenerational risk factors for crime, evidence-based parenting programmes may be a cost-effective intervention that could have longitudinal benefits. They estimate that these programmes cost as little as £600–900 per person for group-based therapies and up to £4,000 per person for individual interventions. The brevity of parenting programmes also means that they could potentially be delivered for women who are serving short sentences.
154. Buston (2010) examined the experiences of and attitudes of young male offenders to pregnancy and fatherhood in Scotland. She concluded that most of the young offenders 'are not the feckless actual and potential fathers that some might assume them to be'. Buston suggested that recent US-based interventions that encourage young fathers to understand issues around their own fathering by reflecting on their experience as sons, could be a first step in enabling young offenders to behave as 'good fathers'. It was suggested that conceptualisations could be explored and built on with the course facilitators, and the men could be offered the resources and skills to develop these with their own children or encouraged to think more about their procreative responsibilities if they have no children.¹⁶⁴

¹⁶³ Sainsbury Centre (2009b) *The Chance of a Lifetime: Preventing early conduct problems and reducing crime*. London: Sainsbury Centre for Mental Health.

¹⁶⁴ Buston K. Experiences of, and attitudes towards, pregnancy and fatherhood among incarcerated young male offenders: Findings from a qualitative study. *Social Science and Medicine* 71(2010) 2212-2218.

Examples of good practice: Eastern England

Ormiston Children & Families Trust works to support children and young people affected by imprisonment. One of their ways is via their accredited parenting programme 'You and Your Child', utilised in eight prisons in Eastern England. The parenting programme has three modules (plus a T-learning module (learning in-cell by television) developed for use at HMP Littlehey):

- 1) Child Development, Play and Behaviour – aims to support fathers in building positive relationships with their children, focusing on the importance of listening to and negotiating with their children and young people, setting boundaries for behaviour and taking a consistent and positive approach to parenting .
- 2) Safety and Health for your Child – introduces practical ways of keeping children safe and healthy, including knowing about hazards, healthy eating and getting enough sleep and exercise
- 3) Distance and Communication – enables fathers to consider ways of maintaining a relationship with their children while they are in prison by making the most of visits, letters and phone calls.

Peer led/Self-management health promotion activities

Self-management of chronic illness

155. The majority of published health research carried out in prisons has focused on risky health behaviours, e.g. substance misuse, blood-borne virus transmission and mental health¹⁶⁵ but there is less research into managing chronic disease within the prison setting. The burden of chronic disease, which is a growing problem in industrialised countries such as Scotland, disproportionately affects deprived and vulnerable populations therefore it is an area that cannot be ignored.
156. For example, the Expert Patients Programme (EPP) is a lay-led, self-management programme specifically for people living with long-term conditions (e.g. asthma, epilepsy, arthritis, mental health problems) aiming to support people in increasing their confidence, improving their quality of life and better managing their condition.¹⁶⁶ Evaluation indicates that EPP has achieved improved health outcomes for patients and reduces the degree to which they use healthcare services. EPP is part of the general move in primary care towards patient-centred care; however, there is an inherent tension between this and the surveillance culture of prison.¹⁶⁷
157. Gately *et al* (2006) explored the perceptions of prisoners to the barriers and opportunities for managing long-term conditions in a prison setting, particularly with the view to readiness to engage in Expert Patient Programmes. They found that on the one hand, the structured

¹⁶⁵ Gately C, Bowen A, Kennedy A et al. Prisoner perspectives on managing long-term conditions: a qualitative study. *International Journal of Prisoner Health*. 2006; 2(2):91-99.

¹⁶⁶ Department of Health (2001). *The expert patient programme: a new approach to chronic disease management for the 21st century*. London: Crown Copyright.

¹⁶⁷ Gately C, Bowen A, Kennedy A et al. Prisoner perspectives on managing long-term conditions: a qualitative study. *International Journal of Prisoner Health*. 2006; 2(2):91-99.

prison regime allowed some prisoners to regain control over previously chaotic lifestyles but on the other hand, the lack of access to a healthy diet and exercise facilities, as well as the lack of opportunities to practise new health behaviours learned while in prison, prevented a healthier lifestyle being adopted. Some prisoners found that access to a healthcare professional was difficult and there was a lack of understanding for their needs related to their chronic disease. Overall, the study found that a number of pre-existing factors would need to be addressed before prisoners were likely to become fully engaged in Expert Patient Programmes.¹⁶⁸

Peer-led health promotion: health trainers

158. In April 2002, Wanless produced a report called 'Securing our Future Health: Taking a Long-Term View'.¹⁶⁹ This outlined projected future health trends in the UK and resource requirements for the NHS. It emphasised the need for health promotion (especially among deprived population groups), and for the general public to have more information on what the NHS will and will not provide so that they can engage in their care in an informed way.
159. Building on this theme, in November 2004, the government produced a white paper called *Choosing Health: Making Healthy Choices Easier*. This aimed to reduce inequalities in health by supporting the public in making more healthy and informed choices regarding their health. In particular, the government wanted to focus on disadvantaged groups and areas, to try to enable previously excluded and marginalised groups to make faster improvements in health, and thus reduce inequalities in health. Thus, part of this initiative involved the creation of a new role – health trainers.
160. The role of health trainers was seen as:

'Offering practical advice and good connections into the services and support available locally, they will become an essential common-sense resource in the community to help out on health choices. A guide for those who want help, not an instructor for those who do not, they will provide valuable support for people to make informed lifestyle choices.' (*Choosing Health*: 106)¹⁷⁰

In short, they represent a move from 'advice on high' to 'support from next door'.¹⁷¹

161. In 2006/2007 for a DH-funded pilot, the New Futures Health Trainer initiative trained prisoners (and offenders who have completed a probation order) to become health trainers – providing prisoners/ex-offenders themselves with the knowledge and skills to be able to improve the health of their peers and improve their engagement with services. The role aimed to empower offenders themselves to overcome health inequalities, which in turn may help to reduce re-offending. Four competences for Health Trainers were identified¹⁷²:

HT1 – Make relationships with communities

HT2 – Communicate with individuals about promoting their health and wellbeing

¹⁶⁸ Gatley C, Bowen A, Kennedy A et al. Prisoner perspectives on managing long-term conditions: a qualitative study. *International Journal of Prisoner Health*. 2006; 2(2):91-99.

¹⁶⁹ Wanless, D (2002), *'Securing our Future Health: Taking a Long-Term View'*, HM Treasury

¹⁷⁰ Department of Health (2004), *Choosing Health: Making Healthy Choices Easier*, London, The Stationery Office.

¹⁷¹ Scorer C. Health Trainers implementing a new public health role. *The Journal of the Royal Society for the Promotion of Health* 2007 127:258.

¹⁷² Skills for Health. www.skillsforhealth.org.uk

HT3 – Enable individuals to change their behaviour to improve their own health and wellbeing

HT4 – Manage and organise their own time and activities

162. An evaluation of the pilot, which included five prisons (122 health trainer prisoner clients) and one probation area, concluded that the impacts had generally been positive both for prisoners that had trained as health trainers (resulting in increased knowledge and changes in attitudes to certain health issues) and for the clients they had contact with. For example, for 45% of health trainer clients in prison, a health trainer was the first health service that they had chosen to engage with. The main issues that clients discussed with prison health trainers were exercise, healthy eating and weight. However, this may have been related to the fact that even before seeing clients, health trainers had reported less confidence in signposting for topics such as sexual health, alcohol, self-harm and immunisation. (The reasons for this lack of confidence were not fully explored but may reflect a similar lack of confidence in tackling many of these issues by healthcare professionals.) A large number of clients were referred onto the prison gym (59%), while a smaller number were referred on to health care (23%).¹⁷³
163. Caveats about the use of health trainers, as highlighted by prisoner health trainers themselves, include the possibility of prisoners abusing their role.¹⁷⁴ Research from other peer-education schemes suggests that in order to be successful, there should be adequate supervision of health trainers. Specific procedures are needed for dealing with issues such as managing confidentiality. However, within the Scottish Prison Service, the Listeners scheme (a face-to-face Samaritans-like service) sets the precedent for prisoner peer-support.

What is the evidence of effectiveness of health promotion delivery among non-healthcare professionals in prisons?

164. Liebling commented that ‘staff-prisoner relationships are at the heart of YOIs and prisons, yet no attention is paid to how staff achieve the task of getting them right.’¹⁷⁵ Woodall interviewed young offenders about the effect of prisoner-staff relations on their wellbeing and mental health. Unanimously, it was suggested that there are ‘excellent prison officers who engage with prisoners and help them toward their rehabilitation through assisting them with education courses and skill development while at the same time, there are staff who abuse their power and treat prisoners disrespectfully.’¹⁷⁶ However, it was acknowledged that getting the balance right is difficult for officers. They have competing demands: to offer, on the one hand, involvement, contact and support, yet on the other hand to represent power, authority and order.
165. Staff health, welfare and training are seen as key to the comprehensive provision of a healthy prison environment. Bogemann¹⁷⁷ highlights that health strategies in prisons must

¹⁷³ Brooker C, Sirdifield C. New Futures Health Trainers: An Impact Assessment. University of Lincoln. 2007. Available at: http://www.lincoln.ac.uk/cjmh/docs/OHTR_final2.pdf

¹⁷⁴ Sirdifield C. Piloting a new role in mental health – prison based health trainers. *The Journal of Mental Health Workforce Development*. Vol 1. Issue 4. Dec 2006.

¹⁷⁵ Liebling A, Price D. Staff-prisoner relationships. A review of the literature. *Prison Service Journal*, 1998:120:3-6.

¹⁷⁶ Woodall J. Barriers to positive mental health in a Young Offenders Institution: A qualitative study. *Health Education Journal* 2007 66:132.

¹⁷⁷ Bogemann H. Promoting health and managing stress among prison employees. In: *Health in prisons. A WHO guide to the essentials in prison health*. Copenhagen, Europe. WHO Regional Office; 2004. Available

include 'the increasingly complex psychosocial problems of prison employees – burnout, alcohol and drug consumption, internal withdrawal and their inability to come to terms with traumatic experiences in daily work'.

166. Although focusing specifically on tuberculosis control, Moller *et al* comment, 'if front-line staff see their role solely as the safe custodianship of prisoners, it will be much more difficult to diagnose, treat and support prisoners with ill health ... If staff are unaware of the personal values that colour their decisions and attitudes, they will be unable to create the caring ethos in which clinical therapy has the best chance of success.'¹⁷⁸
167. There was no research literature found regarding the use of non-health staff in health promotion activities. However, there is evidence of their use in day-to-day service activities which are not always formally labelled as health promotion.
168. For example, the Bradley Report (2009)¹⁷⁹ highlighted that mental health services are still reliant on non-mental health trained staff, i.e. prison officers, to refer clients to them. Prison officers have the most contact with prisoners on a day-to-day basis, and as such often act as their primary carers. In England and Wales, mental health awareness training is currently available for wing-based prison officers, for whom a three-day training package has been developed which includes an introduction to mental health, self-harm and suicide awareness, skills training and mental health awareness. However, an evaluation of the implementation of this training¹⁸⁰ concluded that roll-out has been disappointing. As such, Bradley recommended that awareness training on mental health and learning disabilities must be made available for all prison officers and, where appropriate, the training should be undertaken jointly with other services to encourage shared understanding and partnership. Training should be developed in conjunction with service users.
169. Specifically, alcohol brief interventions (ABI) are routinely being conducted by non-health staff within the criminal justice system. At present, this is happening most regularly in England and Wales where police officers are providing ABIs around the time of arrest and post-sentence, by offender managers in the probation service.¹⁸¹ Within Scotland, ABIs delivered by non-health staff are being trialled within the criminal justice authorities in Perth and Kinross and in South and North Lanarkshire.¹⁸²

¹⁷⁸ Moller L, Gatherer A, Dara M. Barriers to implementation of effective tuberculosis control in prisons. *Public Health* 123 (2009) 419-421.

¹⁷⁹ The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. 2009. Available at:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

¹⁸⁰ Brooker C, 2007, *An evaluation of the roll-out of the self-directed 'Mental Health Awareness' workbook in custodial settings.*

¹⁸¹ Alcohol and Offenders Conference presentation: Mr R Stanbury, National Offender Management Service (England and Wales) 8 Feb 2011.

¹⁸² Alcohol and Offenders Conference presentation: Dr K Skellington, MVA Consultancy. 8 Feb 2011

What are the most useful outcome variables to measure and assess health improvements?

Policy research and strategy

170. WHO (2007)¹⁸³ frames the problems addressed by health promotion in prisons (and implicitly therefore one view of a health and social problem-specific outcomes framework) as follows:

Social, economic and life circumstances	Lifestyle	Health problems
Overcrowding	Smoking	Drugs and dependence
Ethnic diversity, language and religion	Drugs	Mental health
Disability, especially intellectual or developmental disability or brain disease	Alcohol	Dental health
Poverty	Diet	Infections
Poor hygiene or nutrition	Sexual health	Chronic conditions
Chaotic, unstructured lifestyle	Abusive relationships	
Poor educational attainment	Personality disorder	
Few assets or social capital		
History of past abuse		
Poor family capacity, parenting and supportive relationships		

171. The outcomes of health promotion in prisons can therefore be adduced as firstly to improve and prevent health problems through lifestyle change, and then in the longer term to improve the social, economic and life circumstances of prisoners and their families.

172. More process-based and perhaps more immediately useful outcomes for health promotion in prisons could also be derived from WHO (2007) (pp29–30) which states:

‘A service should be developed that incorporates health promotion into the wider work of the prison, such as:

¹⁸³ World Health Organisation. Health in prisons. A WHO guide to the essentials in prison health, Geneva, 2007. http://www.euro.who.int/_data/assets/pdf_file/0009/99018/E90174.pdf.

- encouraging people to acquire basic life skills
- encouraging training towards employment and purposeful activity
- locating suitable accommodation after release
- encouraging participation in programmes to help people stop taking illegal and harmful drugs, smoking tobacco, and drinking excessive alcohol
- encouraging people to exercise regularly and to learn to prepare and enjoy foods that provide a balanced and nutritious diet.'

173. According to Gatherer (2005)¹⁸⁴ the Health Improvement in Prisons Project in the UK has 'decided to develop a prison health database, using indicators to assess progress and allowing HIPP to keep a finger on the pulse of prison health.' This is in collaboration with the European Monitoring Centre for Drugs and Drug Addiction and the Scientific Institute of the German Medical Association. De Viggiani (2004)¹⁸⁵ reported on a health needs assessment, and included the following outcomes (from the Prison health service outcomes report, issued May 2004) in the report:

Service planning and development: Development of needs-based health services in partnership with local PCTs and other NHS agencies that deliver effective evidence-based care to prisoners.

Local policy: Clear and observed policy statements on primary care, dental and specialist clinical services available for prisoners.

Ethos: Health services provided in a clean environment that offers safety and privacy, and delivered with decency and respect for prisoners by appropriately trained and well-supported staff who adhere to professional and ethical codes of practice.

Professional practice: Healthcare staff are appropriately trained, qualified and registered with the appropriate regulatory body to provide care to a professional standard of practice. They must receive ongoing training and development required to maintain professional standards.

Use and protection of patient information: Discrete patient clinical records are maintained for every prisoner from first reception and reasonable attempts made to merge these with previous custody records. Medical information should be managed in accordance with relevant legislation and the NHS Code of Practice on confidentiality.

Health assessment at first reception: Initial assessments of the healthcare needs of all newly received prisoners must be undertaken within 24 hours of first reception

¹⁸⁴ Gatherer A, Moller L, Hayton P. The World Health Organization European Health in Prisons Project after 10 years: persistent barriers and achievements. *American Journal of Public Health* 2005 Oct;95(10):1696-700.

¹⁸⁵ De Viggiani N, Orme J, Salmon D, Powell J, Bridle C, Murphy S. Healthcare Needs Analysis: An Exploratory Study of Healthcare Professionals' Perceptions of Healthcare Services at HMP Eastwood Park, South Gloucestershire., Bristol, University of the West England; 2004. <http://www.offender-health-sw.org.uk/Data/Sites/3/GalleryImages/Eastwood%20Park%20Report%20-%20Published%20Version.pdf>.

by appropriately trained healthcare staff, to identify existing health problems and plan subsequent care.

Suicide and self-harm management: Healthcare teams must work with the multidisciplinary suicide prevention team to manage prisoners at risk of suicide and self-harm in accordance with PSO 2700 and Suicide Prevention Strategies.

Transfer and release: Current healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments, from establishments to outside NHS hospitals for inpatient care, or released into the community.

Mental health services: Establishments should provide services for observing, assessing, treating and care for prisoners with mental healthcare needs. Prisoners should be treated by a multidisciplinary team in line with the Code of Practice on the operation of the Mental Health Act and the standards in the National Service Framework (NSF) for Mental Health.

In-patient care: Establishments with in-patient accommodation must provide appropriate needs-based services for assessing, treating and caring for in-patients.

Communicable disease prevention and control: Establishments must have effective arrangements for preventing, controlling and managing communicable diseases.

Clinical services for substance misusers: Effective clinical management of substance misusers must be delivered by evidence-based services that identify, assess and treat substance misuse in line with Department of Health guidelines, contribute to through-care plans, and provide information to prisoners on high-risk behaviour, harm minimisation and secondary prevention.

Pharmacy: A patient-focused, primary care-based pharmacy service must be provided for prisoners, based on identified need. The service must comply with legal requirements, professional standards and ethical codes comparable to that provided by the NHS and be developed in line with PSI 28/2003 A Pharmacy Service for Prisoners.

Dental services: Prisoners must be provided with dental services based on clinical need.

Promoting health: Services must be provided for prisoners and staff that aim to:

- I. build their physical, mental and social health, as part of a whole prison approach
- II. prevent the deterioration of prisoners' health during or because of custody
- III. help prisoners adopt healthy behaviours that can be taken back into the community upon release.

Consent to treatment: Treatment without consent should only be administered in accordance with professional standards of practice.

Clinical governance: Establishments must ensure that arrangements are put in place to develop clinical governance.

174. Although these do not define detailed indicators for the evaluation of prison health promotion practice, they do provide a framework of outcomes within which criteria and indicators can be agreed.
175. Gatherer (2005)¹⁸⁶ found it was not clear what had changed in practice after 10 years of meetings and statements from the World Health Organization European Health in Prisons Project (HIPP), although vital actions had been taken and important policy documents had been produced. For example, statements on communicable disease (identifying overcrowding and unhygienic facilities as major problems) and mental health (acknowledging that deprivation of freedom is bad for mental health), drugs (advocating harm reduction, including needle exchange schemes and substitution therapy) and special groups needs (women, young people and ethnic minorities). HIPP recognised that prison health was part of the public health of the wider society, and having a separate prison health service isolated from the mainstream led to prison health not being included in national public health strategies.
176. Whitehead 2006¹⁸⁷ in a review of the health-promoting prison literature in relation to nursing suggested that prison nurses must embrace the health-promoting prison reforms. The view is taken that this can only happen through partnership working involving the whole prison community and all nursing disciplines.

Literature

177. Condon 2006¹⁸⁸ reports a study of smoking quit rates across the general population where prisoners' quit rates were not given. She mentions a project where successful quitters were asked to help others to quit (no outcomes reported).¹⁸⁹ The hospital anxiety and depression scale (HADS) has been used in prisons, however wider measures include the impact on families for a number of reasons, including loss of contact with families (increasing social exclusion) that may particularly affect women and young children, because there are fewer prisons available for these groups so they are more likely to be a greater distance from home.
178. The impact on the families of the prisoners is significant. Condon produced a systematic review of prison health and the role of the primary care nurse in prison. While some of the review is more relevant to health care than health promotion, the information on health needs highlights issues for the prevention of disease, primarily that in all areas prisoners health needs are higher than those in the wider community. The main health promotion issue was the lack of a comprehensive health assessment on entry to prison, so no clear

¹⁸⁶ Gatherer A, Moller L, Hayton P. The World Health Organization European Health in Prisons Project after 10 years: persistent barriers and achievements. *American Journal of Public Health* 2005 Oct;95(10):1696-700.

¹⁸⁷ Whitehead D. The health promoting prison (HPP) and its imperative for nursing. *International Journal of Nursing Studies* 2006;43(1):123-31.

¹⁸⁸ Condon L, Hek G, Harris F. Public health, health promotion and the health of people in prison. *Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association* 2006;79(1):19-22.

¹⁸⁹ Jenkins L. Quitting in Prison. *Smoking Cessation* 2011;June 2004:40-4.

identification of health needs at the outset. Without assessment on entry, outcomes (conceived as the difference being in prison makes to health) cannot be measured. This lack of assessment was also perhaps connected to less health promotion carried out than reported in prison because of lack of identified opportunities.

179. In a review of prison healthcare, a narrative review by Watson (2004)¹⁹⁰ includes health promotion, also highlighting the importance of health screening on entry since health needs and problems of prisoners must be known to base effective action plans on. One issue where a prison did not allow diabetic prisoners to keep their own equipment for the administration of insulin was highlighted as an example of the 'tension between the correctional and health care aspects of being in prison.' In terms of improving the health of the whole community, breaking the cycle between homelessness, mental health and incarceration was important. That suggested a further possible outcome measure – of the availability of accommodation outside prison for prisoners on their release. Communicable disease control in prison was of clear importance both in itself and to prevent spread to the wider community.
180. Khavjou 2007¹⁹¹ compared the health of clients of a health improvement project (WISEWOMAN) who were in prison with those clients of WISEWOMAN in the community. She did not report recruitment rates to the programme between prison and community. A higher recruitment rate in the prison owing to the captive population may have carried a selection bias for the comparison. Using clinical outcomes, she found that total cholesterol was the only cardiovascular risk factor that was significantly better in the prison population after adjustment for age and other demographic factors. The factors measured were hypertension, total cholesterol, HDL cholesterol, BMI (overweight and obese) and whether a smoker. The conclusion made from this was that heart disease and stroke risk screening programmes were needed in prisons.
181. Lynch 2007,¹⁹² in a review of prevalence data from the criminal justice system in New South Wales, highlights the high cost-effectiveness of screening interventions for STDs and BBVs in young people and the relatively high proportion of young people in the criminal justice system who test positive for these. She also points out that improved mental health and reduced drug dependence is likely to lead to lower future offending behaviour and that some offending behaviour may result from brain injury, which needs to be identified and appropriate rehabilitation interventions provided rather than punished through the deprivation of liberty. Thus criminal justice outcomes need to be interpreted in the context of health conditions.
182. Minc *et al* (2007)¹⁹³ report an interesting health promotion intervention in New South Wales in Australia. This was a weekly half hour radio program on prison radio called 'Jailbreak', which aimed to reduce the transmission of blood borne viruses and promote healthy lifestyles among prisoners. The method was to broadcast the queries and stories of prisoners themselves in their own words, with quizzes included to communicate clear

¹⁹⁰ Watson R, Stimpson A, Hostick T. Prison health care: a review of the literature. *International Journal of Nursing Studies* 2004 Feb;41(2):119-28.

¹⁹¹ Khavjou OA, Clarke J, Hofeldt RM, Lihs P, Loo RK, Prabhu M, et al. A captive audience: Bringing the WISEWOMAN program to South Dakota prisoners. [References]. *Women's Health Issues* 2007 Jul;Vol.17(4):193-201.

¹⁹² Lynch C, Matthews R, Rosina R. Health as a mediator of change in the trajectory of young people in contact with the criminal justice system. *International Journal of Adolescent Medicine & Health* 2007 Jul;19(3):269-76.

¹⁹³ Minc A, Butler T, Gahan G. The Jailbreak Health Project--incorporating a unique radio programme for prisoners. *International Journal of Drug Policy* 2007 Oct;18(5):444-6.

information about prevention, but without making this the obvious aim. Process outcomes were used. Of a sample of 500, 23% of women and 16% of men (who were 93% of the sample) had listened to 'Jailbreak' at some time. Some staff were concerned the harm reduction messages encouraged drug use, and that led to the messages being recorded outside prison with ex-prisoners.

183. Thornton-Jones (2003)¹⁹⁴ did a survey of prison staff (mainly nursing and medical, and some prison governors) to assess the impact of the NHS modernisation agenda in prisons. She found the main impacts (conceived as structural outcomes or changes to structure) were the reported existence of prison-NHS partnerships, and health needs assessments. In the development of a health improvement plan, the most difficult part was that doing health needs assessment was time consuming, for example having to spend time outside the prison meeting NHS colleagues.

Summary

184. There are a number of different classes of outcome connected with health promotion in prisons. Clearly health outcomes, in terms of disease and even health status, need careful base lining to be meaningful, and comparison between prisons is not feasible because of various confounding factors. A focus on health alone is likely to undervalue efforts to improve the many factors related to health both in prisons and outside it involved in efforts to entrench health gains and prevent re-offending. Process measures related to outcome can, at least in the short term, be more useful for programme monitoring.

¹⁹⁴ Thornton-Jones H, Hampshaw SM. Modernising beyond the NHS: Prison healthcare can benefit too. *Quality in Primary Care* 2003;11(4):271-6.

Annex E – Focus group results

Prisoner views on health promotion

These are the findings from focus groups carried out with prisoners in four representative Scottish prisons in early 2011. This was part of a consultation towards a new framework for health promotion across Scottish prisons. The views reported from these focus groups were balanced subsequently with a range of other information from the literature and other stakeholder interviews. The aim was not to challenge but to report straight the views of the prisoners.

Concepts of health promotion

- There was knowledge that health promotion had a wide range and scope
- Appreciation was evident of the effect on health promotion of constraints on choice in prison
- Mention was made of individual and population level changes
- Awareness existed of the distinction between prevention of disease and health care

Health promotion events

Events

- Understandings of health promotion events included the chance to taste ‘better’ food, health checks, information about diet, exercise, smoking, cooking, first aid, food hygiene, oral hygiene, health and safety, weight management.
- Other examples of events were Well Man days, independent living courses, yoga, walks.
- An education session provided by a dietitian (on weight management) and sessions by a hygienist (on independent living) were very well received.
- There was a perception that events had reduced in frequency (closed prison).
- Events were also seen as one-off: there was a feeling the health promotion should have been a springboard to sustained improvement (all prisons).
- Back up was needed to cover staff absence that hindered continuity.
- Sustainability and resilience were countervailing pressures for health promotion in the prison environment, underlining the need for a holistic approach.

Health promotion topics

Food

Prison catering is free to prisoners. Prisoners can order-in a limited range of purchased food through the Canteen system. There was a general low opinion of catering in prison. Prisoner’s views were expressed as follows:

- Fruit bags were seen as too costly, too small and under ripe.
- Fruit orders were not always received.
- There was a perception that the quality of food varied between different types of prison. This created perverse incentives for some YOs, for example it was seen as a reason to commit a crime on release to go to an adult jail for the better quality food

- Healthy options that were badly presented had the unintended consequence of deterring healthy eating
- Prisoners perceived a deterioration in food quality in closed prisons both over time and compared to open prisons experience
- There were issues with staff eating in the presence of prisoners
- A greater range of 'normal' food on menus was desired, however prisoner perceptions of normal food often varied from a public health view of a healthy and balanced diet
- A longer rotation on menus was requested, to cut down on repetition and monotony
- There was a request that more sophisticated cooking facilities for self-preparation be extended to more prisons.

Exercise, activity and gym

There are set times for physical activity within the prison regime. Most activities are supervised. Elements take place both inside and outside.

- There were general scheduling issues around physical activity, for example clashes between indoor and outdoor exercise sessions and in one case the order in which cells were opened in the morning limited access for those in the last cells.
- YO's were concerned they were not getting enough sunlight (for vitamin D) as winter exercise was in the dark.
- Prisoners said restrictions on the availability of suitable outdoor clothing also deterred them from outside exercise, though the precise nature of the restriction varied between prisons.
- Other physical activity issues included delays in repair to gym equipment.
- There was a demand for more football at the YOI.
- Unemployment in the closed prison came out spontaneously as an important activity issue, with wider implications than physical activity alone. Prisoners mentioned their financial wellbeing.
- Cardiovascular machines were seen as a part substitute for work but their availability was restricted at the closed prison.
- YO's under 18 years of age felt they were missing out because they were not allowed to work.
- Weights were more popular than cardiovascular machines at the YOI.
- Women felt there was a lack of recreational activity in some blocks, though a good range for others, but did not mention unemployment.
- YO's said there were issues with getting a good nights sleep.

Relationships

- Long travelling times and high travel costs for short visits were mentioned at the YOI and the closed prison.
- Visits were seen (especially by YO's) as an opportunity for visitors to bring funds for prisoners' accounts.
- Saving up visiting time was allowed but felt to be over too long a period (6 months).
- Family visits timing, refreshments, children's play areas and barriers to physical contact were an issue, and could be emotionally disturbing, especially at the closed and open prisons.
- The attitude of prison staff supervising visits was described as 'bad', for example lack of sensitivity to health issues in visitors.
- YO's reported frustration with lack of privacy for personal phone calls and getting cut off through shortage of funds.

- Prisoners were happier if able to maintain good relationships, and felt this could help them not to re-offend (YOI, closed prison).

Mental health

- At the women's prison more one-to-one therapy or talking therapy (e.g. through peer support) was wanted rather than drug therapy.
- The mental health team was thought to overreact at the women's prison.
- At the closed prison, relaxation activities such as yoga were valued but limited in their capacity.
- Discouraging staff attitudes caused stress in all prisons.
- There was often a sense of disempowerment in the focus groups.

Substance misuse

- There was said to be limited access to help after initial screening (open prison and YOI).
- There were allegations of prison staff bringing alcohol into a women's prison.
- YOI staff participated in stigmatising behaviour in regard to drug misuse, thus deterring YOs from seeking help from them.
- More acceptance of drug misuse in closed conditions was thought to be the case by YOs.
- Methadone was alleged to be easier to access for pain relief than other painkillers or nicotine replacement therapy in the closed prison.

Blood-borne viruses

- Testing for BBV was carried out on educational days, but these were said to be not very well attended (closed prison).
- One prisoner in closed conditions who was on interferon treatment for hepatitis C said the amount of extra food provided was not enough to counteract the low energy levels resulting from the treatment.

Maintaining healthy behaviour outside prison

- The issues in maintaining physical activity levels on release were twofold for gym users, firstly gyms were free in prison but had to be paid for outside (e.g. YOI), secondly there were other distractions from social networks outside (open and closed prisons).
- Adult male prisoners suggested exercise on prescription.
- A staged approach to release with a home visit arrangement was viewed positively by a YO.
- Women stated that keeping to the home household routine helped motivate them to stay healthy.

Prisoner involvement in prisons

We would like to highlight that prisoners were generally enthusiastic about some form of involvement in health promotion planning and implementation in their own prisons.

- There was a general view that it was important to identify an individual prisoner as a focus for prisoner representation on health promotion issues.
- It was suggested that the representation should be at block or hall level.
- Questionnaire surveys were not thought suitable (some literacy issues).
- Prisoners had issues with validity of prison-run focus groups.
- Prisoner-run prisoner focus groups were wanted.
- Trusted long-term prisoners were thought best for that role.
- At the closed prison a desire for topic-based forums, for example on food, was expressed.

Prisoner health trainers

It is also important to highlight that the idea of prisoner health trainers emerged spontaneously in some of the focus groups and received clear support from all.

- There was a positive response from prisoners and YOs to the idea of prisoner health trainers.
- Women prisoners suggested the trainers should be matched to those trained by age.
- Longer term prisoners were suggested for the role to make giving the training worthwhile (women prisoners).
- Prisoner health trainers were thought to have a possible role in induction (women prisoners).
- YOs saw the role as training on how to live independently.
- Peer health trainers were thought to be more likely to be listened to than a member of the prison staff.
- Peer health trainers were seen also as a job opportunity.
- YOs felt less confident about substance misuse as an area for peer health trainers.

Change agents

Prisoners were asked who or what in the prison would influence them to change to more healthy behaviour.

- An important theme was that individuals had to want to change, (forced change would not be maintained), so 'yourself' was generally the first answer.
- For YOs, celebrity role models were seen as influencing prisoners to want to change to a healthier lifestyle.
- Ex-prisoners who had made a success of their lives after release were also seen as potential influencers by YOs.
- Children were generally an important motivator for prisoners to be healthy to be able to participate in activities with them after release.
- Prison officers, and people in general, were seen as not caring about prisoners' health, (open prison and women's prison). A caring and mentally healthy relationship was needed to influence prisoners for the better.
- There were rare exceptions to the above – personal officers who carried out sentence planning might be influential, but increases in the number of prisoners per officer (to eight) made it less easy to have a personal relationship (closed prison).
- Prisoners with a role as 'Listeners' were seen as having a use, but not seen as change agents, as not suitable for confidences.
- Work programme trainers and physical training instructors had some limited influence.
- Some doctors were criticised, but other healthcare professions had made an impact on awareness at least, for example a dietician and hygienist at the women's prison.

- Women stated some health promoting facilities were out of use. This was the case elsewhere too, and that was a disincentive to change.
- Although there was concern at lack of outreach by the chaplaincy at one prison, the restorative justice approach had been very effective for one prisoner at the closed prison.

Change points

- A change point for a man was starting to use the gym in prison; for a woman it had been pregnancy that encouraged her to eat more healthily.
- Awareness that some prisoners received special diets for conditions such as celiac disease triggered interest in their own diet among women.
- People with diabetes in some cases did not receive the full diabetic pack they were entitled to, and resorted to carrying sugary food in case their blood sugar fell.
- Seeing your life suddenly from a new perspective was characteristic of a change point, one example was at the start of a second sentence, another was seeing a video of yourself – bereavement might be another.
- Prisoners felt staff needed to be alert to and make the most of these opportunities.
- There was a general view from the open and closed groups that prisoners were healthier in prison than they had been outside.
- However, that was felt in at least some cases to be more due to coercion than wanting to be healthier (lack of funds for tobacco, alcohol ban in prison).

Annex F – Stakeholder questionnaire results

Stakeholder questionnaire themes

The questionnaire was sent out in February 2011 to a variety of stakeholders including prison staff (healthcare and disciplinary), NHS Board health improvement staff, relevant non-governmental organisations and to the Scottish Government. The themes detailed below emerged from the collation of the 26 responses to the Stakeholder Questionnaire (19 questions).

Current health promotion activities in your prison

1) What do you understand health promotion to be?

- Affected by the determinants of health
- Must include a holistic approach, i.e. taking into account prison environment, ethos, systems, policies, education
- Entails empowerment, control and responsibility
- Focuses on healthy lifestyles and needs-led information giving
- Also involves staff with Healthy Working Lives participation

2) What prison health promotion activities are you aware of – where are they happening and who is leading them?

- Some specialist responses, e.g. regarding nutrition, dental health
- Other responses are prison-specific
- Address health promotion for prisoners and for staff
- Healthy Working Lives including staff health promotion group
- In general, provision of health promotion is complex, varied and there are many local initiatives which are unique to particular prisons

3) In your opinion, how well do current prison health promotion activities achieve the goals of health promotion?

- There is variability of events but many are perceived as enjoyable individual activities/events
- Issues regarding sustainability of health promotion initiatives over time once the initial event is over
- General 'feeling' that health promotion is helpful and fills a need but no clear proof since limited evaluation and difficult to assess achievements
- Incomplete achievement: try to lessen harm but within constraints of safe custody and security resources
- Issues regarding empowerment within a prison environment
- Healthy Working Lives – useful framework

4) Please give examples of any areas of good practice in prison health promotion. Please explain why you consider that this practice is working.

- Some specific examples of good practice
 - HMP Barlinnie: Operating two health promotion groups – one for prisoners and one for staff. Some activities are done separately but others are done jointly. Groups comprise representatives from health, discipline, physical education, social work, education etc.
 - HMP Perth and Open Estate: NHS Tayside provides a Keep Well nurse, based within Criminal Justice Service, who follows up on prisoners on release and provides throughcare. Also, Community Integration work is done by Mental Health Services within the Open Estate to promote life skills development in preparation for release.
- Recognition of the need for incentives.
- ‘Success’ – thought to specifically include managing to get non-healthcare staff involved, e.g. joint physical activity initiatives at HMP Dumfries.
- Individual events are usually well-organised and enjoyable.

5) Please give examples of prison health promotion practice that you consider does NOT work and explain why you think that it doesn't work.

- Compulsory attendance
- Leaflets/posters without a supporting workshop – highlights literacy issues as well as motivation
- ‘Hotch potch’ (uncoordinated) giving of health promotion information can be misleading
- Smoking cessation having insufficient resources
- For YO's – health promotion that is not tailored to their needs, e.g. smoking cessation/short sentences
- One-off awareness sessions
- Not engaging wider workforce
- Not having enough ‘fun’ in events and considering ‘what’s in it for me?’
- Single health topic approach requires multiple access to prisoners to cover all topics, therefore consider a ‘lifestyle’ approach that covers it all in one go
- Budget (e.g. cash) and resources (including SPS operational staff support) for events is not always available

6) Where do you consider that there are gaps in current prison health promotion practice? For example, are any particular population groups or health areas missed or under-served?

Specific groups

- Young – under 21s
- Women
- Older prisoners
- Remand prisoners
- BME
- Those with disability
- Those with literacy problems
- People with mental health problems

Health areas

- Mental health
- Diet – Vitamin D
- Family-based issues
- Parenting
- Linking spiritual care and health changes: ‘Changes to life’
- Bereavement

Methods

- Whole prison approach
- Spiritual
- Psychology

7) What anticipatory care¹⁹⁵/primary prevention activity takes place at health assessment?

- Keep Well
- Mental health suicide assessment/prevention
- General and broad health screening, e.g. immunisation/risk behaviours
- Substance misuse – particularly during withdrawal stage

The future of health promotion for Scottish prisoners

8) Healthcare staff, prison officers, prisoners, chaplains/prison ministers, social care staff all interact with prisoners. In your opinion, what opportunities do each of these staff groups have in promoting health in prisons?

- General consensus is that it is everyone’s business and that idea should be ‘owned’ throughout the organisation, ultimately leading to cultural change, e.g. in an environment that is respectful and challenges bullying. Each person has a role to play – determined by specific discipline.
- Prison staff are important: there should be a specific part of prison staff awareness and training, e.g. health promotion PDP (therefore need first line managers’ support). Staff are viewed as potential positive role models and for their role in positive relationships. There is a role for staff to get involved in brief intervention training.

9) In your opinion, how should health promotion be delivered to Scottish prisoners in both SPS and private prisons?

- ‘Every contact with a prisoner should be an opportunity to promote health and reduce inequalities’
- Prisoner involvement in choosing

¹⁹⁵ Initiatives characterised by a number of features including a focus on early detection of problems and engaging patients as co-producers of health. See http://www.healthscotland.com/uploads/documents/6037-Anticipatory_Care_Report_1.pdf

- Share best practice between prisons but base health promotion on the health needs of individual prisons
- It should be the responsibility of both prison management and healthcare, and integrated and embedded in prison environment, e.g. policies/training/roles of prison officers/job descriptions
- There should be a framework of themes and less single themes
- Same approach to SPS and private prisons
- In partnership between prison services and NHS
- Lifestyle approach including wider determinants of health
- Coordinated by prison staff but coincide with national and local events

10) In your experience how aware are staff groups of how social circumstances, e.g. housing relationships can impact on prisoners' health?

- Overall, understanding of wider determinants of health is probably limited: will depend on staff group – however, slightly more respondents believed that there was a good understanding
- Differences in whether staff are looking at determinants affecting time while in prison or looking beyond them to factors affecting health on release
- Many staff feel unable to influence determinants of health therefore ignore them. This may be partially driven by belief that pressure from family and peer bonds may be more influential than health/social interventions
- Prison programmes are already quite joined up in provision of programmes addressing topics from relationships/employment/financial issues etc

11) In your experience, in the Scottish prison setting, what health promotion is most effective to:

a) Reduce smoking

- Smoking cessation groups – but difficult to access (capacity issues)
- Understanding context of prisoners quitting smoking, e.g. limited 'freedoms', currency of tobacco, mental health problems
- Ban smoking
- Tailored approach – a few need 1:1
- For staff: robust smoking policies + 1:1 support on site

b) Alcohol

- Alcohol awareness sessions + 1:1 support
- Antabuse pre-liberation/home leave
- Alcoholics Anonymous
- Alcohol brief intervention

- But: limited general alcohol health promotion activity or evaluation of effectiveness of other interventions

c) Illicit drugs

- No specific health promotion activity by health care but SPS 'programmes' do a 'Drug Awareness' module
- Success depends on length of sentence
- Focus is on treatment but therefore affects a smaller proportion of those that need
- Take home Naloxone
- Reducing supply with improved security

d) Physical activity

- Popular with the motivated already; the challenge is how to motivate the sedentary
- PTIs do good work but sustaining efforts in all but a highly motivated few is hard
- Need to tailor activities to needs of: women/older people/ those with mental health problems
- Gym is vulnerable to staff shortages
- Important to link physical activity to wellbeing (e.g. mental wellbeing/weight management)
- Should be fun
- Choice of activities should help with tailoring to individual needs
- Among staff: cycle to work scheme
- Importance of tailoring general population's literature, e.g. not appropriate to advise prisoners to walk rather than take a bus to work!

e) Healthy eating

- Impact of prison regime, e.g. on timing of meals
- Menu choices – need to clearly mark the healthy choices
- Teaching skills, e.g. cooking/budgeting household finances
- Practical solutions e.g. access to fridges in halls for healthier (often perishable) snacks/milk, e.g. offering 'tastings' of need items on menu
- Quality of food is perceived as very poor
- Access to buying healthy snacks is limited – need healthy vending
- Portion control

- Catering management: menu planning/budgetary constraints/leadership
 - Nutritional guidelines are available
 - Attainment of Healthy Living Award
- f) Dental hygiene
- Dental health promotion is welcomed by prisoners but variable provision
 - Dental packs are needed and used, e.g. brushes and good quality toothpaste
 - High demand for dental services outstrips supply
 - Variable provision of oral health care (and promotion)
 - Need to link with prisoner-bought snacks – particularly to drinks
- g) Sexual health
- Generally good provision of awareness/information
 - Generally good access to condoms/lubrication/dental dams – but some variability due to individual staff attitudes to sex in different prisons
 - Need to focus on condom provision on liberation/home leave
 - Potential to work with prisoner partners
 - 1:1 intervention was considered most effective after self-referral
- h) BBV
- Harm reduction for some issues, e.g. Hepatitis A and B vaccination is offered on admission
 - Opportunistic screening is available but long waiting lists
 - There is a need for staff training
 - 1:1 intervention with known users
 - Opiate substitution therapy
 - Harm reduction, e.g. paraphernalia swaps, foil-wrapped confectionery, 'in house' tattoo parlours
- i) Mental health
- Main focus is on suicide prevention, drug addiction and anger management (part of Offender Management Programme) and treatment of mental illness but less on general mental health wellbeing and promotion
 - A few programmes exist, e.g. 'Healthy Reading' programme (Pilot at HMP Shotts)

- Staff training required for recognising issues
- Mental Health First Aid course recommended – rolled out variably, e.g. nursing staff, then chaplains and occasionally to prisoner listeners
- Call for better environmental conditions
- Intervention sessions by social work staff, family liaison staff and prison staff
- Specific projects focusing on, e.g. relationships/sexual health/parenting/women and youngsters/relaxation/theatre/community art

j) Parenting

- Courses available variably across estate, e.g. mellow parenting/life skills course/Book at Bedtime programme (Cornton Vale and Shotts)
- Needs partnership with families and family contact time
- Not aware of health links between parenting and health promotion
- Projects – relationships and sexual health

12) Please rank 8 a–j in order of priority of need. Please state the reasons for your ranking of the top three:

- 1) Mental health underpins all (tackling low level mental health issues are a key component of illicit drugs and alcohol abuse – cannot address one without the other)
- 2) Alcohol: significant factor as a cause of crime especially in YO's as it enters them into a lifetime of poor choices
- 3) Smoking cessation: underpins good physical health
- 4) Diet/healthy eating
- 5) Drugs
- 6) Parenting – breaks the cycle of poor health

13) Are there other areas of health promotion that should be covered in prisons?

- Always a balance between reducing risk and tailoring health promotion to needs but also needing to challenge behaviour completely to change offending lifestyle
- Well man, e.g. testicular self-examination
- Health literacy/general literacy
- Life skills
- Whole systems approach
- Relationships and families
- Drugs – needle exchange
- Promoting health benefits of work

- Alcohol awareness – make it mandatory and delivered through Link Centre (i.e. take it out of programmes/interventions team)

14) What do you think are the challenges for delivering a 'healthy prison' approach at present in Scotland?

- Needs to become 'must do' not 'nice to do': needs clearer targets/performance measures and clear lines of accountability
- Resources
- Staff prioritisation
- Support from governors: link with reduced re-offending/priorities of staff
- Liaising with the community from which prisoners come and return
- Public opinion – engrained cultural beliefs, e.g. being Scottish/attitudes to crime and punishment
- Building SPS: NHS relationships
- Embedding it into and underpinning everything prisoner services do
- Understand that the environment and application of certain policies and procedure ('how we do things') can impede the understanding of health promotion messages and buy in to health

15) Do you have any other comments about issues that are important to consider when re-writing this prison health promotion strategy?

- Focus on 'win-win' to enhance COCO (custody-order-care-opportunity) and staff health and wellbeing
- Prisoner involvement is key
- Being holistic
- Emphasise outcomes
- Multi-, including staff development, e.g. PDPs – but lead by governors in-charge
- Include international evidence and best practice
- Develop a core of expertise as a 'dedicated resource'
- Demonstrate value for money
- Short-term targets, e.g. canteen pricing, target day for no smoking
- Communication strategy for staff and prisoners
- Not a task-oriented tick box exercise but clear aims/objectives and ethos (interpretation should be tailored to individual needs of prisons/prisoner groups)

16) Where are the health needs of prisoners recorded?

- PR2 system
- Healthcare records
- ICM (Integrated case management)

17) Has there been an audit of all systems with prisoner information in the past two years – what were the findings relevant to health promotion?

- Prisoner surveys/complaints/visiting committee reports/inspection
- Little audit going on therefore it is not being used to assess and inform health promotion at the population level
- Not enough HP activity occurs

18) How do local prison health promotion groups identify which areas of health promotion to take forward as part of their health promoting prison action plans?

- Very variable approach
- NHS Calendar of health promotion events
- Ask prisoners
- Health promotion committee
- Advice from NHS health promotion group
- Tend to repeat previously successful events

19) What health promotion support to continuing healthy behaviour is there to prisoners on their transfer or liberation?

- Throughcare, e.g. SACRO
- Generally little/none
- Pre-release course for long-termers in the Open Estate

Annex G – Comments from stakeholder event

These are the findings from the round-table discussions carried out with stakeholders at a stakeholder event held on 29 March 2011. This was part of the consultation. The aim has not been to challenge comments but to report the views of the event participants.

<p>Questions</p>	<p>Workshop 1</p> <p>Who contributes to prisoner health improvement?</p> <p>What does each party contribute to prisoner health improvement?</p> <p>What are the cultural differences between key parties?</p> <p>What are the cultural challenges and opportunities?</p> <p>What factors do we need to consider in order to determine health improvement outcomes?</p> <p>What health improvement outcomes should we seek and why? Of these, who should be responsible for each outcome?</p> <p>Which health improvement outcomes can we currently measure?</p>	<p>Workshop 2</p> <p>What is your general opinion of the ‘5 Pillars’ concept?</p> <p>Which pillar(s) would you find easiest to implement first and why?</p> <p>Are there other elements that should be considered? e.g. As another/replacement ‘pillar’?</p> <p>Who are the key parties who should be involved in the framework’s delivery?</p> <p>What should/could each party contribute to achieve each of the elements of the ‘5 pillars’?</p> <p>To what extent should every prison deliver towards the framework? Is there a case for a graduated approach, e.g. bronze, silver and gold achievements? What should each stage look like?</p>
<p>Table 1</p>	<p>Who contributes to prisoner health improvement? Everybody, really.</p> <ul style="list-style-type: none"> • Policy – government, prison and NHS Board HQs. • Strategy health promotion specialists, public health. • Planning – multi-disciplinary health promotion team with some of the above, health service managers, governor, heads of relevant services in prison. • Staff – be inclusive, including chaplaincy for instance. • Prisoners – example of Listeners. • Don’t forget NHS in-reach – the example of blood borne viruses. <p>What does each party contribute to prisoner health improvement? Each stakeholder has at least one role – for instance prisoners have an effect on their own health, those of their peers, those of the wider prison, then families and communities when they get out.</p>	<ul style="list-style-type: none"> • Another pillar – culture, a culture of everyone’s business. • Key partners – service users, healthcare professionals, prison professionals, peer support, government. • Regime – consistency, fairness, structure, certainty, health, controls, consent. • Leadership is more than government and Governor. Champions are leaders. • Regime and leadership are core. • 5 pillars are a good starting point. • Framework – work to outcomes, common purpose and values

	<ul style="list-style-type: none"> • Points on the importance of the environment, and a structured regime. • Comments on government making signalling policy, and making it easy to achieve in prisons. <p>What are the cultural differences – many. Government department and policy priorities.</p> <ul style="list-style-type: none"> • Competing priorities and restrictive resources. • Culture of organisations. • Levels of understanding about health and its creation. • Remedies – a need for mutual respect, understanding each other’s cultures. • Integrated, partnership planning and delivery. • Talking the right language – prison may be a justice function but health may wish to hear about high-risk lifestyles rather than offenders or prisoners in order to get the message across and the job done. <p>Factors – health improvement outcomes.</p> <ul style="list-style-type: none"> • Don’t stop measuring things even if it’s bad news. • Define sub-populations so that outcomes are appropriate for them – e.g. youngsters, long-term prisoners – alcohol drugs and smoking. • Recognise complexity – smoking may become lower in a hierarchy of addictions to drugs and alcohol. • Hierarchy of needs (MASLOW) – if you don’t have a home, then some of the health issues don’t really matter so much. • We need a basket of outcomes but focus on some – for guidance according to policy, but also for local selection according to need. <p>Outcomes to seek and why – who should be responsible – joint governance, responsibility to derive outcomes from a variety of sources.</p> <ul style="list-style-type: none"> • Limitations with the prisoner survey – perception in large measure. • Management information is important – actual provision or consumption – for instance, example of food, catering. 	
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	<ul style="list-style-type: none"> • Need to market what is good about services before perceptions become over-important. • Targets should be locally appropriate, according to the population. • We should measure the same in prisons as the NHS outside. • What is a good service? – depends on who you ask – example of the prisoners’ perception – a good health service gives you sleeping tablets on request. Throughcare and its potential – the difficulties of measuring it, the need for unified data standards – like with like, prison and outside. <p>Current measurement?</p> <ul style="list-style-type: none"> • We need priorities for data collection, to come to terms with what we have. • Also we need to know more about groups we don’t know enough about – for instance brain injury, learning disability. 	
<p>Table 2</p>	<p>Who?</p> <ul style="list-style-type: none"> • Prisoners • SPS staff – catering, PE instructors, chaplaincy, family contact officer, healthcare/nursing, prison listeners, visiting committee, managers • Voluntary groups – counsellors, arts projects and therapists, pet care, hobby groups, dance and drama • NHS staff – health promotion specialists, Keep Well team, sexual health, health visitors and midwives, dieticians, oral health, BBV, mental health, substance misuse <p>What?</p> <ul style="list-style-type: none"> • SPS – diet, nutrition, healthcare, physical fitness, environment, policy development – local and national implementation, health promotion strategy and structure and events, parenting and family support, rehabilitation, harm reduction. • Other agencies – Phoenix, education, Caledonian. • Voluntary groups – additional specialist support and activities, e.g. football, arts. Visiting committee – monitoring and advocacy. Counselling – mental wellbeing. • NHS – Topic specialist support, funding and resources, strategic support, connecting with Throughcare, delivering specific initiatives, public health advice. 	<p>5 pillars and general opinion</p> <ul style="list-style-type: none"> • Leadership – SPS heavy, a bit to simplistic. • Regime – needs expanding, to restricted – broaden. • Environment and structural change – where do resources come from/to? – expand, make more flexible. • Individual Prevention Plans – yes, need to emphasise individual ‘whole prisoner’ approach rather than prescriptive system. • Leadership (or is it partnership?)/regime – integrate health promotion for staff prisoners, work together. Foster relationships trust and responsibility and wellbeing. • Education and peer support and prisoner involvement – e.g. BHF kit. • Practical small steps in partnership, need incentive and engagement? • Individual prevention plans and regime – needs to tie in with broader agenda, e.g. tackling poverty, social exclusion, self esteem, family, employment education. • Do we need another pillar – broader ... social environment, external. • Need to disentangle/define health promotion/health improvement <p>Key parties and contributions</p> <p>We feel we discussed this aim, but maybe needs work on a higher level strategic coordination at national level between key agencies agreement and</p>

<p>Challenges</p> <ul style="list-style-type: none"> • Custody and order/discipline vs. care/prevention and promotion • Security vs. intervention and therapy • Information sharing • Prisoners ‘manipulating’ different staff • Boundaries – which staff responsible for what? • (Job roles) – (SILOS) • Restrictions/risk assessment and ‘aversion’ • Conflicting priorities, e.g. food – costs • Staff attitudes/cynicism • Here and now vs. broader long term <p>Opportunities</p> <ul style="list-style-type: none"> • Structure • Reflection • Long-term behaviour • Different perspectives and expertise • Comprehensive integrated approach • Innovation and new approaches <p>Other factors</p> <ul style="list-style-type: none"> • Practicalities – e.g. length of sentence • Realistic • Needs specific population, e.g. old/young/male/female • Need for security and discipline • Financial constraints • Continuity of treatment and intervention <p>Outcomes</p> <ul style="list-style-type: none"> • Cardiovascular health • Sexual health/unwanted pregnancies • Should be same as general population • Integrated – hard to capture • Mental health • Alcohol and drugs <p>Measures</p> <p>Current –</p> <ul style="list-style-type: none"> • Drugs: measures – referral stats to additions/phoenix, Intel, i.e. drugs found on halls, prisoners engaged on detox/methadone programmes, prisoners engaged in naloxone training. • Diabetes: when last seen specialist/nurse for diabetes, blood results, chiropodist, diabetic retinopathy, *access to own insulin and needles* • Mental health: referral statistics, diagnoses, medications, number acutely unwell/sectioned, officers engaged in 	<p>consistency census, regarding budgets, roles, responsibilities and contracts.</p> <p>Which pillar first?</p> <p>Graduated approach?</p> <p>Every prison?</p> <ul style="list-style-type: none"> • Agencies may have different views so leadership important – Who? • Ownership? Complex? Do we need a – specific HIA tool for a prison policy to embed and build in? Buy in at all levels. • Health champions could be good at first step. • Individual plans? Quick win as already? Partially in place but needs development – needs more work to tie different elements together and more holistic approach, improve communication and info sharing, electronic record – GPs. • Allow time for transition. • Agree need standards and targets – share learning. Graduated approach useful – incentive and motivation. • Organisations will have different approach but need some shared milestones/clear objectives – who assesses this? <p>3 Key Points</p> <ul style="list-style-type: none"> • Huge range of services and cultures, provides constraints (political and cultural) but also opportunities (long-term holistic outcomes and innovation) • Outcomes should be the same as general population – but need to come up with broader ‘softer’ outcomes integrated across services – creative qualitative measures. • 5 pillars – do we need another regarding wider external social environment • Is it leadership or partnership (both locally and nationally between agencies and prisoners/staff). • Consistent standards and milestones with clear objectives and ownership – but allowing some flexibility.
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	<p>training in mental health first aid, positive mental health.</p> <ul style="list-style-type: none"> • Smoking cessation • Nutrition/catering • HEAT targets • Referrals • Violence reduction • Attendance at clinics and programmes <p>Future</p> <ul style="list-style-type: none"> • Broader and softer outcomes, e.g. wellbeing, long-term integration • Info exchange • Shared outcomes – inside ↔outside 	
<p>Table 3</p>	<p>Who?</p> <ul style="list-style-type: none"> • The prisoner • Everyone in the establishment and wider society • Governors and all staff below • Not one size fits all • Build it into what already exists • Partnerships <p>What?</p> <ul style="list-style-type: none"> • SPS role – to assess where we are (prisoner assessment) • For short term health promotion lead a basic management plan • Throughcare health learning capacity <p>Factors in Health Promotion Outcomes</p> <ul style="list-style-type: none"> • Include in offender outcomes • Need a holistic approach • Whole person <p>What Health Improvement outcomes</p> <ul style="list-style-type: none"> • 2002 document is holistic – but no outcomes there • Measurable, e.g. Alcohol, BI, got a GP • Voluntary sector for assessment after release <p>Prioritise who for intervention, e.g. gym. Mental/social benefits of gym. Own prisoner health portfolio.</p> <p>Engagement of prisoners and prison officers. Attend CPD on health improvement. Job descriptions – reframing vs. adding more work.</p>	<p>Opinions of the five pillars</p> <p>There are no links to outside world. The prison appears to be a closed system, should be an open system.</p> <p>Health topics – should not be in silos.</p> <p>A framework should not mention individual disease.</p> <p>Within the health champions pillar there should be two triangles one upside down, to put prisoners at the top.</p> <p>Needs to be emphasised that prison officers will need a lot of support and training for their relationships to prisoners to promote health, if that is to become one of their responsibilities.</p> <p>There is a time constraint on earning trust. Personal officers should have no more than a family-sized group of prisoners.</p> <p>There was some discussion about whether there was a need to separate environment and regime, or if shown separately also to show links as they were interdependent – e.g. you could not have the more relaxed regime (timetable and what prisoners are offered but need not accept) that exists now in an environment as it was 20 years ago with very basic cells, kept locked nearly all day. The regime was thought to include things like the role of tobacco as currency in prison.</p> <p>There was a question about whether this was a logic model and if it was, there should be connecting arrows.</p>

	<p>Measurement</p> <ul style="list-style-type: none"> • Reoffending • Employment/training • Smoking cessation • Oral Health – 1st appt after release • HEPC • Self-awareness <p>Access to programmes</p> <ul style="list-style-type: none"> • Who will coordinate and manage • Health outcomes/health improvement outcomes 	<p>There was a suggestion to add on a new pillar for Throughcare and linkups with community organisations. Also needed to be a continuous link with the NHS outside.</p> <p>The pillars did not address the housing issue.</p> <p>The pillars did not address capturing learning.</p> <p>Key groups in delivery</p> <p>Voluntary/community sectors, SPS, POs NHS, community partnerships, the Police – e.g in moderating their responses to ex-offender minor crime. Groups were thought best not formalised too much, but one felt still useful to have targets.</p> <p>Key groups contributions</p> <p>Each role could contribute to each pillar.</p> <p>Extent that each prison should deliver the strategy</p> <p>All should help to coordinate, direct involvement depending on local circumstances. Need to find the right language to discuss the common ground.</p> <p>Have a behavioural programme in prisons.</p> <p>Base targets on wealthier, smarter, healthier and greener. The smart goal could be at two levels both for overall establishments and for each prison.</p>
<p>Table 4</p>	<ul style="list-style-type: none"> • Monitor and share practice – quality and service improvement. • Moving from topic specific to improving health and wellbeing. • Evaluation of prisoner journey (distance travelled). • Monitoring → Evaluation → Policy driver • Understanding of health promotion. • Robust communications plan. • Changing cultural attitudes from improving belonging to health! • Everyone’s responsibility Community → Prison → Community. • Focus on assets of prisoners. • Promoting health and wellbeing and part of core role. • Using the core screening to measure prisoner journey and incorporate health improvement. 	<ul style="list-style-type: none"> • Governors KPI (in order to be implemented). • Implementation of pillars in existing resources. • Health champions pillar and individual disease prevention (to be underneath). • Include throughcare. • Collating best practice. • Offender outcomes to focus on social and emotional areas. • No award scheme (core business). • SPS strategies (existing) encompass framework. • Health promotion from WHO guidance. • Presentation to governors on how this contributes to health improvement. • Doesn’t it capture whole prison approach?

	<ul style="list-style-type: none"> • Ensure it does not turn out to be health education messages, • Business monthly review discussing health promotion. 	
<p>Table 5</p>	<ul style="list-style-type: none"> • Who is responsible to deliver – staff and self-support. • Health improvement – capacity approach vs. asset-based approach. • Ensuring we do what we say we are doing – performance management. • Internal (SPS/NHS) disjunctions may be amplified by the transition. • Role of NHS Health improvement Strategy in prison health care. • Recognition of ‘communities’ needed within prison community and movement within them. • Prisoner lead outcomes and harm reduction. • Throughcare – community → custody → community. • Mental Health and LD(?) – Where to place in priority list. • See health Improvement and harm reduction as equally important. • Consent to seeking change. • Culturally neither organisation is ‘good’ at change. • Need to be organisationally mature to have ongoing SPS/NHS dialogue. • Do we improve prisoners outcomes or the organisation outcomes for health. • How do we help people to want to change? Especially for the short term. • How to engage with people who need life circumstances dealt with. • How do we build on approaches to self-determination. • Impact of – social and educational circumstances. • Work on behaviour change is labour intensive. • Who is going to do the face to face with chaotic people with multiple needs. • Can we avoid creating new boundaries within the system? • Role of ‘health’ in throughcare and CJA role. • Is there a role for visiting committees in general, complaints in NHS 	<ol style="list-style-type: none"> 1. What is your general opinion of the ‘5 Pillars’ concept? <ul style="list-style-type: none"> • Inspiring hope should be ultimate aim • Triangle should be inverted • Approach should be dynamic • Outcomes approach may not work with prisoners and the approach should be prisoner centred • Early assessment is important but timing is critical as is prioritisation (pillar 5) • Need a holistic (like GIRFEC) approach to health improvement 2. Which pillar(s) would you find easiest to implement and why? <ul style="list-style-type: none"> • Leadership (pillar 1) but involving prisoners • Elements of pillar 5 may be the <u>easiest</u> but not the best to tackle first • Aim for maximum concurrent activity 3. Are there other elements that should be considered/ e.g. as another/ replacement pillar <ul style="list-style-type: none"> • Partnership • Integrated care • Has to be needs led • Listen to prisoners 4. Who are the key parties who should be involved in the framework’s delivery <ul style="list-style-type: none"> • Prisoners, voluntary sector, SPS, CJAs, NHS, families, HMIP, visiting committees, Scottish Government • Important to distinguish between policy/strategy, delivery and assurance roles 5. What should/could each party contribute to achieve each of the elements of the ‘5 pillars’

<p>Environmental</p> <p>↓</p> <p>Individual</p> <p>↑ ↙</p> <p>Engineered Encouraged</p>		Policy Development/ Strategic	Delivery	Assurance
	Prisoners	✓		
	Voluntary Sector	✓	✓	
	NHS	✓	✓	✓
	SPS	✓	✓	✓
	LAs	?	✓	
	SOA/CPP	✓		
	Families	✓	✓	
	Friends		✓	
	HMIP			✓
	SG	✓		✓
	VCs			✓
	Audit Scotland			✓
	Mental Health Teams	✓		
	Private Sector		✓	✓
FE Sector		✓		
<p>6. To what extent should every prison deliver towards the framework? Is there a case for a graduated approach? What should each stage look like?</p> <ul style="list-style-type: none"> • Adopt an incremental approach • Identify some early wins 				
Table 6	<ul style="list-style-type: none"> • Influences prisoners to change • Children • Brief interventions • Influenced by those with whom they have a positive relationship • Personal officer role – training to provide brief intervention 	<p>Performance</p> <ul style="list-style-type: none"> • Who provides? • How to engage? • How do you measure? <p>Life improving rather than health improving</p>		

	<ul style="list-style-type: none"> • Solution-focused approach • Families • 'Healthy' staff role models • Not health improvement outcomes – life improvement outcomes • Nine offender outcomes • Collect data to see where we are – <ol style="list-style-type: none"> 1. Measuring current health improvement outcomes 2. Drug services 3. Criminal Justice 4. Improved IT systems 5. Utilising PR2 6. Improved data recording 7. Integrated case management 8. HEAT targets 9. Mapping of national data 	<ul style="list-style-type: none"> • Can see what is already happening in the framework. • Must avoid creation of new organisational boundaries within the framework. • Life improvement by 'stealth'. • Responsibility for achieving standard is <u>shared</u> SPS/NHS (and performance tested). <p>Implementing 'pillars'</p> <ul style="list-style-type: none"> • Elements already in place in many locations.... • Ensuring consistency – shared • All will be hard in own area. • Pillars → OK as long as the individual is at the heart of things. • Where does the behavioural change issue sit within the pillars? • Where is the role/accounted need/bit about integration? • Need to integrate health delivery into prison regime (& vice versa). • Declare prisons 'smoke-free' environments. <p>Are we delivering?</p> <ul style="list-style-type: none"> • Must have a consistent standard against which to assess.
<p>Table 7</p>	<ul style="list-style-type: none"> • Not sure about peer support! Often the 'educators' do better than the 'educatees'. • All new Prison Officers should be trained in HP/HI. • Strategic Approach. • Objectives/PDPs. • Outcomes must be aspirational. • Integration and thru put. • Partnership in commitment. • Parenting. • Change management offers opportunities. • Consistency across prisons. 	<ul style="list-style-type: none"> • Are the strategic goals aspirational enough? • Model – should it be a circle. • You have missed out 'prisoners' as an asset. • Like the idea of PDPs. • Coaching model should use a holistic approach rather than lifestyle specific. • Pillar – Mental health and wellbeing (to address issues such as abuse and social problems). • Key parties – prisoners, leaders, managers, HR, Gym Staff, 3rd sector – social care and CHPs • Pilot – expect to get volunteers but requires national evaluation. • Key partner – joined up national work/shared practice, join up Keep Well and other national programme. • Award Scheme set in SLAs (with service improvement targets, use existing PM frameworks – no to B,S,G), recognition of stakes. • Leaders – Anyone could be a leader/is this an ethos?

ⁱ Scottish Health Survey 2010.

ⁱⁱ Scottish Household Survey 2011.

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