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Editorial Comment

As has been discussed many times in this journal, the purpose of imprisonment is contested and controversial. Is it there to punish, rehabilitate, incapacitate or control? How are those competing ideas to be interpreted, applied and balanced by practitioners? What are the consequences of failing to maintain an appropriate balance? Such questions encompass some of the fundamental social and practical issues that prison staff manage on a daily basis.

This edition of *Prison Service Journal* takes up the idea of a 'healthy' prison. On the face of it, this may seem straightforward, the idea that there is equivalence between health services available inside and outside prisons. However, the articles in this edition highlight that in practice the challenges are much broader, deeper and more complex.

The Inspectorate of Prisons use the term 'healthy prison' to describe what they expect of prisons. This falls under four main areas: safety (prisoners, even the most vulnerable, are held safely); respect (prisoners are treated with respect for their human dignity); purposeful activity (prisoners are able, and expected, to engage in activity that is likely to benefit them); resettlement (prisoners are prepared for release into the community, and helped to reduce the likelihood of reoffending). From this perspective, 'healthy' does not have a medical connotation but instead means that this is a test as to whether a prison is operating in a sound manner. This is a process of public accountability.

The first article in this edition is from Professor Alison Liebling who offers a digested overview of the Measuring the Quality of Prison Life (MQPL) assessment. This is carried out in all prisons over a two year cycle and is one of the ways in which prisons are measured and assessed. This is an attempt to understand the nature and effects of imprisonment from the ground up by engaging prisoners directly in understanding and evaluating prison life. The idea here of a healthy prison is one that pays appropriate attention to the 'social, relational and moral climate'. From this perspective, the healthiness of a prison is the subject of sociological exploration.

Two articles explore the idea of a healthy or health promoting prison from a clinical professional perspective. Interestingly, they do not suggest a solely medical model, focusing on a narrow range of public health concerns, but instead locate health within a broader socio-economic perspective. Their arguments raise important questions about who prisons hold, for what purpose, the effects of this and what should be done on an organisational and wider political level to respond to this. These articles not only pose challenging questions, but also provide some practical guidance on how prisons can ameliorate some of the effects. From the perspective of these contributors, the problem of the healthy prison is a socio-medical one.

This broader view of medicine and health is taken up in three subsequent articles which explore specific issues. The first is an article by James Ward, Di Bailey and Sian Boyd, which considers the use of participatory action research. This is an approach that engages service users and those with direct experience and focuses on creating and sustaining change. They discuss a project at Low Newton, a women's prison in the North East of England, in which prisoners were involved in developing and delivering an awareness session for staff regarding self-harm. This is a fascinating project which shows a bold approach to addressing a chronic problem in women's prison, but one that is sensitive to the issues of domination and subjugation, and the importance of the affective and emotional qualities of prison life. Paula McAdam, a nurse at HMP Liverpool, contributes an article discussing some of the challenges facing prisoners with autism. This she describes as an unexplored issue in prisons. She reveals the ways in which the prison experience may be more intense and painful for those who are on the autism spectrum and how increased awareness and sensitivity to the issues would be a valuable first step to improving services and reducing disadvantage. Finally, Jude Caie, a nurse at HMP Manchester, discusses some of the challenges faced by older prisoners, a rapidly growing group in prisons.

Together, these articles reveal that the idea of a 'healthy' prison is not simply a matter of medical treatment and a legalistic or managerial idea of equivalence or clinical service delivery. Instead, the articles in this edition suggest that the role of prison professionals is to adopt a wider and deeper perspective and incorporate this into their practice. The wider perspective is one that recognises the social causes and effects of both criminal justice and health. Sensitivity to ideas of power and inequality are not solely theoretical, but also raise questions about how services are designed and operated. The deeper perspective is one that sees health from an individual human perspective, treating people with respect for their individual dignity. Again, this is not an abstract moral argument but raises questions about interactions, roles and involvement.

The detailed micro-studies contained within this edition, focusing as they do on specific prison practices also work together to reveal the complex issues at the heart of prisons: what are prisons for, who do they hold and what are their effects? The articles in this edition also reveal how prison staff (and in some cases prisoners themselves), are involved in creatively exploring, interpreting and addressing these challenges in their daily practice.

What is 'MQPL'?

Solving puzzles about the prison

Professor Alison Liebling *is the Director of the Prison Research Centre at the Institute of Criminology, University of Cambridge.*

In empirical science everything depends on how fruitfully and faithfully thinking intertwines with the empirical world of study ... and since concepts are the gateway to that world, the effective functioning of concepts is a matter of decisive importance.[1]

Blumer argues that the role of 'the concept' in social science is to 'sensitise perception' — to change the perceptual world[2] so that we can describe and understand it more precisely. The prison quality or 'moral performance' survey developed by members of the Cambridge University Prisons Research Centre (known in the Service as MQPL) attempts to do just this: to provide a conceptual and methodological foundation for understanding prison life. It is always important in social science research to be self-critical and cautious about how well social scientific variables indicate the complex abstract categories they are designed to measure, and this developmental exercise is no exception. Neither the concepts nor the items in them are intended to be definitive. The projects underlying the development and use of the survey represent a series of attempts to reflect with some precision the social, relational and moral climate of a prison. This places us in a better position to solve analytic puzzles about the nature, quality, management and effects of prisons.

The 'MQPL' (Measuring the Quality of Prison Life) survey is a 'tick box questionnaire' for prisoners designed and refined over several research projects aimed at improving our understanding of prison life and its effects. Unlike many surveys used to measure prison quality, it has a highly standardised format (a characteristic of any good survey), but has been developed analytically and inductively from extensive, grounded explorations with staff and prisoners about what matters in prison[3]. It has an underlying conceptual framework incorporating notions of legitimacy, 'right relationships' and 'value balance'. More recently, the concepts of 'staff professionalism' and 'use of authority' have emerged as key components in this framework[4], confirming the centrality of the complex work of prison officers to the quality of life in prison. All attempts to measure prison quality tend to include at least the three broad dimensions critical to prison life of 'relationships', 'personal development' and 'order and organisation'; these dimensions are broadly related to humanitarian, rehabilitative, and custodial goals respectively[5].

The MQPL survey arose from social scientific rather than policy interests. Its original development was funded by a competitive Home Office *Innovative Research Challenge Award* granted to the author (with Charles Elliott and Helen Arnold) in 2000-2001, although prior to this, the exploration began as a result of a policy-level dispute about the appropriate measurement of a particular prison's (lack of) quality, into which the author was drawn[6]. Its origins are in 'research-for-knowledge', and its main goal is therefore accurate and authentic description, explanation, and conceptual clarity. Its cumulative or recursive development over a ten year period (2001-2011) to date means that empirical observations can be used to develop theories or conceptual categories relevant to prison life and experience, which can in turn lead to better observations.

The survey consists of a number of empirical-conceptual dimensions, such as 'respect', 'staff-prisoner relationships', 'humanity', 'fairness', 'staff professionalism', organisation and consistency', 'policing and security', 'personal development' and 'well-being', which reflect aspects of prison life that vary significantly, and that matter most to prisoners[7].

1. Blumer, H (1969) *Symbolic Interactionism: Perspective and Method*, N.J : Prentice-Hall p.143-4.
2. Ibid p.152.
3. Liebling, A; assisted by Arnold, H (2004) *Prisons and their Moral Performance: A Study of Values, Quality and Prison Life* Oxford: Clarendon Press.
4. See Liebling, A (2011) *Being a Criminologist: Investigation as a Lifestyle and Living* in M. Bosworth and C. Hoyle (eds) *What is Criminology?* London: Sage and Crewe, B, Liebling, A. and Hulley. S. (2011) *Staff culture, the use of authority, and prisoner outcomes in public and private prisons* in Australia and New Zealand Journal of Criminology.
5. See Liebling, A., Hulley, S. and Crewe, B. (2011), *Conceptualising and Measuring the Quality of Prison Life* in Gadd, D., Karstedt, S. and Messner, S. (eds.) *The Sage Handbook of Criminological Research Methods. London: Sage* p358-72, Moos, R H (1975) *Evaluating correctional and community settings* New York: Wiley, Saylor, W. G. (1984) *Surveying Prison Environments* Washington, DC: Federal Bureau of Prisons, Toch, H (1992) *Living in Prison* (Revised edition). Washington, DC: American Psychological Association, APA Books, Logan, C.H. (1992) `Well Kept: Comparing Quality of Confinement in Private and Public Prisons', *Journal of Criminal Law and Criminology*, 83(3): 577-613.
6. see further, Liebling, assisted by Arnold 2004: 141-4 see n.3.
7. For a detailed account of its recent development and current content, see Liebling et al (2011) see n.5.

This process of identification of relevant dimensions, and their translation into measurable items or statements, is never regarded as 'finished', so that as in science, the research on which the survey is based is:

> *A continuous enterprise in which advance is made by successive approximations to 'the truth' and by a never-ending series of small excursions into the unknown'*[8].

This social-scientific and conceptual commitment underlying its development is one of its most significant properties and may explain its perceived usefulness to senior practitioners (it was adopted for routine use by the Prison Service's Standards Audit Unit, now Audit and Corporate Assurance Unit, in 2004): It is often the case that exploratory, innovative, and curiosity-driven research is, in the end, of most value to policy and practice, precisely because it avoids the narrow limits set by 'working assumptions', and it follows leads originating in 'the real world' (this has also been true of other prison research projects conducted 'off the policy agenda'[9]). The commitment of this kind of research is to 'the phenomena and their nature'[10]. Its in-depth qualitative origins may also explain its 'face validity' (staff and prisoners 'recognise the results'); and its reasonable performance at an explanatory level (the results can be used statistically to explain variations in suicide rates, levels of well-being, experiences of personal development, and the risk of disorder).[11] Meaningful concepts, carefully operationalised from 'the ground up', are more likely to lead to meaningful output (mature quantitative data) than random theories of prison life and quality of interest mainly to policy-makers or less 'prison grounded' scholars. It is a coincidence, but also relevant to its formal adoption by the Prison Service (NOMS), that it captures 'difficult-to-measure', essentially qualitative and moral aspects of prison life known to be missing from existing performance figures. It shows up important differences between prisons, within security and function categories[12], between as well as within and between the public and private sectors[13], and across jurisdictions[14]. It allows for the identification of 'better' prisons, and facilitates some understanding of the differences between these 'exceptional performers' and average or poor performing establishments.

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The other significant property of the survey is that it is based on the use of Appreciative Inquiry (AI). This is a method originally developed to bring about organisational and economic change[15], which has much in common with the 'positive organisational scholarship' movement, but it has been adapted by the author and colleagues for use in research[16]. Its values, and effects, are powerful and result in the careful identification of 'what *is*', and what is experienced as *'best'*, as well as what is lacking: an important supplement to the usual social science preoccupation with 'problem-identification'. It inquires about what gives the research participants life and energy, and often leads to energetic (otherwise silenced) narratives about what 'the best practice', or 'better days or experiences in prison' look like. It can in this way be used, as can MQPL results (where the methodology and design of the questionnaire has AI as its foundation), to lead to change[17]. But this has to date been a somewhat underdeveloped aspect of its

8. Lewin, K (1951/1977) *Field theory in social science: selected theoretical papers by Kurt Lewin*, ed Cartwright, D. London : Tavistock.
9. For example Liebling, A, Price, D and Shefer, G (2010) *The Prison Officer (second edition)*. Cullompton: Willan.
10. Matza, D (1969) Becoming Deviant, N.J., Prentice-Hall, Liebling (2011) see n. 5.
11. Whilst the research agenda we began with was far from 'correctional', the current PRC team are, as a result of the emergence of 'personal development' as a key dimension of the prison experience, now curious about the possible links between MQPL scores and post-release survival. This is another complex research agenda, but we hope to make some tentative explorations soon.
12. Liebling, assisted by Arnold 2004 see n.3.
13. Liebling et al (2011) see n.5, Crewe et al 2011 see n.4.
14. For example Johnsen, B, Granheim, P K, and Helgesen, J (2011) *Exceptional prison conditions and the quality of prison life: Prison size and prison culture in Norwegian closed prisons* in *European Journal of Criminology*, 8(6), 515-29.
15. Elliott, C. (1999) *Locating the Energy for Change: An Introduction to Appreciative Inquiry,* International Institute for Sustainable Development, Winnipeg.
16. For example Liebling, A; Elliot, C and Price, D (1999) *Appreciative Inquiry and Relationships in Prison* in *Punishment and Society: The International Journal of Penology* 1(1) pp 71-98.
17. Liebling, A; Elliott, C and Arnold, A (2001) *Transforming the Prison: Romantic Optimism or Appreciative Realism?* in *Criminal Justice* 1(2) pp 161-180.

potential. Consistent with many organisations undergoing modernisation of their management practices, *measurement* of performance has tended to be prioritised by senior practitioners over *management of better* performance. Translating MQPL results into a 'science of prison management and performance' would require an altogether separate research-practitioner effort.[18]

Some longitudinal studies including MQPL have been conducted, showing significant change (both improvement and deterioration) in particular establishments, sometimes as the result of a deliberate strategy (for example, a carefully implemented safer custody strategy, leading to dramatic improvement at Eastwood Park) but sometimes for reasons that are not easy to explain without further information. Surveys conducted routinely by the Prison Service's Audit and Assurance Team are reported on with historical as well as comparative data, so it is easy to see prisons and their quality of life compared to themselves over time, as well as against their comparator group. Sometimes the results are so outstanding (that is, outstandingly good (see, for example, survey results for Grendon 2009 and 2012[19]), or outstandingly poor (see, for example, the recent survey results for Pentonville[20]) they deserve a separate study aimed at explaining their outlier status. But this type of inquiry is not resourced (it might be in the future) and would inevitably be time consuming to carry out. Members of the Prisons Research Centre team sometimes attempt such tentative 'further explorations', out of interest, but are often too committed to other specific research projects to divert time and attention in this way.

The MQPL survey has limits. It is too long. It is too tempting to 'go for the dimension scores' instead of unpicking the detail. It can be conducted (for example, by inexperienced researchers) without qualitative exploration — not consistent with its original spirit, and leading to frustration when interpretation is required. Its results are detailed and complex and not easy to interpret without good working knowledge of prisons, and extensive qualitative exploration of, and familiarity with, the establishment to which the results belong. Its conceptual framework — values-driven and closely related to the concept of legitimacy — is only partially understood 'in the field' (and, in the survey's most recent iteration, is under-articulated by its developers).[21] It does not address some important (and continually changing) dimensions of the prisoner experience (like meaning and identity, religious feeling and activity, or the nature of relationships with family) and it is, as yet, not integrated with measurement or analysis of attendance on offending behaviour programmes or other constructive activities in prison. It was developed in England and Wales, and yet is appealing to the research and policy community in some highly unexpected places, where cultural translation is extremely tricky. All of these challenges, if faced, are likely to add to the most important goal of the original project: to understand, and find an appropriate language for describing, the prison experience and its effects. Its results help us to remain properly critical about the uses and purposes of the prison, and its varied manifestations.

18. There is, however, also a staff survey, the results of which often help to explain prisoner perceptions. See further Liebling et al 2010: 210-17 see n.9; and Crewe et al 2011 see n.4).
19. Ministry of Justice (2009) *Results from an MQPL Survey at HMP Grendon*. Audit and Assurance: NOMS and Ministry of Justice (2012) *Results from an MQPL Survey at HMP Grendon*. Audit and Assurance: NOMS.
20. Ministry of Justice (2011) *Results from an MQPL Survey at HMP Pentonville*. Audit and Assurance: NOMS.
21. The results produce knowledge about what is, and what *'ought to be'*. The term 'moral performance' was coined at the end of the original study, and has been retained ever since (Liebling, assisted by Arnold 2004 see n.3). This term reflects the role of the survey in describing how prisoners *feel morally treated* by the institution. That safety and security are as significant in the prisoner experience as respect and humanity suggests that the survey reflects prisoners' 'strong evaluations' of what a legitimate prison looks and feels like, rather than superficial preferences about material goods and freedoms.

Health promoting prisons:

an overview and critique of the concept

Dr James Woodall *is a Lecturer in Health Promotion at Leeds Metropolitan University.*

The notion that prisons should become more 'health promoting' is a policy agenda that is gaining increasing momentum, particularly in England and Wales[1], Scotland[2] and across other European nations. The political strides made in this regard have been recognised globally, especially in the United States, where penal health reformers are attempting to replicate successful policy initiatives in Europe[3]. Despite the favourable rhetoric, the extent to which the concept of a 'health promoting prison' is fully understood and implemented 'on the ground' by prison staff and managers in England varies[4]. The primary aim of this article, therefore, is to open up and stimulate discussion on the World Health Organisation's (WHO) concept of a health promoting prison, as the extent to which this idea has been critically considered and debated is minimal. To encourage this wider discussion, the paper has three primary aims. It will first seek to introduce the origins and principles underpinning the health promoting prison; it will then set the health promoting prison within a political context. The paper will go on to explore some drawbacks to the approach, including the underlying conceptual and practical challenges.

The concept of a health promoting prison is one which has been located in public health and health promotion discourse for almost the past two decades. It is an idea which has germinated from the 'healthy settings' philosophy which originated from the Ottawa Charter[5]. The Ottawa Charter was an influential health promotion strategy document in the late 1980s, which indicated that health needed to be more than just about healthcare. It proposed that people's health was influenced by the environmental 'settings' of everyday life. This idea of a 'settings approach' embraces the perspective that health and well-being is influenced by a number of determinants, not just simply individual choice of whether to smoke, take drugs etc. Health, it is proposed, is determined by an interaction of social, political, environmental, organisational as well as personal factors within the places that people live their lives. Guided by the WHO, and stimulated by the enthusiasm created by the Ottawa Charter, interventions focussing on settings and a holistic view on health began to be implemented in the late 1980s.

The premise of the settings approach is, therefore, that investments in health should be made in social systems where health is not their primary remit[6]. Initially, these developments in settings happened in schools (where there primary remit is education) and workplaces (productivity and profit) and, over time, other geographically bound locations began to come under the 'healthy settings' umbrella. In the mid 1990s prisons were also recognised as a 'setting' and seen as a distinct opportunity to promote health. Indeed, whilst prisons are not necessarily in the primary business of promoting health[7] there is a clear rationale for their inclusion, as they do provide an opportunity to access marginalised (often unhealthy) groups who would otherwise be classified as 'hard to reach' in the wider community. This means that prisons stand as a prime setting to contribute to tackling inequalities in health[8].

Theoretically, the health promoting prison concept does not only concern prisoners who '(temporarily) live' there, they also seek to consider staff need. Health promoting schools, for example, have developed a 'look after the staff first' approach[9], which addresses quality of life, health and productivity

1. HM Prison Service (2003) Prison Service Order (PSO) 3200 on health promotion. London, HM Prison Service.
2. Scottish Prison Service (2002) The health promoting prison. A framework for promoting health in the Scottish Prison Service. Edinburgh, Health Education Board for Scotland.
3. Weinstein, C. (2010) The United States needs a WHO health in prisons project. *Public Health*, 124, 626-628.
4. Woodall, J. (2010) Control and choice in three category-C English prisons: implications for the concept and practice of the health promoting prison. Unpublished PhD thesis. *Faculty of Health*. Leeds, Leeds Metropolitan University.
5. WHO (1986) Ottawa Charter for health promotion. *Health Promotion*, 1, iii – v.
6. Dooris, M. (2007) Healthy settings: past, present and future. Unpublished PhD thesis. *School of Health & Social Development*. Victoria, Deakin University.
7. Smith, C. (2000) Healthy prisons: a contradiction in terms? *The Howard Journal of Criminal Justice*, 39, 339-353.
8. Baybutt, M., Hayton, P. & Dooris, M. (2010) Prisons in England and Wales: an important public health opportunity? IN DOUGLAS, J., EARLE, S., HANDSLEY, S., JONES, L., LLOYD, C. & SPURR, S. (Eds.) *A reader in promoting public health. Challenge and controversy*. 2nd ed. Milton Keynes, Open University Press.
9. Mason, J. & Rowling, L. (2005) Look after the staff first – a case study of developing staff health and well-being. *Promotion & Education*, 12, 140-141.

for employees. In work on health in prisons, the focus has been almost exclusively on prisoners[10]; yet, it is axiomatic that for prisoners to be rehabilitated and released into the community as law abiding, healthy citizens, prison staff need to feel valued and in good physical, mental and psychosocial health[11]. One of the underpinning principles therefore, includes a focus on all those within the setting and a 'whole prison approach' to health and well-being.

Underpinning principles

Although the concept of a healthy setting includes all those who live and work there, at the core of the health promoting prison are arguably prisoners' rights. It was acknowledged in England and Wales, for instance, that imprisonment should not remove the rights of prisoners to receive a good level of healthcare and it should not make it more likely that they become ill or experience deterioration in their health status[12]. Also linked to prisoners' rights, is the principle of health service equivalence. The premise is that individuals detained in prison must have the benefit of care equivalent of that available to the general public, this would include health promotion interventions. Though government policy for prison health is saturated with references to these laudable goals (e.g. equivalence), this does not reflect the complexity and reality of delivering health services in the setting. To reflect this, a definition of a health promoting prison, taking into consideration the complexity of this environment, has been offered. It states that the health promoting prison is:

> *…a place of compulsory detention in which the risks to health are reduced to a minimum; where essential prison duties such as the maintenance of security are undertaken in a caring atmosphere that recognizes the inherent dignity of all prisoners and their human rights; where health services are provided to the level and in a professional manner equivalent to what is provided in the country as a whole; and where a whole-prison approach to promoting health and welfare is the norm.*[13]

Although the concept of a healthy setting includes all those who live and work there, at the core of the health promoting prison are arguably prisoners' rights.

According to some, the health promoting prison should include all facets of prison life from addressing individual health need through to organisational factors and the physical environment[14]. Current guidance from the WHO suggests that the health promoting prison should be underpinned by four key pillars[15]. These pillars acknowledge that prisons should be: safe; secure; reforming and health promoting; and grounded in the concept of decency and respect for human rights.

Political context

Whilst political developments have been apparent in other countries, such as Scotland[16], the focus here is specifically on England and Wales, where it has been argued that policy developments are considerably ahead of other nations[17]. However, despite being at the forefront, a dedicated health promotion strategy for prisons in England and Wales did not emerge until 2002[18], despite original consultations happening much sooner. However, the publication in 2002 of 'Health Promoting Prisons: A Shared Approach' legitimised and championed a health promotion focus in prison healthcare, advocating the prevention of deterioration in health as well as encouraging prisoners to adopt healthy behaviours. The strategy advocated the need to view prisons as healthy settings

10. Woodall (2010).
11. Bögemann, H. (2007) Promoting health and managing stress among prison employees. IN MØLLER, L., STÖVER, H., JÜRGENS, R., GATHERER, A. & NIKOGOSIAN, H. (Eds.) *Health in prisons*. Copenhagen, WHO.
12. HM Prison Service & NHS Executive (1999) The future organisation of prison health care. London, DoH.
13. Gatherer, A., Møller, L. & Hayton, P. (2009) Achieving sustainable improvement in the health of women in prisons: the approach of the WHO Health in Prisons Project. IN HATTON, D. C. & FISHER, A. (Eds.) *Women prisoners and health justice*. Oxford, Radcliffe.
14. de Viggiani, N. (2009) A healthy prison strategy for HMP Bristol. Project report. Bristol, University of the West of England.
15. WHO (2007) Health in prisons. A WHO guide to the essentials in prison health. Copenhagen, WHO.
16. Scottish Prison Service (2002).
17. Gatherer, A. & Fraser, A. (2009) Health care for detainees. *The Lancet*, 373, 1337-1338.
18. Department of Health (2002).

with the potential for health improvement, rehabilitation and reform and enhancing the life chances of all who live and work there.

'Health Promoting Prisons: A Shared Approach' set the foundations for the introduction of a Prison Service Order (PSO 3200) on health promotion in 2003[19]. The PSO was considered a major breakthrough for health promotion within the prison setting because the translation of a Department of Health strategy into an auditable prison document was a crucial step forward as it provided a level of commitment to health promotion within the offender management system[20]. The PSO sets out required actions for prison governors to promote health as part of a whole prison approach. This includes focussing on: mental health promotion and well being; smoking; healthy eating and nutrition; healthy lifestyles and drug and other substance misuse. Prison health performance indicators have also been developed which focus on the delivery of health promotion in prisons through PSO 3200[21]. Although not obligatory, the performance indicators provide guidance on the arrangement of health promotion action groups and offer direction in relation to how success may be measured.

The accumulation of strategy documents, PSOs and policy drivers has shown a great deal of promise within the health promoting prisons field. Nonetheless, there has been minimal investment in fully embedding and evaluating the approach[22] and some are unclear as to the impact these documents have made to prisons and prisoners' health[23]. Some would even suggest that these policy reforms are actually making very little difference in regards to prisoners being able to make consistently healthy choices[24].

Conceptual and practical challenges

The translation of policy rhetoric to practice may be inhibited by several conceptual and practical challenges. This is not surprising, as the prison environment ultimately undermines the values associated with health promotion. The question of how key values within health promotion, such as empowerment, free choice and control, can be applied in a setting where security must govern all activities is always going to be problematic. Indeed, critics have suggested that health promotion in prison is a contradiction in terms[25], an oxymoron[26] and simply incompatible[27]. Moreover, in a study by Douglas et al.[28], women prisoners described a prison environment which was very much 'at odds' with the notion of the health promoting prison. A starting point for examining some of these challenges within the health promoting prison is to scrutinise how 'health' itself is defined and applied within the setting. How are professionals meant to 'promote health' if there is not a common understanding of what 'health' means?

The question of how key values within health promotion, such as empowerment, free choice and control, can be applied in a setting where security must govern all activities is always going to be problematic.

Historically health in prison has been aligned with a biomedical perspective[29], with a focus on the prevention of disease and illness. Morris and Morris[30], in their study of Pentonville prison, encapsulated the

19. HM Prison Service (2003).
20. Baybutt et al. (2010).
21. NOMS, HM Prison Service & Department of Health (2007) Prison health performance indicators. Guidance booklet. London, Offender Health.
22. Dooris, M. (2009) Holistic and sustainable health improvement: the contribution of the settings-based approach to health promotion. *Perspectives in Public Health*, 129, 29-36.
23. Douglas, N., Plugge, E. & Fitzpatrick, R. (2009) The impact of imprisonment on health. What do women prisoners say? *Journal of Epidemiology and Community Health*, 63, 749-754.
24. Condon, L., Hek, G. & Harris, F. (2008) Choosing health in prison: prisoners' views on making healthy choices in English prisons. *Health Education Journal*, 67, 155-166.
25. Smith (2000).
26. McCallum, A. (1995) Healthy prisons: oxymoron or opportunity? *Critical Public Health*, 6, 4-15.
27. Greenwood, N., Amor, S., Boswell, J., Joliffe, D. & Middleton, B. (1999) Scottish Needs Assessment Programme. Health promotion in prisons. Glasgow, Office for Public Health in Scotland.
28. Douglas et al. (2009).
29. Sim, J. (1990) *Medical power in prisons*, Milton Keynes, Open University Press.
30. Morris, T. & Morris, P. (1963) *Pentonville: a sociological study of an English prison* London, Routledge.

predominant discourse which surrounded prison health:

> *For the prison, health is essentially a negative concept; if men are not ill, de facto they are healthy. While most modern thinking in the field of social medicine has attempted to go further than this, for the prison medical staff it is not an unreasonable operational definition.*

More recently, reviews of prison health services have described a reactive and inefficient approach which is underpinned by a medical, rather than social, model of health[31,32]. Defining health through a biomedical lens has notable implications; primarily, health is defined by its absence of disease and not the attainment of positive health and well-being. Applying a biomedical view to health promotion can also result in an emphasis on prevention of disease instead of the promotion of good health. This perspective also has the danger of obscuring the wider political, social and environmental determinants that can impinge upon offenders' health, such as poverty, education, employment and housing.

More recently, reviews of prison health services have described a reactive and inefficient approach which is underpinned by a medical, rather than social, model of health.

Since the introduction of PSO 3200 by HM Prison Service, practical action has been taken to displace the medical model. For example, a member of the senior management team (a non-health professional) must chair health promotion committee meetings[33]. However, an evaluation of the implementation of PSO 3200 with prisons in the North West of England showed that healthcare workers still remained in control. Of the sixteen prisons that completed the audit, eleven were carried out by the healthcare manager and a further prison response completed by a public health nurse. Only two audit responses were completed by non-healthcare workers[34]. In addition, there is no mandate within PSO 3200 for prisoner representatives to participate within the health promotion group even though earlier policy developments recommended that their voice should be central to the development of interventions and programmes[35]. This is in contrast to the Scottish Prison Service which encourages active prisoner involvement on Local Health Promotion Action Groups (LHPG)[36].

Courtenay and Sabo's[37] perception is that prisons are not generally about wellness and that healthcare delivery is about treating illness after not before it occurs. Their view is epitomised when mental health promotion in prison is considered, as interventions are often targeted as a way of coping with existing mental health problems (illness) as opposed to promoting positive mental well-being and advancing the health status of individuals[38]. This is despite commitment from the WHO in acknowledging that the mental well-being of prisoners and staff is vitally important[39]. Initiatives often launched under the rubric of health promotion remain reactionary and individualistic, addressing specific disease prevention targets that respond to the physical, psychological, emotional and social needs of individuals in only a partial way[40,41]. The 'upstream' health promotion emphasis (quite simply focussing on the determinants of health) which should be integral to prison health has often been neglected by a preoccupation with acute healthcare provision.

31. HMIP (1996) Patient or prisoner? A new strategy for health care in prisons. London, Home Office.
32. de Viggiani (2009).
33. HM Prison Service (2003).
34. Baybutt, M. (2004) PSO 3200 health promotion baseline audit. Report of findings. Preston, University of Central Lancashire.
35. WHO (1995) Health in prisons. Health promotion in the prison setting. Summary report on a WHO meeting, London 15-17 October 1995. Copenhagen, WHO.
36. Graham, L. (2007) Prison health in Scotland. A health care needs assessment. Edinburgh, Scottish Prison Service.
37. Courtenay, W. H. & Sabo, D. (2001) Preventive health strategies for men in prison. IN SABO, D., KUPERS, T. A. & LONDON, W. (Eds.) *Prison masculinities*. Philadelphia, Temple University Press.
38. Bird, L., Hayton, P., Caraher, M., McGough, H. & Tobutt, C. (1999) Mental health promotion and prison health care staff in Young Offender Institutions in England. *International Journal of Mental Health Promotion,* 1, 16-24.
39. WHO (1998) Mental health promotion in prisons. Report on a WHO meeting. Copenhagen, WHO.
40. de Viggiani, N. (2006) A new approach to prison public health? Challenging and advancing the agenda for prison health. *Critical Public Health*, 16, 307-316.
41. de Viggiani, N. (2006) Surviving prison: exploring prison social life as a determinant of health. *International Journal of Prisoner Health*, 2, 71-89.

Caraher et al.[42] similarly note that health promotion in prison is often influenced by a mechanistic approach to health with an underlying preoccupation and concern with practical dangers such as self harm and the prevention of suicide. These interventions are perhaps aimed at the effective management of the prison population, rather than for promoting health benefits *per se*.

As well as conceptual, there are a number of practical challenges that inhibit the development of the health promoting prison. First, health promotion, like in other organisations, remains under resourced, under funded and an activity on the periphery of the organisation's priorities. Some prison healthcare assessments, for example, have indicated that limits on staff numbers have been insufficient to provide a complete health promotion service for prisoners[43]. Second, prison staff working closely with offenders often view health promotion as constituting additional work, something which is perceived as being outside their professional remit or something to do when time is available from their regular daily duties[44]. Bird et al.[45], for example, found that mental health promotion was not seen as being a core duty of prison staff. Activities in relation to promoting mental health were seen as being 'nice to know' rather than 'essential to know'. Healthcare staff also perceived health promotion as a specialist activity and not part of their role.

. . . health promotion in prison is often influenced by a mechanistic approach to health with an underlying preoccupation and concern with practical dangers such as self harm and the prevention of suicide. These interventions are perhaps aimed at the effective management of the prison population, rather than for promoting health benefits *per se*.

Future challenges

The development and future of the health promoting prison is currently unclear within England and Wales, as the Department of Health has recently widened its focus towards focussing on 'offender' rather than 'prison' health. This concentrates on all those who come into contact with the criminal justice system as opposed to focussing solely on the prison population[46,47]. Consequently, policy movements are shifting from discrete action in prison settings in favour of a more 'healthy criminal justice system' perspective. Indeed, Lord Bradley, in his recent report on offenders with mental health problems or learning disabilities, highlighted the value of a whole criminal justice system approach[48].

If the health promoting prison concept is to progress, several theoretical and practical issues require further thought. Prisons irrefutably contribute to addressing the acute and immediate health needs of many prisoners; however, prison policy seems preoccupied with disease prevention activities. If a settings approach is to be fully realised, a more radical, upstream and holistic outlook is required in prisons. First, the notion of a prison setting should be reconceptualised, moving away from a purely instrumental view which considers the prison as a convenient venue for addressing the health lifestyles of offenders, towards making health integral to the institution's culture. This includes considering

42. Caraher, M., Dixon, P., Hayton, P., Carr-Hill, R., McGough, H. & Bird, L. (2002) Are health-promoting prisons an impossibility? Lessons from England and Wales. *Health Education*, 102, 219-229.
43. de Viggiani, N., Orme, J., Salmon, D., Powell, J. & Bridle, C. (2004) Healthcare needs analysis: an exploratory study of healthcare professionals' perceptions of healthcare services at HMP Eastwood Park, South Gloucestershire. Bristol, South Gloucestershire NHS Primary Care Trust and the University of the West of England.
44. Caraher et al. (2002).
45. Bird et al. (1999).
46. Department of Health (2009) Improving health, supporting justice: the national delivery plan of the health and criminal justice programme board. London, Department of Health.
47. Rennie, C., Senior, J. & Shaw, J. (2009) The future is offender health: evidencing mainstream health services throughout the offender pathway. *Criminal Behaviour and Mental Health*, 19, 1-8.
48. Bradley, K. (2009) The Bradley report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London, Crown.

architecture, policies, structures, prisoner-staff relationships and how these impact on individuals. Furthermore, whilst managing modern prison systems is complex, there is a need for enlightened leadership for the settings approach to truly flourish, as previous research has noted how health promotion within prison can prosper when there is active support from senior figures in the setting[49].

Conclusions

Prison based health promotion is not an easy task to execute and those who are currently working and delivering successful health promotion in this setting are doing so within an environment of paradoxical values and philosophies. We need to learn from these examples in order to truly embed health promotion within prison settings. The aim of this paper was to spark debate and critical thinking in relation to the health-promoting prison, as in comparison to research and commentary surrounding other 'mainstream' settings, prisons have a long way to come. Due to the nature and background of the prison population, the prison undoubtedly offers a unique opportunity to address the health needs of vulnerable members of society and the proposed model of a health promoting prison by the WHO and Department of Health may be a viable approach to address this. However, there remain several conceptual and practical challenges that inhibit this implementation. Whilst the notion of a settings approach in prison is not currently fully understood, it was the intention of this paper to draw awareness to the concept. More discussion about the health promoting prison is needed from a range of stakeholders, including: academics; prison governors and staff; policy makers and, perhaps most importantly, the prison population. There needs to be some urgency about this as, in theory, the health promoting prison not only has benefits for prisoners and staff, it can contribute to improving the health of society as a whole.

49. Caraher et al. (2002).

Creating a Healthy Prison:

developing a system wide approach to public health within an English prison

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Introduction

Prison-based public health is commonly associated with communicable disease control and health protection, and probably less so to health improvement or health promotion. The World Health Organisation (WHO) advocates an 'upsteam' approach orientated towards addressing key health determinants, based on evidence of health impact, health need and health inequality; its goal for public health is to improve health across the setting as a whole[1]. Prison-based health promotion in England and Wales is performance monitored against Prison Service Order 3200[2] and Department of Health prison health performance indicators[3], and require prisons to work with NHS Organisations to integrate health promotion within their core business.

In 2009, HM Prison Bristol and NHS Bristol embarked on developing a new public health strategy, based on the 'healthy prisons' approach. This was based on the recommendation of the Prisons Inspectorate[4,5] and following a Health Needs Assessment conducted by NHS Bristol[6], which advised that existing health promotion efforts should take a broader focus on health need and health improvement outcomes, with stronger commitment and involvement from the prison's workforce and senior management team. The author was invited to work with the prison to establish a new strategy with a performance framework[7]. This paper explores the implications this work may bring to developing the public health function within prisons, and suggests a possible framework for developing prison based public health.

The Healthy Prison Approach

The 'healthy prison' approach is based on the WHO's 'healthy settings' approach, a system-wide strategy aimed at creating healthy, supportive environments[8,9]; health is perceived to be influenced by individual, cultural, social, environmental, political and economic determinants[10]. The goal is to create conditions for health improvement and health protection, with Public Health performing a supportive, stewardship role[11,12]. Health improvement requires a whole prison, system-wide approach, to minimise health risks, respect dignity and human rights, and provide services equivalent to those provided for the general population[13]. This approach engages at all levels of prison life — personal, social, organisational and environmental — recognising their interdependence in relation to health and the roles of all those involved with the prison — prisoners, the workforce, prisoners' families, the wider community, and other sectors and agencies involved directly or indirectly with prisons.

The healthy prison approach is consistent with European directives governing imprisonment within member states, including the Prison Rules on standards of prison healthcare, the Convention on Human Rights, and the Standards for the Prevention

1. World Health Organisation (2010) *Strategic objectives for the WHO Health in Prisons Project*. Copenhagen, WHO Regional Office for Europe. Available at: http://www.euro.who.int/prisons, accessed 19 February 2010.
2. Her Majesty's Prison Service (2003) *Prison Service Order 3200: Health Promotion*. London, Home Office.
3. Department of Health (2009) *Guidance notes: prison health performance and quality indicators*. London, DH.
4. Her Majesty's Inspectorate of Prisons (2005) *Report on a Full Announced Inspection of HMP Bristol, 10-14 January 2005*. London, HMIP.
5. Her Majesty's Inspectorate of Prisons (2008) *Report on an unannounced short follow-up Inspection of HMP Bristol, 3–6 March 2008*. London, HMIP.
6. Kipping, R. & Scott, P. (2008) HMP Bristol Health Needs Assessment. *Bristol, NHS Bristol*.
7. de Viggiani, N. (2009) *A Healthy Prison Strategy for HMP Bristol: analysis, outcomes and recommendations from a scoping exercise January-March 2009*. Bristol, University of the West of England.
8. World Health Organization (1991) *Report on the Third International Conference on Health Promotion*. Sundsvall, WHO.
9. World Health Organization (2007) *Health in prisons: a WHO guide to the essentials in prison health*. Copenhagen, WHO Regional Office for Europe.
10. Dahlgren, G. & Whitehead, M. (1991) *Policies and strategies to promote social equity in health*. Stockholm, Institute of Futures Studies.
11. World Health Organization (2003) *Declaration on Prison Health as a Part of Public Health*. Copenhagen, WHO Regional Office for Europe.
12. See 9.
13. See 9

of Torture and Inhuman or Degrading Treatment or Punishment[14]. In common with these, it shares the principle that prison authorities should provide humane, empowering conditions for prisoners. Similarly, the Prisons Inspectorate identifies 'safety', 'respect', 'purposeful activity' and 'resettlement' as key performance standards for a healthy prison, albeit this is a wider concept that the delivery of healthcare services alone[15]. These depend upon commitment, leadership and political will, and a shift from single-issue health promotion to system-wide development. The World Health Organisation[16] also recommends that prisons foster positive identities or 'brands' as public services, not only serving society's needs for retribution, security and safety, but functioning as agencies for health improvement, social inclusion and social justice.

Commitment to the healthy prison approach was evident in the former UK government's reform of criminal justice health policy[17,18] and in the rhetoric of the Prisons Inspectorate[19]. It was acknowledged that a 'healthy prison' could be instrumental in tackling health inequalities and reducing social exclusion[20,21]. Criminal justice health policy developed apace in the wake of the Bradley and Carter reviews[22,23], the Darzi Report[24], and the Health Care Commission's review of prison healthcare[25]. It was argued that health improvement across the criminal justice system could bring reductions in re-offending, especially given the evidence linking ill-health, social exclusion and offending[26,27]. The policy goal was to create equivalent and integrated services and, under 'World Class Commissioning', release resources to improve health and reduce inequalities[28]. Primary Care Trusts (PCTs) were tasked to lead on this 'upstream' agenda via their commissioning powers[29].

The Bristol Strategy

The challenge for HMP Bristol was to develop and 'own' a public health strategy, based on these principles, orientated towards health improvement, reducing inequalities and respecting human rights. This necessitated a shift in focus from issue-based health promotion activities towards system-wide action across the institution.

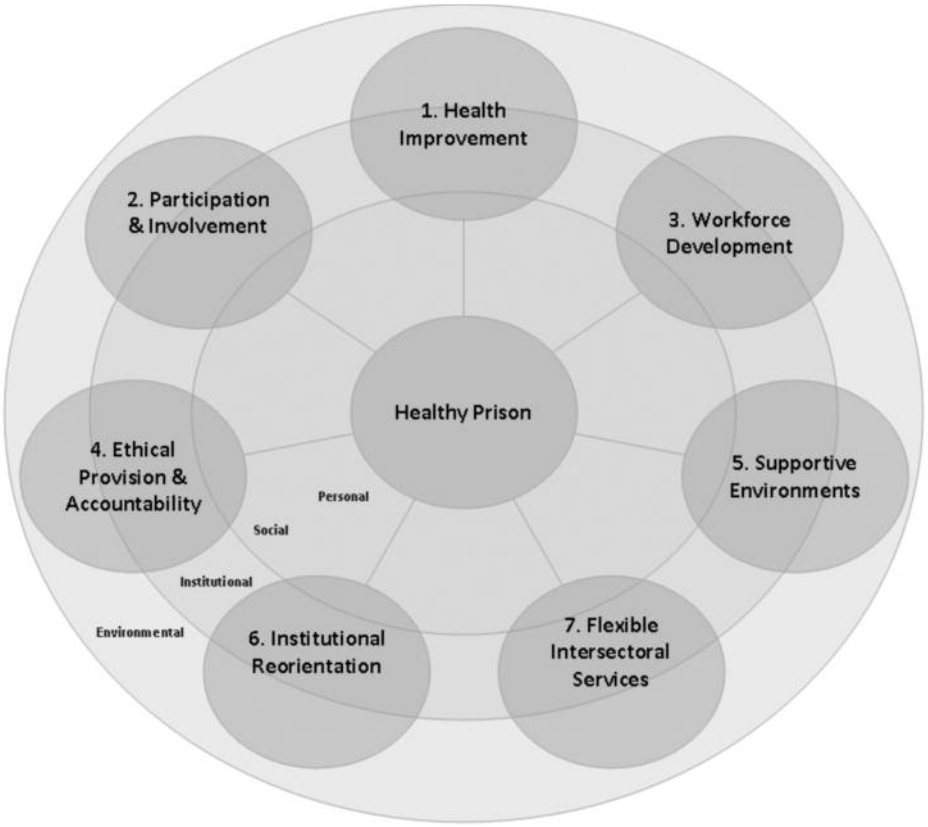
Consultation with mid- and senior level prison-based staff elicited perceptions and beliefs about the healthy prison approach, including how the strategy should be developed, what could constitute realistic objectives, how the prison environment could be improved, the nature of existing health promotion interventions, the scope to tackle inequalities and social exclusion, relations with external agencies, and feasibility of creating a caring and supportive custody environment. Discussion with senior management team members led to the formation of an interdisciplinary Healthy Prison Strategy Group with establishment of Terms of Reference, Performance Standards and an Action Plan[30]. Seven action areas were identified for developing the strategy, schematically represented in figure 1, which form the basis for the prison's current action plan and performance targets.

Healthy Prison Action Domains

Figure 1 illustrates, non-hierarchically, how different levels of the system — individual, social, institutional and environmental — are interlinked and can impact on health and wellbeing. The ensuing discussion describes and contextualises these domains, offering hypothetical performance standards, objectives and targets for each domain, against which a prison's healthy prison performance could be evaluated.

14. Council of Europe (1987) *Council of Europe Committee of Ministers Recommendation No. R(87)3 of the Committee of Ministers to Member States on the European Prison Rules 1* (Adopted by the Committee of Ministers on 12 February 1987 at the 404th meeting of the Ministers' Deputies).
15. Her Majesty's Inspectorate of Prisons (2009) *Annual Report 2007–08*. London, Stationary Office. Available at: http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/annual-report-2007-08.pdf, accessed 19th February 2010.
16. See 9.
17 . Department of Health (2008) *Improving Health Supporting Justice*. London, DH.
18. Bradley, Rt Hon Lord (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London, DH.
19. See 15.
20. Department of Health (2002) *Health Promoting Prisons: A Shared Approach*. London, Stationery Office.
21. Social Exclusion Unit (2002) Reducing re-offending by ex-prisoners. London, SEU.
22. See 18.
23. Carter of Coles, Rt Hon Lord (2007) Lord Carter's Review of Prisons, Securing the future: proposals for the efficient and sustainable use of custody in England and Wales. London, House of Lords.
24. Darzi, Rt Hon Lord (2008) *High quality care for all: NHS next stage review final report*. London, DH.
25. Healthcare Commission (2009) Commissioning healthcare in prisons: the results of joint work between the Healthcare Commission and her Majesty's Inspectorate of Prisons in 2007/08. London, Commission for Healthcare Audit and Inspection and HM Inspectorate of Prisons.
26. See 17.
27. See 21.
28. See 17.
29. See 25.
30. See 7.

Figure 1. Healthy Prison Action Domains



1. Health Improvement

Prison populations are highly transient with disproportionately high levels of health and social need that transcend more immediate lifestyle concerns[31]. Health behaviour change is difficult to achieve with most groups, evidence overwhelmingly suggesting this is usually only likely with highly motivated individuals[32,33]. Health improvement interventions with prisoners should therefore be appropriate and realistic, enabling individuals to make lasting changes to their lives and effectively reintegrate into society as healthier citizens. Interventions should be relevant to individuals' social and economic circumstances; priority areas are likely to encompass mental and emotional health problems, family relationships, drug or alcohol treatment and rehabilitation, health and educational literacy, safety (in custody), violence, exploitation or bullying issues, sexual health and relationships, and issues of resettlement after release.

A core principle and objective underpinning the WHO health promotion ethos is 'enablement'[34], achieved though empowerment, participation and collective action. 'Responsibility' is central to this, where the goal is for individuals to become empowered to take personal responsibility for their health under supportive conditions, a supportive (empowering) environment being an important prerequisite for promoting personal responsibility. This is consistent with the aims of the Prison Service, the National Offender Management Service (NOMS) and the Youth Justice Board (YJB) with regard to facilitating development of personal responsibility among offenders. It implies the need to develop realistic health, welfare, education and employment initiatives that have real potential to change individuals in positive ways, through effective, evidence based interventions.

Arguably, an integrated approach to health improvement is preferable to an individualistic, purely lifestyle focused approach. It recognizes the need for synergy between health, welfare and offender management (resettlement) goals and interventions, and acknowledges the roles of both the system and the individual. The National Reducing Re-offending Delivery Plan[35] emphasised the importance of partnership

31. See 21, 17, 15 and 1.
32. Tones, K. & Tilford, S. (2001) *Health Promotion: Effectiveness, Efficiency and Equity*, 3rd edition. Cheltenham, Nelson Thornes.
33. Naidoo, J. & Wills, J. (2000) *Health Promotion: Foundations for Practice*. 2nd Edition. London, Bailliere Tindall.
34. World Health Organization (1986) *The Ottawa Charter for Health Promotion*. Geneva, WHO.
35. National Offender Management Service (2006) *The National Reducing Re-offending Delivery Plan*. London, Home Office.

working across seven pathways: Accommodation; Education, Training and Employment; Health; Drugs and Alcohol; Finance, Benefit and Debt; Children and Families; and Attitudes, Thinking and Behaviour. From a Public Health perspective, these pathways correspond with public health goals, suggesting common ground in terms of tackling inequalities, reducing social exclusion, improving health and reducing re-offending. Local Public Health teams can provide strategic leadership and intelligence relating to the needs of prison populations, while health improvement programmes should be developed as cross-cutting, system-wide activities, as replicated in other sectors such as schools and workplaces.

Performance Standard – Health Improvement

Hypothetical Objectives

- ❒ *Provide opportunities for prisoners to transform their life chances through participation in activities that provide skills and motivation, relevant to their circumstances.*
- ❒ *Develop innovative and appropriate interventions that address health and social need, identified through Health Needs Assessments.*
- ❒ *Evaluate interventions for ongoing value and effectiveness.*
- ❒ *Involve prisoners in developing and delivering interventions.*
- ❒ *Involve different agencies and professionals in developing and delivering interventions.*

Hypothetical Targets

- ❒ *Small group based activities focused on relevant issues for prisoners (e.g. parenting, communication skills, life skills, peer education, mentoring schemes).*
- ❒ *Topic based workshops underpinned by team building and group work approaches.*
- ❒ *Health Trainer strategy based on active learning, peer education and advocacy.*
- ❒ *Arts based workshops and programmes to build social, emotional and psychological resilience and skills.*

2. Participation and Involvement

User involvement in planning, delivering and evaluating services is recognised as a key principle of health service management[36], endorsed by the WHO as a healthy prison objective[37] As public services, the Prison Service and the NHS are required to conform to equal opportunities standards, which include promoting diversity and supporting the rights and voices of various groups, according to ethnicity and race, nationality, age, gender and sexuality, and disability[38]. In this regard, the service user perspective should be reflected and represented at all levels of policy and practice, with 'diversity' as the core theme.

The MacPherson Report emphasized that public services should take proactive measures to ensure that socially marginalized or disadvantaged groups have fair and appropriate access. Since inequalities prevail in society, treating all individuals equally does not necessarily guarantee equity[39]. Rather, disadvantage and discrimination can become embedded within social, institutional, political and economic systems where the same rules of access or opportunity are applied to unequal status groups, via 'open door' policies, thereby generating and provoking inequality. A socially just approach requires proactive measures.

The principle of equity may be illustrated through reference to 'disability'. The Prison Reform Trust[40] advocates a broad, integrated, inclusive approach, which implies effective screening, assessment and intervention for prisoners' non-registered or unreported needs, such as learning disabilities.

Performance Standard – Involvement, Participation and Representation

Hypothetical Objectives

- ❒ *Actively enable potentially disadvantaged or marginalised individuals to access services.*
- ❒ *Comprehensively screen and assess all prisoners for health and social needs.*
- ❒ *Build service user involvement into all aspects of service planning, delivery and evaluation.*
- ❒ *Develop peer representation, advocacy and consultation as integral to the core business of the organisation.*

Hypothetical Targets

- ❒ *Prisoner consultation groups for all areas of service planning and delivery*
- ❒ *Listener and Insider schemes*
- ❒ *Patient Advice and Liaison Services*
- ❒ *Expert Patient programmes*

36. Department of Health (2006). *Our Health, Our Care, Our Say*, London, Stationery Office.
37. See 1.
38. See 17.
39. MacPherson, W. (1999) *The Stephen Lawrence Inquiry*. London, Stationery Office.
40. Prison Reform Trust (2000) *Bromley Briefings: Prison Factfile, June 2009*. Available at: www.prisonreformtrust.org.uk; accessed 23rd February 2010.

- ❒ *Health Trainers scheme, with advocacy and mediation roles.*
- ❒ *Active learning approaches across education programmes.*
- ❒ *Equity monitoring of services/processes.*

3. Workforce Development

Building effective, multi-agency partnerships, where the workforce shares collective goals and objectives, is a third healthy prison objective. The challenge is to establish an institutional culture where traditional polarised professional values and norms — such as the prioritisation of custody before care or of treatment before prevention — are reduced, and professional differences are reconciled through a common human rights based approach. Staff are important role models for prisoners and must therefore be supported and empowered to carry out their roles.

Workforce development requires a multi-level approach. External to the institution, one important goal is to develop regional and national workforce plans, involving academic partners to forge appropriate career pathways, especially for those professions peripheral to the Prison Service (NHS, Local Authorities, Third Sector, etc.). At the institutional level, creating a supportive living and working environment could enable different professional groups to work towards common goals and objectives. Staff retention levels depend upon job satisfaction, self-efficacy, self esteem, staff support, development and appraisal, staffing levels, access to resources to effectively deliver services, work environments, and professional relationships, all issues that should be prioritised by prison senior management teams. Training and workforce development could focus on efforts to create a common value base within the setting, across professional groups, focused on human rights, reducing re-offending, improving health, and tackling exclusion and inequality.

Performance Standard – Workforce Empowerment

Hypothetical Objectives

- ❒ *Create a positive work environment across all locations / professional areas.*
- ❒ *Foster an interdisciplinary team culture at all levels of decision making and practice.*
- ❒ *Build a work culture based on respect, reciprocity, professionalism and equity.*
- ❒ *Develop an inter-professional and inter-sectoral approach to planning, consultation, organisation and delivery of all prison-based interventions and services.*
- ❒ *Develop a workforce development strategy in collaboration with the prison partnership board and in liaison with all commissioning and provider stakeholders.*

Hypothetical Targets

- ❒ *Accessible and appropriate opportunities for staff social support, contact and interaction.*
- ❒ *Inter-professional staff training and support opportunities, focused on team building/development, career development and professional skills.*
- ❒ *Accountability, mentoring and appraisal across all staff groups, with opportunities for staff development.*
- ❒ *Workforce engagement and representation at partnership board and other higher level external decision making bodies.*
- ❒ *Links with local higher and further education institutions to develop knowledge exchange, education and training initiatives.*
- ❒ *Evaluation and audit of the staff experience.*

4. Ethical Provision and Accountability

Under their duty of care and as a public service, prisons should provide ethical services that respect prisoners' human rights and dignity. Under the Tavistock Principles[41], health is recognised as a human right and extends to health improvement, disease prevention and alleviation of disability, orientated towards maximum health gain and continuously improved quality, best achieved through partnership between professionals and clients.

The human rights imperative infers that health services, including public health, should be equivalent to those provided for the general population and should provide proactively for those considered most vulnerable, excluded or at risk. Bradley[42] emphasised the need to create integrated health services across the criminal justice system, especially given the transience of the population; services should enable individuals to move from one setting or sector to the next, receiving seamless, continuous support. This is a challenge for services, given the complex and chaotic lifestyles of this client group. It requires assessment, liaison and referral processes to be coordinated across professional groups and agencies, where responsibility may fall to more than one organisation and budget. For healthcare professionals, this means working collaboratively with the Prison Service, other NHS organisations, local authority providers, and Third and independent sector providers.

41. Smith, R., Hiatt, H. & Berwick, D. (1999) Shared ethical principles for everybody in health care: a working draft from the Tavistock Group. *British Medical Journal* 3:18:248-251 (23 January).
42. See 18.

It is also essential that prisons are able to accommodate services to an appropriate standard, especially in terms of ensuring dignity and respect, for instance in relation to issues of informed consent, privacy, confidentiality and safety. These may be compromised where substandard facilities limit what service providers can offer or where liaison, referral or diversion schemes are ineffective or under-developed.

Performance Standard – Ethical Health and Social Care

Hypothetical Objectives

- ❒ *Guarantee ethical standards of health and social care.*
- ❒ *Build professional accountability across all services/pathways.*
- ❒ *Provide access to health and social care commensurate with need.*
- ❒ *Orientate services towards maximum health gain across the population.*
- ❒ *Ensure all services aim to prevent or reduce ill-health or disability.*
- ❒ *Base all services on Inter-professional and inter-sector/agency working and cooperation.*
- ❒ *Ensure client or patient-centred service planning and delivery.*
- ❒ *Demonstrate continuous commitment to service quality improvement.*

Hypothetical Targets

- ❒ *Policies and procedures that safeguard client rights and entitlements to dignity and safety, based on clinical governance principles.*
- ❒ *Audit and evaluation of services (against ethics and governance standards).*
- ❒ *Prison Service management dialogue and consultation with partner agencies.*
- ❒ *Interprofessional training and consultation.*

5. Supportive Environments

The principal purpose of imprisonment is the deprivation of liberty, which can impede a prison's efforts to be supportive in the sense of being empowering and participatory. This then presents a challenge when it comes to reconciling public health and offender management goals, with seemingly contradictory philosophies having the potential to create irresolvable differences. After all, the prevailing ethos of the prison system is established upon core values of security, discipline and control, and not the empowerment of the prisoner.

While prisons employ a range of personnel, prison officers perform a 'front-line' role with prisoners. Their responsibilities include upholding prisoners' rights and welfare via their Duty of Care and the Decency and Respect agendas. However, these may be compromised by such factors as low staff-to-prisoner ratios, large wing populations and overcrowding, rapid turnover of the population, the authoritarian status and persona of staff, scheduled and unscheduled lock-down, the relatively inflexible Core Day and the built environment. On balance, security and control are prioritised above public health goals, reflecting a long tradition of penal policy.

The goal for a supportive environment is for participants to feel safe, to function to their optimum, to realise their potential, to participate in their progress and to feel empowered; essentially, individuals should have some control over their circumstances. There may be alternative ways of re-orientating prison environments to make this possible, so that security and control imperatives, along with other environmental constraints, have a lesser impact on health and wellbeing. New developments could include introducing multidisciplinary staff teams to residential wings, reforming the 'personal officer' role and increasing opportunities for social interaction (e.g. team building) or pastoral support for prisoners. For most prisoners, sanctuary, safety and emotional support are highly valued yet difficult to access in a prison environment. Measures that strive to facilitate a supportive environment could therefore have a potentially positive impact on prisoner health and wellbeing.

Performance Standard – A Supportive Environment

Hypothetical Objectives

- ❒ *Create and maintain a healthy physical environment, fit for purpose.*
- ❒ *Reconcile potentially health-limiting, competing professional values.*
- ❒ *Use the Core Day creatively, geared towards productivity, purpose and resettlement.*
- ❒ *Develop interdisciplinary training to tackle entrenched professional values and norms.*
- ❒ *Liaise with partner agencies to effectively manage prisoner placement and transfer.*
- ❒ *Manage prison processes, systems and structures to uphold principles of empowerment and participation.*

Hypothetical Targets

- ❒ *Multi-professional, inter-disciplinary residential staff teams.*
- ❒ *Reform of the 'Personal Officer' function.*

- ❒ *Opportunities for group activities, team building, creativity within and outside the Core Day.*
- ❒ *Develop alternative purposeful activities inside and outside the Core Day, with equivalent remuneration/wage levels.*
- ❒ *Opportunities (times and places) for 'sanctuary', safety and emotional support (e.g. informal counselling, mentoring or buddying).*
- ❒ *Third Sector involvement in the daily life of the prison.*
- ❒ *Health Impact Assessment of the institution.*

6. Institutional Reorientation

Prisons are strictly regimented institutions whose purpose is to manage order and discipline while preparing prisoners for release through 'purposeful activity'. The Incentives and Earned Privileges Scheme (IEPS) was introduced in England and Wales in 1995 to incentivise prisoners to behave responsibly and progress via a system of earned privileges, and to create disciplined, controlled and safe prison environments[43]. It operates on three tiers: basic, standard and enhanced, where prisoners move between levels according to their behaviour. Prisoners are initially placed on the standard tier and their behaviour is continuously monitored. Consistent good behaviour may merit advancement to the enhanced tier, while poor behaviour may mean a prisoner is downgraded to the basic tier. Entitlements comprise earnable privileges such as extra or improved visits, higher wages, in-cell television, choice of clothing, access to additional external finances, or extra time out of cell for association.

Privileges affect the daily life of prisoners, enabling greater economic and material freedom for those who are compliant. However, this approach can theoretically create disincentives (e.g. education and skills development on a lower rate of pay) or may create inequalities among prisoners through the opportunity for entrepreneurial or exploitative behaviour. If the employment system is underpinned by the IEPS, this represents a 'market economy' model of rehabilitation that can potentially disadvantage, exclude or disempower individuals with poor motivation, low skill or competency. Under the principles of McPherson, this could constitute a form of institutional discrimination on account of some prisoners not possessing the aptitudes or life skills to respond to an incentives-based system. Where the IEPS is not carefully operated and regulated, there is potential for it to become unjust and divisive[44,45,46]. This argument suggests the IEPS may be problematic as a system of regulation, and that there may be a case for reviewing its impact on health and wellbeing and its implementation across different institutions.

Performance Standard – Reorientated Institutional Priorities

Hypothetical Objectives

- ❒ *Create / maintain an equitable and productive prison regime.*
- ❒ *Reduce the potential for inequalities created by institutional processes.*
- ❒ *Ensure prisoner rehabilitation is or remains the overarching aim of imprisonment.*
- ❒ *Ensure imprisonment is a productive and empowering process for all prisoners.*
- ❒ *Guarantee that imprisonment does not disadvantage or discriminate.*
- ❒ *Create/maintain a prison environment that upholds principles of decency, humanity and equity.*

Hypothetical Targets

- ❒ *Staff training on implementation of the IEPS.*
- ❒ *Review and evaluation of institutional processes (e.g. IEPS; staff uniform policy; staff-to-prisoner ratios; scheduled lock-up; association; Core Day; etc.).*
- ❒ *Review and evaluate work programmes ('purposeful activities') as incentives.*
- ❒ *Health Impact Assessment of prison regime and policies.*
- ❒ *Health Equity Audit/evaluation of prison regime/IEPS.*
- ❒ *Wing-based feasibility studies/pilots to trial alternative management/regime scenarios.*
- ❒ *Creative use of non-Core Day periods for purposeful activity.*

7. Flexible Multidisciplinary Provision

NHS Commissioning has enabled the criminal justice sector to link with a wide range of health and social care provision traditionally beyond its reach. Given the transience of prison populations, with the movement of individuals between NHS catchment areas, NHS commissioning organisations have started to work with neighbouring organisations to attempt to join up service provision to meet offenders' healthcare needs. The process of needs assessment often begins on reception

43. Her Majesty's Prison Service (2000) PSO 4000 – *Incentives and Earned Privileges*. London, Home Office.
44. Liebling, A., Muir, G., Rose, G. & Bottoms, A. (1999) *Incentives and Earned Privileges for Prisoners – an Evaluation*. Home Office Research, Development And Statistics Directorate; Research Findings No. 87. London, Home Office.
45. de Viggiani, N. (2006) Unhealthy prisons: exploring structural determinants of prison health. *Sociology of Health and Illness*, Vol. 29 No. 2, pp.115–135.
46. Woodall, J. (2010) *Control and choice in three category-C English prisons: implications for the concept and practice of the health promoting prison*. PhD Thesis. Leeds Metropolitan University.

into prison, and should detect prisoners' individual physical, mental, emotional and social needs to set in place appropriate care planning. Increasingly, the role of NHS commissioning organisations has been to link prisoners with services appropriate to their needs, irrespective of their custody or offending status. The ideal scenario would be for early screening, detection and assessment to take place prior to imprisonment, possibly at the point of arrest, especially where diversion or referral to non-custodial care are preferable.

Progressive Criminal Justice public health should engage all systems of health, education, employment, social care and offender management and link synergistically with the wider criminal justice system — police, courts, prison, probation and youth justice services. Lord Bradley's[47] review identified the need for integrated, joined up services based on health and social need. This may be achievable through bespoke, tailored intersectoral programmes that capture the skills, expertise and experience of community and Third sector organisations, many of which are not always known to mainstream service providers or commissioners. A bespoke approach would require flexible commissioning[48] to enable individuals' health, social and offending needs to be managed in an integrated way, which could ensure that health and criminal justice services are consistent and progressive.

Performance Standard – Flexible Multidisciplinary Provision

Hypothetical Objectives

- ❒ *Develop integrated, bespoke care pathways for offenders.*
- ❒ *Underpin health, social care and offender management with common goals.*
- ❒ *Create a climate of flexible joint commissioning.*
- ❒ *Strengthen local commissioning partnerships between NHS, NOMS and Local Authorities.*
- ❒ *Develop evidence based, needs-led services.*
- ❒ *Engage effectively with community and Third sector organisations.*

Hypothetical Targets

- ❒ *Bespoke, service 'portfolios' for offenders via regional and local partnership boards.*
- ❒ *Feasibility studies of bespoke multidisciplinary 'pathway care'.*
- ❒ *Engagement with community and Third Sector organisations to pilot alternative service provision.*
- ❒ *Prison Health Delivery Plans based on Health Needs Assessment and Health Impact Assessment data to drive services.*

Conclusion

This paper offers a somewhat unconventional model for developing a public health approach for the prison setting. As has been argued elsewhere[49], the 'healthy settings approach' should not be restricted to a single organisation or institution nor, moreover, interpreted as isolated health promotion practices within settings[50,51]. Rather, the settings approach infers an interconnected, synergistic system of public health — located across criminal justice — with the focus on determinants of health, inequalities and reducing (re)-offending. Such an approach depends on political and organisational will, where there is sympathy to the needs of vulnerable or excluded groups. The challenge is to discover innovative ways for the different sectors to engage collectively with people in the criminal justice system towards common goals.

Whether this vision can be fully realised is uncertain. Nevertheless, where political will prevails to deliver a cost effective service, there is the possibility that measures to reduce (re)offending, rehabilitate offenders and improve health may be seen as positive goals for reducing public spending. As effective public services, prisons can perform a vital role in improving health and reducing healthcare costs, improving social capital and inclusion and reducing welfare costs, and preventing (re)offending thereby reducing criminal justice costs. Public health's important stewardship function can support criminal justice institutions and their partner agencies to develop system-wide health improvement and social development, potentially leading to longer term reductions in inequalities and the protection of human rights. For this to happen, inter-sector partnership working is essential.

47. See 17.
48. See 36.
49. Dooris, M. (2004) Joining up settings for health: a valuable investment for strategic partnerships? *Critical Public Health* 14: 37-49.
50. Wenzel, E. (1997) A comment on settings in health promotion. *Internet Journal of Health Promotion*. Available at http://www.ldb.org/setting.htm, accessed 15/7/2010.
51. Whitelaw, S., Baxendal, A., Bryce, C., Machardy, L., Young, I. & Witney, E. (2001) Settings based health promotion: a review. *Health Promotion International* 16:339-352.

Participatory Action Research in the Development and Delivery of Self-Harm Awareness Sessions in Prison:

Involving Service Users in Staff Development

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Introduction

The issue of self-harm is of great public concern[2] and subsequently much researched. Self-harm in prisons is an equally relevant topic of examination given the rates of self-harm in custody, especially amongst women in prison[3]. This substantial body of literature has forwarded theories of the functions of and risk factors for self-harm[4,5] interventions and methods of 'managing' self-harm[6], the attitudes of healthcare staff to self-harm[7] and how such attitudes impact upon treatment in a prison setting[8].

Despite the wealth of research in this area and the existence of highly regarded community support services for self-harm such as the Bristol Crisis Service for Women, 42nd Street and the National Self-harm network to name a few, there has been scant publication of participatory action research (PAR) in the area of self-harm (with the notable exception of McElroy and Sheppard[9]). The use of PAR is also, to our knowledge, an unprecedented methodology in prison based research. The prison service has a history of service user involvement through the use of prison councils, wing representatives and the Listening scheme. However this largely represents consultation with prisoners[10] whilst the Sainsbury Centre for Mental Health[11] highlighted the dearth of service user involvement in prison research, indicating the service user involvement in prisons remains in its 'infancy' (p.14).

This article describes the development of a staff awareness training session about self-harm using a PAR approach. The training session represents just one initiative falling out of a 3-year study aimed at providing improved outcomes for women who self-harm in prison and a reduction in the number of incidents of self-harm across the jail. The study is located in a single women's prison in England and is a joint venture between the local offender health commissioners, a local university and the prison. For the purpose of the study self-harm is defined as: *a non-fatal act, regardless of the act's nature, that was completed in the knowledge that the act would be harmful*[12,13].

Using PAR Methodology

PAR is a cyclical process involving research, action, observation and critical reflection[14] by all interested stakeholders[15]. The emphasis of PAR is to use research to produce action towards change rather than solely creating knowledge. In the case of the present study

1. Sian Boyd is a pseudonym.
2. SANE, (2008) Understanding Self-Harm. Available at: http://www.sane.org.uk/Research/SelfHarmIntro Last accessed 12th May 2011.
3. Corston, J. (2007) The Corston Report. Ministry of Justice. London: HMSO.
4. Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. Clinical Psychology & Social Practice, 10, 192-205.
5. Chapman, A. L., Gratz, K.L., & Brown, M.Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. Behaviour Research and Therapy, 44, 371-394.
6. Hawton, K., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A., van Heeringen, K. (1999). Psychosocial and pharmacological treatments for deliberate self harm. Cochrane Database of Systematic Reviews, 4.
7. Pembroke L (Ed.). (1994) Self-harm: Perspectives from personal experience. London: Survivors Speak Out.
8. Kenning, C., Cooper, J., Short, V., Shaw, J., Abel, K., & Chew-Graham, C., (2010) Prison staff and women prisoner's views on self-harm; their implications for service delivery and development: A qualitative study. Criminal Behaviour and Mental Health, 20 (4).
9. McElroy, A., & Sheppard, G. (1999) The assessment and management of self-harm patients in an accident and emergency department: An action research approach. Journal of Clinical Nursing, 8, 66-72.
10. Rose, D. (2003) Collaborative research between users and professionals: Peaks and pitfalls. Psychiatric Bulletin. 27, 404-406.
11. Sainsbury Centre for Mental Health (2008). A review of Service User Involvement in Prison Mental Health Research (p.14).
12. Hawton, K., & Van Heeringen, K. (2000). The International Handbook of Suicide and Attempted Suicide. Chichester: Wiley.
13. Morgan, H. G. (1979) Death Wishes: Assessment and Management of Deliberate Self-Harm. Chichester: Wiley.
14. O'Brien, R. (1998) An Overview of the Methodological Approach of Action Research. Available at http://www.web.net/%7Erobrien/papers/arfinal.doc last accessed 12th April 2011.
15. Wadsworth, Y. (1998) What is Participatory Action Research? Action Research International, Paper 2.

identified stakeholders were the women in prison who chose to undertake the research and become involved in the development of the staff awareness package, the local university, the Prison service and the Offender Health Commissioners.

The initial phase of research involving completion of questionnaires, process mapping and interviews with staff and prisoners identified a need for additional staff training[16]. More detailed analysis of these findings identified that the skills gap was not related to staff's understanding of the functions or antecedents of self-harm or the prisons procedures for the management of self-harm (ibid). This suggested that the requests for additional training related to a, perhaps unfounded, lack of confidence in dealing with women in crisis or who have used self-harm and a need to identify useful strategies to use in such situations. Given this it was clear that the opportunity to hear from 'experts by experience'[17] as to what women who have used self-harm find useful in managing their self-harm and what constitutes helpful responses would be beneficial to staff.

The initial phase of research involving completion of questionnaires, process mapping and interviews with staff and prisoners identified a need for additional staff training.

An initial focus group (six women who had participated in the research) brainstormed key messages to convey in the training. The group decided to call the training package *At Arm's Length* and identified three key messages they felt were important to put across:

1. The importance of a firm but fair approach.
2. The value of non-judgemental listening in managing self-harm.
3. How empathy can help women in distress.

Three of the women agreed to help develop the package but one was subsequently transferred to another prison. This resulted in a team of three, two women and the second author, who together spent several hours over a number of meetings developing the awareness package.

The prison's Senior Management Team agreed to a pilot training session. The length of the session was limited to 30 minutes due to the time constraints and limited resources available to prison staff. It was felt that even though the session would be short the key messages that the women participants wanted to convey could be. Residential managers and the prison's security department were involved in the identification of suitable women to co-deliver the session and this was also discussed with Offender Supervisors and other key workers. At the start of each session it was stressed that the package had been written in collaboration with a number of women, who would remain anonymous.

To date the awareness sessions have been delivered to 104 members of prison staff. The sessions are co-delivered with the second author and Sian a woman in prison who agreed to deliver the session. At the end of each session Sian is de-briefed to discuss her experience of the session, offer support if necessary, and to identify opportunities to develop the content of the package further.

Reflections on the session

Gregor and Smith[18] highlight the need for reflection and review of the potential emotional impact of service user involvement in social work training. This is arguably even more important in the prison environment because of the inherent power relationships between 'prisoners' and 'staff', along with the further relationship issues where a prisoner may be perceived as 'teaching staff' is also a further consideration. It seemed to the authors that it was important that Sian shared her experience of her involvement in the delivery of the session. Whilst Moores, Fish and Duperouzel[19] reflected the experiences of a service user involved in a similar project and feminist ethnographies of women in prison in the United States have been published[20] we believe this is the first account of a woman's experience of being involved in such a project whilst in custody.

This is what Sian wanted to convey:

Sian's reflection

My name is Sian and I am 29 years of age. I have one older sister and two younger

16. Ward, J., & Bailey, D. (2011) Improving outcomes for women who self-injure using an action research approach in prison. In Press.
17. Bailey, D. (2011) Interdisciplinary Working in Mental Health. London: Palgrave Macmillan.
18. Gregor, C., & Smith, H. (2009) I'm not a performing monkey: Reflections on the emotional experience of developing a collaborative training initiative between service users and lecturer. Journal of Social Work Practice, 23 (1), 21 – 34.
19. Moores, P., Fish, R., & Duperouzel, H. (2011) 'I can try and do my little bit' – training staff about self-injury. Journal of Learning Disabilities and Offending Behaviour, 2 (1), 4-7.
20. Richie, B. E. (2004) Feminist Ethnographies of Women in Prison. Feminist Studies. 30, (2) 438 – 451.

brothers. My parents split up when I was young and I lived with my mum until I was about 7 years of age. A little while after my mother and father had split up my mum met a new partner who subsequently sexually abused me and all my siblings. Eventually the abuse came to light and we all went to live with my father. The abuse case came to court and my abuser was given 9 years imprisonment. My mother stuck by her partner and we never had any contact with her for the rest of our childhoods. I met my children's dad when I was fifteen and at that time he was 20 years older than me. I had two children with him, my first being at 17 years old and the second when I was Eighteen. I found being a young mum hard and on top of that my partner became very violent. I turned to drugs and eventually lost custody of my children to social services. My children have now been adopted, and for the past 7 years I have had no contact other than 'letter box' contact twice a year.

Before coming to prison I was committing crime on a daily basis in order to fuel my drug addiction to Heroin and Crack Cocaine. I was arrested for Robbery in 2005 and received an indeterminate sentence for public protection (IPP) with a tariff of at least 2½ years to serve until I could be considered for parole. To date I have served 5 years 3 months and am due to 'sit' my parole in 2 days. I have struggled throughout my life and sentence with regards to my mental health and have had issues surrounding the loss of my father in 2007. I had a bad drug habit for the first 2½ years of my sentence. My drug use certainly contributed to the many 'breakdowns' that I have had. When first coming to prison I did not have a good rapport with most of the staff, but as I have grown up and come to terms with my sentence and the death of my father I have become more willing to work with staff.

I have been diagnosed with a number of mental health problems, the most recent being a personality disorder. I have in the past suffered auditory hallucinations, paranoia, threat and social anxiety, emotional disregulation and obsessive compulsive disorder (OCD). I have also been told that I have traits of Post Traumatic Stress Disorder. I am quite an intelligent person and I have an exceptional insight into my own mental health problems, but it has only been since working with the 'At Arm's Length' project that I actually accepted I had self-harmed a lot more than I was ever willing to admit i.e. obsessive washing. Accepting that OCD has nearly always been a form of self-harm has made me accept that I will need help for years to come instead of putting it down to being 'just a little stressed'. It has been a relief to admit to myself that I am a self-harmer in regards to my OCD as I don't beat myself up about it as much as I used to.

The way staff deal with self-harm, in my opinion, is quite good. You do get staff that aren't helpful but then you get staff that will always go out of their way to try to help and understand.

I have always been able to have a good relationship with other prisoners, this is mainly due to the fact that I have been in prison many times before and have a reputation as being a firm but fair person. I also have the ability to empathise with other ladies in prison as there is not much I haven't been through myself. People interest me and I will always give someone a chance. I have better relationships with people when I am in prison and I am not focussed on drugs all of the time. When I used to be out of prison I had no time for anyone, all that interested me was taking drugs.

I have been resuscitated a couple of times after tying ligatures but I don't 'cut up'. I have self-harmed through limiting my food intake and washing obsessively. I have had a lot of experience of being around others that self-harm and believe that I have a good understanding of the reasons why they do it. Even though I have been in prison a long time I still find it hard to deal with. The way staff deal with self-harm, in my opinion, is quite good. You do get staff that aren't helpful but then you get staff that will always go out of their way to try to help and understand. You get good and bad in all areas of life and prison is no different.

I didn't know anything about the 'At Arm's Length' project until I found out that my name had been put forward as someone who had the ability to deliver PowerPoint presentations. Once I was introduced to James, the research associate, I had a look over the material and decided that it was something I would like to be involved with. I did have reservations about my ability to deliver presentations to staff, not because I didn't think I was capable, I just doubted myself being able to put aside the irrational assumptions I was thinking in regards to staff opinion of me. But I decided to stick it out regardless. I felt that, as a prisoner, I had somewhat of a responsibility towards the girls who had worked with James to make the project, as they had put so much work in to it and in a way I felt like I was representing them. There were times when, mostly due to nerves, I didn't want to turn up but I did, and I am glad that I was so determined as I have gained so much confidence from it. My self-esteem and confidence have grown since getting involved with the 'At Arm's Length' and I have greater understanding of self-harm. The most important thing to me though is that I feel like the presentations are making a difference.

My self-esteem and confidence have grown since getting involved with the 'At Arm's Length' and I have greater understanding of self-harm. The most important thing to me though is that I feel like the presentations are making a difference.

The response from staff has been a lot different than what I expected it to be. When we first started to roll out the presentations I thought that most staff would be sitting there thinking it was wrong for a prisoner to be telling them about anything, let alone self-harm which they deal with first hand on a daily basis. I assumed they would be looking at me with the opinion I had no right to tell them anything as I was a prisoner. How wrong I was! The staff listen to what I have to say and it appears they appreciate the insight in to self-harm they get being as they get it from an prisoner's point of view. This is also reflected in the questions I get asked after almost each presentation and the comments that are written on the feedback forms. In my opinion I feel that the staff are different towards me as it seems they now feel they can approach me and me things without them worrying whether or not they are going to offend me.

I think that the awareness sessions have made a big difference and have given the staff a better understanding of self-harm in general. I believe the officers now feel that what they are doing is right which makes making them more confident in dealing with and helping self-harmers. Most importantly I believe it has gone a long way in addressing the prisoner-officer divide and as a prisoner it has been overwhelming the support and the positivity shown towards me. The staff's eagerness to engage and learn more, not just about self-harm but other subjects such as drugs, domestic violence etc. The staff are also utilising the packs[21] and I have seen them using them with confidence. The activity boxes[22], in my opinion, in the past have been viewed as nothing more than a waste of time, whereas the packs are being used as a legitimate tool that can help not only the women help themselves, but also help the staff help the women. I don't think that there is a prison in this country that wouldn't benefit from the same kind of awareness programmes.

Staff's reflections

Evaluation of the awareness sessions is, as discussed, an integral aspect of the PAR methodology and service users are arguably not the only 'experts by experience'. Staff delivering frontline services also have expertise that can be sought in order to inform evaluation/critical reflection and utilised in the development of initiatives. For these reasons staff attending the awareness sessions are asked to complete an evaluation form. These focus upon three

21. The 'packs' are care planning action packs designed with the aim of empowering women to develop their own care plans and consider what actions they can take, and what they can ask of others, to help maintain mental wellbeing.
22. Activity boxes contain activities for distraction such as puzzles, colouring sheets etc.

key areas i) how useful attendees found the session and what they practically gained from attending ii) what could be developed to better meet staff's training needs and iii) whether there are other areas staff would benefit from service user led awareness sessions. Responses were anonymous and attendees were encouraged to identify areas of development.

To date the sessions have been delivered to 104 members of staff and 99 evaluation forms have been completed representing a 95 per cent response rate. The authors independently review the evaluation forms to identify themes in each of the three areas outlined above. These independent reviews were then discussed and key themes identified:

i) Usefulness and practical relevance:

Attendees are asked to rate the usefulness of the session on a scale of 1-4, a score of 1 representing 'not at all useful' and a score of 4 reflecting 'very useful'. The mean score over the 99 responses was 3.7 (range 2-4) with a modal average of 4.

When asked about the most useful aspects of the session the vast majority of responses indicated that this was the opportunity to listen to a prisoner's perspective on the use of self-harm.

'Sian's perspective was really useful and informative'

'Hearing Sian's point of view as that is often overlooked when dealing with incidents'

'The perspective of a person who has self-harmed and knows what she's talking about'

'…It's especially helpful to hear what women 'themselves' feel is beneficial rather than what we as staff assume is helpful.'

Attendees were also asked to identify any practical implications they could take from the session. Responses included recognising the importance of using non-judgemental listening skills and of trying to make time to do this.

'Be more aware, listen more'

'Spend more time listening, not judging and using humour!'

'Listen more to prisoners'

There was also a suggestion that staff felt more confident in working with women who use self-harm or at least less fearful of exacerbating the distress.

'Listen more, talk more, don't be afraid to talk in case of saying something wrong.'

'Be less wary of talking about self-harm with women'

'Trust your instincts'

ii) Developments to the session

Constructive feedback received reflected the overall positive response received with attendees suggesting that the sessions could have been longer and delivered more detail:

'Length could be longer'

'Maybe Sian could give more of her insight of self-harming, because it is about their experiences'

'More women to talk about their stories.'

'More women involved (prisoners).'

'Including the views and experiences of more service users.'

To date the sessions have been delivered to 104 members of staff and 99 evaluation forms have been completed representing a 95 per cent response rate.

iii) Future Service User Involvement

Participants were also asked whether there were additional areas in which they felt they would benefit from awareness raising sessions that are developed through service user involvement. 64 (62 per cent) of participants responded 'yes'. Beneficial areas for future awareness sessions included substance use, violence and bullying, mental health problems, sentence planning and reasons for re-offending. One participant commented that:

'This should be done all the time; the women have the knowledge and the realism of the experience'

Discussion

Despite PAR being an underused methodology in the prison system it is clear that staff value initiatives such as awareness sessions written and delivered by those with first hand experience of the subject matter. The use of the method involves close working partnerships with the both the participants and the prison management and this necessarily involves compromise and communication. This was reflected in initial concerns around 'staff'-'prisoner' relationships and how this dynamic may impact upon the women

involved in the project and those that attend the sessions. These concerns were shared by Sian, senior prison managers and the project team alike. The feedback from all those involved however suggests that, whilst such factors need to be considered and monitored, careful planning can overcome such concerns. This may also be assisted by the openness of prison staff to learn and develop their knowledge. The evaluations suggest that, on the whole, prison staff do not claim an expert knowledge on self-harm, despite undoubtedly being very experienced in this field, and as such value learning from the expertise of experience that service user involvement brings. One mutual benefit of the sessions appears to be an increase in confidence. For Sian this is in her ability to deliver training and speak in public and for staff an increased confidence in their ability. It is apparent that, to date, both those attending the sessions and those delivering them reflect that the experience is positive and beneficial.

It is also evident that the sessions are delivering the key messages intended by those who developed the package. Thirty minutes is very brief and given more time more depth and more of the women's stories could be included. However time and resource constraints along with other mandatory training requirements within the prison do not allow for longer at this point in time. A further limitation of the project is that, to date, around only one third of the staff in the prison have received the session and it is acknowledged that this may skew the current evaluation. As the sessions continue to be delivered to more staff it may be expected that more negative evaluations or constructive criticism is received. Feedback will continue to be monitored and the package reviewed as a part of the PAR cycle[23] . The author's feel however that the awareness session and its method of development is a positive first step in the advance of service user involvement in prison staff development and addressing the Sainsbury Centre's criticisms[24] of around the use of PAR in prison research.

On-going evaluation of the sessions' impact as well as the impact of other initiatives in the prison will explore staff attitude and women's experience of care as well as rates of self-harm across the prison and associated costs.

Conclusions

From Sian's and the staff's experience of the sessions there are three key conclusions to be drawn:

1. PAR in the prison setting is possible.
2. The use of PAR in the development of such awareness sessions can be useful for both those developing and delivering the package as well as those receiving it.
3. Prison staff can see the value of service user involvement in other areas of prison life and appear to welcome the use of the method.

Given these we suggest that the continued and developed use of PAR in prisons can ensure research is relevant and practically beneficial for the participants, the wider prison population and the prison staff alike.

23. O'Brien, R. (1998) *An Overview of the Methodological Approach of Action Research*. Available at http://www.web.net/%7Erobrien/papers/arfinal.doc last accessed 12th April 2011.
24. Ibid.

Knowledge and understanding of the autism spectrum amongst prison staff

Paula McAdam *is a Registered General Nurse who works in the primary health care unit of HMP Liverpool.*

Introduction

There will be a number of individuals in the prison system at any given time who are on the autism spectrum. The size of this population is unknown as they may not be diagnosed and there is no mechanism to collect data on those who do disclose this information. Some have written about the incidence of offending and the autism spectrum[1,2] but generally there is very little literature on the topic. Despite a literature search of electronic databases (IngentaConnect, International Bibliography of the Social Sciences, Social Science Information Gateway and Swetswise) little research, other than Myers in Scotland[3], has touched upon the understanding of the autism spectrum by those who work in prisons. Talbot and Riley[4] claim that people who work in the criminal justice system (CJS) do not always know how to support people with certain learning difficulties and the same is likely to be true within prisons. The nature of a prison environment will be particularly challenging for some individuals on the autism spectrum, although there may be some aspects of prison that suit some individuals (e.g. routine; predictability; social isolation; clear rules). This study set out to explore the knowledge that staff have on the autism spectrum, working within one particular prison.

Adjustments required to meet individual needs

In the report, *Fair Access to Care*, the Department of Health[5] talks of the need for people on the autism spectrum to get the services they need. It is not clear whether prisons are included in this or not, but they should be. Her Majesty's Prison service website[6] does make reference to the duty of care of prisoners with disabilities, including autism. They emphasise how reasonable adjustments must be made to accommodate these prisoners, citing legislation in line with the Equality Act[7]. Debbaudt[1] recognises the need for law enforcement awareness campaigns but acknowledges that these need to be sensitive to the needs of the victim, the CJS, and the offender with autism. He believes national and international autism advocacy groups must become more involved in the CJS to organise, lobby and bring media and credibility presence to these endeavours.

Potential issues for a person on the autism spectrum living in prison

The needs of a prisoner on the autism spectrum should be assessed in relation to the three main areas affected, that is, in relation to their communication, their social understanding and their flexibility of thought and behaviour. In addition, some adults may experience difficulties in terms of their sensory processing and responses to particular stimuli[8]. They are likely to have problems in communicating their needs; in understanding the communication of others; in understanding the social and emotional behaviour of others; and in managing change and transitions. Their anxiety levels are likely to be high and their response to both staff and inmates may be inappropriate and misinterpreted as challenging. Bullying is a known phenomenon amongst the prison population generally and those on the autism spectrum are likely to be key targets of this. Prison staff need to be vigilant and however good the prisoner's level of functioning appears, carers should look for the areas of vulnerability and provide appropriate support[9].

1. Debbaudt, D (2002) *Autism, advocates and law enforcement professionals: recognising and reducing risk situations for people with autism spectrum disorders.* London: Jessica Kingsley.
2. Murrie, D.C, Warren, J.I, Kristiansson, M and Dietz, P.E. (2002) Asperger's syndrome in forensic settings, *International Journal of Forensic Mental Health.* 1, 1, 59-70.
3. Myers, F (2004) *On the borderline? People with learning disabilities and/or autistic spectrum disorders in secure, forensic and other specialist settings.* Scottish development centre for mental health. 25 June 2004 (www) http://www.scotland.gov.uk
4. Talbot, J and Riley, C (2007) No one knows: *Offenders with learning difficulties and learning disabilities, British Journal of Learning Disabilities.* 35, 3, 154-161.
5. Department of Health (2006) *Better services for people with an autistic spectrum disorder. A note clarifying current Government Policy and describing good practice.*
6. HM Prison Service (2007) (www) http://www.hmprisonservice.gov.uk
7. Equality Act (2010) (WWW) http://w.w.w.legislation.gov.uk
8. Bogdashina, O (2003) *Sensory perceptual issues in autism and Asperger syndrome,* London: Jessica Kingsley.
9. Jordan, R (1999) *Autistic spectrum disorders: an introductory handbook for practitioners.* London: David Fulton.

Knowledge of the autism spectrum amongst other professional groups

Generally, the literature on how knowledgeable other professional groups are about the autism spectrum is relatively scant. Morton-Cooper[10] argues that medical and nursing staff have patchy knowledge. Similarly, Preece and Jordan[11] found that the knowledge of social workers was insufficient. Kirby, Davies and Bryant[12] investigated teachers versus GPs knowledge of six specific learning difficulties, including Asperger syndrome. They found teachers fared better at defining the term, although both groups gave many incorrect responses.

The autism spectrum and criminality

Some of the literature supports an association between the autism spectrum and criminality, but not all. Haskins and Silva[13] found that those with high functioning autism were over represented in criminal populations in the United States of America compared with their prevalence in the general population. Scragg and Shah[14], in their Broadmoor special hospital study demonstrated similar findings and suggested that there may well be more people on the autism spectrum in prisons in the UK than is realised. However, there are many more researchers refuting these findings. Howlin[15] doubts the findings of the study by Scragg and Shah[14] as the numbers were very low. A significant body of research suggests that those on the autism spectrum are no more likely to commit offences than anyone else[16,17,18,19.]

Design of the study

A survey was the main approach used amongst a group of prison staff. A questionnaire was devised and piloted to ascertain the level of awareness and understanding on the autism spectrum. Autism and Asperger syndrome were used as separate terms in the questionnaire. Confidentiality and anonymity of participants was made explicit. Ethical considerations and official permission from the Deputy Prison Governor and the Primary Care Trust (PCT) employer were adhered to. Respondents were given time to read the consent form before signing and returning to the author, via the internal mail system. A month was allowed for the return of questionnaires.

A five point Likert[20] scale was used predominantly for the questionnaire. Occasional questions or statements asked for either/or responses as well. Likert scaling allowed respondents to specify their level of agreement to a statement. It is suitable for this diverse staff group as it provides them with a structure and is user friendly. However, there is no scope to get richer information on their exact knowledge or understanding, as in qualitative methods.

Sample

The sample consisted of 75 staff who worked with the prison population (see Figure 1):

Figure 1:
Staff who received the questionnaire

- Registered General Nurses (RGN) (Primary care in GP surgeries)
- Registered Mental Nurses (RMN) (In Patients (hospital))
- Dual diagnosis nurses (dealing with those with mental health and drug or alcohol problems) and a crisis intervention nurse
- Mental Health In- Reach team (RMNs and a social worker)
- Psychologists
- GPs and visiting psychiatrists
- Teachers
- Drug dependency team RGNs and RMNs.
- Probation officers
- Prison Governor
- Prison wing officers
- Prison workshop officers
- Chaplains

Independent Monitoring Board members (I.M.B). These are a group of ordinary, independent, unpaid members of the public who monitor day-to-day life in prison to ensure that proper standards of care are maintained.

10. Morton-Cooper.A (2004) *Health Care and the autism spectrum. a guide for health professionals, parents and carers.* London. Jessica Kingsley.
11. Preece, D and Jordan, R (2007) Social workers' understanding of autistic spectrum disorders: An exploratory investigation, *British Journal of Social Work* 37, 925-936.
12. Kirby, A, Davie, .R and Bryant.A (2005) Do teachers know more about specific learning difficulties than general practitioners? *British Journal of Special Education* 32, 3, 122-126.
13. Haskins.B.G. and Silva. J.A. (2006) Asperger's disorder and criminal behaviour: Forensic-psychiatric considerations, *Journal of the American Academy of Psychiatry Law,* 34, 374-84.
14. Scragg, P and Shah, A (1994) Prevalence of Asperger's syndrome in a secure hospital, *British Journal of Psychiatry* 165, 679-682.
15. Howlin, P (2000) Outcome in adult life for more able individuals with autism or Asperger syndrome, *Autism* 4, 1, 63-83.
16. Ghaziuddin. M, Tsai.L.Y. and Ghaziuddin. N (1991) Brief report. Violence in Asperger syndrome: a critique, *Journal of Autism and Developmental Disorders* 21, 349-354.
17. Attwood, T. (1998) *Asperger's syndrome: a guide for parents and professionals*, London: Jessica Kingsley.
18. Woodbury-Smith, M.R., Clare, I.C.H, Kearns, A and Holland.A.J (2006) High functioning autistic spectrum disorders, offending and other law breaking: Findings from a community sample. *Journal of Forensic Psychiatry and Psychology* 17 , 1, 108-120.
19. National Autistic Society (2005) *Autism: A guide for criminal justice professionals*. London: National Autistic Society.
20. Likert, R (1932) A technique for the measurement of attitudes. *Archives of Psychology* 140, 1-55.

Findings

The survey was conducted in the autumn of 2007. A total of 53 out of seventy five questionnaires were returned (71 per cent) which was an excellent return rate for this type of survey. The rate was probably enhanced as the author worked within the prison and so was known to many.

Knowledge of autism and Asperger syndrome

Thirty five respondents (66 per cent) said they knew what autism was and a smaller number of staff (49 per cent) said they knew what Asperger syndrome was. Ten years ago, hardly anyone would have heard of Asperger syndrome (Attwood[17]). But, it is perhaps those with Asperger syndrome who are more likely to experience prison, according to the present author's experience and that of others (Holland et al[21] and the National Autistic Society[19]). The vast majority of respondents (83 per cent) agreed that autism or Asperger syndrome varies from person to person. Five respondents (9 per cent) disagreed or strongly disagreed and four respondents (8 per cent) did not know. Almost two thirds of respondents recognised sensory sensitivities in this population and almost one third did not. The senses staff thought were affected are shown in Figure 2: The most commonly affected sense was given as auditory, followed by tactile and visual.

Figure 2:
Senses that staff think are affected in autism or Asperger syndrome

Sight	18	(34 %)
Sound	31	(58 %)
Touch	22	(42 %)
Taste	11	(21 %)
Smell	9	(17 %)
Don't know	17	(32 %)

The general noise level in a prison, the potential for intimidation and confrontation, frequent fighting and disruptions cannot fail to have an impact on those on the autism spectrum. The potential for sensory overload is a real one and staff must recognise this.

The majority of respondents (85 per cent) thought did not think it was possible to detect autism or Asperger syndrome merely by looking at a prisoner. Six respondents were undecided and two thought that it would be possible. Eighty per cent of respondents recognised that eye contact in these prisoners would be different than most people.

Sources of information on autism and Asperger syndrome

Staff were asked where they got their information from (more than one box could be ticked). Respondents gave the following sources:

- Job contact
- Son being investigated for Asperger syndrome
- Friend has Asperger syndrome; friends child has Asperger syndrome; personal contact
- University, College, Teacher or Learning Disability Nurse training
- My own research
- Prisoner contact.
- Partner is a teacher.
- Information from my manager.
- Working with people with Asperger syndrome.
- Contact through my GP practice.

Six respondents did not specify where they got their information from.

Respondents were also asked which media sources they had gained information from. Television (30 per cent) and books (21 per cent), with only 6 per cent of respondents mentioning the Internet and newspapers.

Staff views on the likelihood of individuals on the autism spectrum offending

Only 6 per cent of staff thought there was an increased likelihood of offending in this population, with 51 per cent stating that this was not the case and 38 per cent being undecided on this issue.

Number of staff who thought they had worked with a prisoner on the autism spectrum

Twenty one staff (40 per cent) said they had worked with a prisoner on the autism spectrum, 11 said they had not and 40 per cent of respondents said they did not know. It is apparent that quite a number of staff may not know that some prisoners they work with are on the autism spectrum. This may have serious implications for the nature and outcome of their interactions. The knowledge deficits of staff indicate a need for in-prison staff training on the autism spectrum. A training programme geared towards a prison environment is recommended by the author and ideas for an information sheet are listed in **Appendix 1**.

Views on the stress levels of prisoners on the autism spectrum

Almost 80 per cent of respondents felt that the stress levels amongst prisoners on the autism spectrum would be higher than those of other

21. Holland.T, Clare, I.C.H. and Mukhopadhyay, T (2002) Prevalence of criminal offending by men and women with intellectual disability and the characteristics of offenders: Implications for research and service development. *Journal of Intellectual Disability Research*, 46 Supplement 1, 6-20.

prisoners. In terms of the most suitable location within the prison for these prisoners, 35 per cent of respondents felt that the prison hospital might be the best location, or in the segregation wing (6 per cent), but 59 per cent felt that the main prison wing would be fine. Over a third chose hospital admission but this may not always be best practice according to the *Prison Service Order 2855 — Prisoners With Disabilities*[22]. This mandatory prison instruction includes those on the autism spectrum and advocates 'normal' location if possible, so as to not miss out on accessing all of the prison regime. Only a small number (4 per cent) thought the segregation wing to be most appropriate. Debbaudt[1] advocates segregation first until an initial assessment is completed. Overall, it is crucial that a detailed assessment of the needs of each individual is made to determine provision, rather than provision which is allocated on the basis of the diagnostic label alone. One size does not fit all.

Implications and recommendations

The Director of the Prison Reform Trust recently stated,

'The prison service is our least visible and, arguably, most neglected public service.' [23].

The need for a new and reliable evidence base for more appropriate care practices for those on the autism spectrum in our prisons is apparent. Moving away from prison staff being reactive in nature, as Lyon[23] suggests is the case at the moment, to reaching a better understanding through autism-specific training would be beneficial. If staff have some basic knowledge, they may then be able to appropriately and effectively assist prisoners on the autism spectrum. Disability awareness training (including autism) is not readily available for staff in prisons according to Talbot and Riley's[4] '*No-One Knows*' research. It is encouraging to note that Autism West Midlands, in the UK, is currently planning in-house prison staff training in their local young offenders institute (Hatton, personal communication).

Further research needed

Further research would be beneficial. A study examining the perspective of prisoners on the autism spectrum and their prison experiences would be useful. If practitioners consult with those who receive the service, then service provision is more likely to match needs. Gaining access to prisoners on the autism spectrum is problematic though, due to small numbers, identification difficulties and ethical considerations, to name but a few.

Greater coordination of information and assessment within prison environments and a shared single assessment model within secure settings is advocated by Myers[3]. Collaboration amongst all criminal justice agencies, so all staff are informed and are able to assist and support prisoners on the autism spectrum throughout the criminal justice process, makes sense. A key worker to assess each prisoner's needs and to make appropriate provision as soon as possible would be of benefit. A screening tool or special needs assessment at the point of admission could be used for all prisoners. The initial information could be shared with the Disability Discrimination Officer (with the prisoner's permission) to follow up care. A multi-disciplinary network should be in place whereby continuity of support (perhaps including advocacy arrangements) are in place to help, especially with transitions (e.g. from prison to court). The Department of Health[5] states that people on the autism spectrum sometimes get excluded from advocacy initiatives. Talbot and Riley[4] found that it was the local prison for adult men that were the least likely of all prisons to have advocacy arrangements.

Concluding comments

Forensic services for those with learning disabilities have been slow to address the needs of those on the autism spectrum. It would be wise to make use of learning disability psychiatrists, competent in dealing with this population, in the assessment and treatment of offenders, as current learning disability services are not resourced to provide a service to prisons. Implementing a service would require dedicated funding which would have cost implications. More research is needed to justify a service such as this. A dedicated regional autism forensic unit could also be an option for those not managing a conventional prison placement. Services in prisons tend to have a radically different philosophy which is centred on security and control. The Equality Act[7] stipulates that public organisations need to understand how their services are experienced differently by those on the autism spectrum and to make reasonable adjustments as a consequence. Realistically though, developing a clear service responsibility or policy focus on the autism spectrum in prison is a tall order.

To conclude, it is clear that we have an under-served population of vulnerable prisoners who may be misunderstood by a significant number of people looking after them. The results of this study form a first step, but

22. HM Prison Service (2008) Prison Service Order 2855. Prisoners with Disabilities (www) http:/www.hmprisonservice.gov.uk
23. Lyon, J (2007) *Locked in a crisis*, 30.08.07 (www) http://www.commentisfree.guardian.co.uk

more extensive research and greater analysis needs to be done on a scale not permitted by this study. To conclude, Mills[24], the Director of Public Prosecutions, said,

'*People with particular disabilities need help from everyone in the CJS, and we must all be on the alert to do the best we can for them.'*

Appendix 1:
Suggested information on the autism spectrum for staff working in prisons

Autism Spectrum – The Facts

Autism spectrum is an umbrella term which includes a range of conditions, including autism and Asperger syndrome.

Three areas of development are affected:

1. Communication.
2. Social and emotional understanding and interaction.
3. Flexibility of thought and ability to problem-solve.

These affect the way a person communicates and interacts with other people. Their intelligence may be average or well above average, but problems with social awareness and understanding remain.

What can you do to help?

1. Use the prisoner's name when you are talking to him.
2. Keep your language clear and minimal.
3. Wait and allow a little longer for information to be processed.
4. Listen to the prisoner. Ask direct, concrete questions.
5. Avoid abstract language. This prisoner takes things literally, so be exact.
6. Do not shout. This prisoner may be noise sensitive.
7. Be consistent. Tell this prisoner what is happening next.
8. Deal with one thing at a time.
9. Visual support often helps, so write things down if the prisoner is unsure.
10. Avoid crowds if possible.
11. Avoid queueing. (eg. wait until the queues are short or attend to this prisoner first or last).
12. Keep physical restraint to a minimum. This prisoner may be touch sensitive.
13. Allocate a key worker for support.
14. Keep to a daily routine and avoid change without warning.
15. Put rules and structure in place.
16. Offer purposeful activity (e.g. education or work).
17. Consider single cell accommodation or segregation on the vulnerable prisoner's wing.
18. Consider the befriending or anti bullying scheme.
19. Encourage daily exercise.

Everyday prison noises can be stressful and may cause pain and anxiety. This prisoner may plug his ears. If so, try to remove him to a quieter environment as soon as you can.

Invading personal space and touch can be stressful. If you have to search this prisoner or apply hand cuffs, please explain what you are doing first.

Remember!

1. Autism/Asperger syndrome is not a mental illness. It is a neurological difference in development.
2. You can not see it.
3. If the prisoner appears rude, aloof, or ignores you, this is not intentional. It is an aspect of his condition.
4. This prisoner may not look at you or he may have a different type of eye contact, because of his condition.
5. This prisoner may not be able to ask for help when he really needs it.
6. This prisoner tends to like rules, but be explicit with them.
7. This prisoner may get easily startled.
8. This prisoner tends to be anxious so offer explanations, reassurance and support.
9. Everybody is unique. No two prisoners with autism/Asperger syndrome will be the same.

24. Mills, B (1998) *Crown prosecution service: Criminal justice system must help people with learning disabilities.* (www) http://www.cps.gov.uk Archived press release 12.02.98.

The impact of the custodial setting on the mental health of older prisoners:

a biopsychosocial perspective

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Introduction

Much literature and research exists around the issue of mental health within the prison setting. It is an accepted fact that incidences of mental health problems, personality problems and drug and alcohol use are substantially higher within the prison walls than in the community which lies outwith them[1]. However, little acknowledgement is made of the variety of sub-groups within the prison population and the particular effects that imprisonment has on their mental health. One such group is older prisoners.

This paper will highlight those biopsychosocial factors which impact on the mental health of older male prisoners in particular. Considering this issue from a biopsychosocial perspective also raises opportunities within such a framework to promote positive mental wellbeing amongst this group of prisoners.

The Elderly Prison Population

For the purposes of this paper, older prisoners shall be taken to refer to those members of the prison population who are aged 50 and over. There is some disparity within the literature as to what constitutes an 'older' prisoner. However, in terms of the prison population, those over the age of 50 are relatively elderly in comparison with the overwhelming majority of younger prisoners[2].

A search of the literature has shown that surprisingly little is written about this group of prisoners and their unique needs, and that no local or nationwide policy exists that relates to any mandatory requirement to meet these needs within the prison environment. This is the case despite the fact that since 2004, the Disability Discrimination Act (DDA) has applied within prisons[(2)], and has obvious repercussions for the treatment and management of elderly prisoners who may be less mobile or able than the general prison population.

The DDA carries the requirement that all public authorities will proactively promote equal opportunities for disabled people, eliminate discrimination, actively encourage participation in public life of disabled people, and to account for individual's disabilities – including positive discrimination if necessary[3].

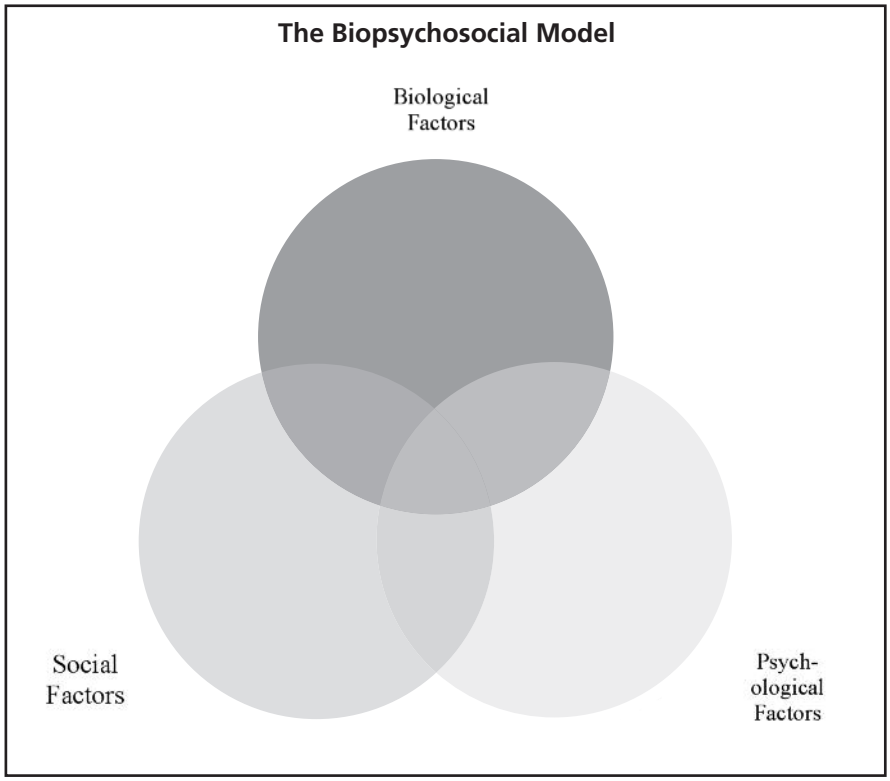
The application of such legislation within the prison setting is challenging. As we shall explore, the regimen is often rigid and inflexible, allowing little leeway for allowances to be made in order to accommodate such stipulations.

No Problems: Old and Quiet

This is the title of a thematic review produced in 2004 by HM Inspectorate of Prisons[4] which aimed to look at the specific issues, including the mental health, of older prisoners in England and Wales. The report highlighted the specific needs of the 1700 older prisoners in the system at that time as a neglected area, with specific areas of good practice being few and far between. Major problems for older prisoners were highlighted in the areas of the physical environment of the prison, limitations and restrictions created by the regimen, appropriate assessment of health and social care needs and preparation for release and resettlement.

Of the 83 000 people incarcerated within England and Wales in 2009[5], 7358 were aged 50 and over, and 518 were aged 70 and over. This represents around 9 per cent of the total prison population and the number is continuing to increase. In actual fact older prisoners are the fastest growing group within the prison population[6]. This statistic reflects both a large number of prisoners convicted of lengthy sentences who are growing old within the prison walls, as well as a number of prisoners convicted (often of sexual offences) later in life and who may reasonably expect to

1. Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. (1997). *Psychiatric Morbidity Among Prisoners.* ONS; London.
2. Kakoullis A, Le Mesurier N, Kingston P. (2010). The Mental Health of Older Prisoners. *International Psychogeriatrics;* 22, 5, pp693-701.
3. Disability Rights Commission. (2006). *Statutory Code of Practice for England and Wales on the New Disability Discrimination Act 2005*.
4. HMIP. (2004). *No Problems – Old and Quiet: Older Prisoners in England and Wales*. HMIP; London.
5. MoJ. (2009).
6. Prison Reform Trust. (2010). *Doing Time: Good Practice with Older People in Prison – the Views of Prison Staff*. Prison Reform Trust; London; ISBN: 0946209944.



end their lives in prison. The latter may well have committed their crimes earlier in life, and have been convicted now, years or decades later[7].

The Biopsychosocial Approach

Based on the work of George Engel[8], this framework for looking at the health and mental health of individuals can also provide us with a means of examining those custodial factors which may impact either positively or negatively upon the mental health of older prisoners.

In investigating the primary mental health of older male prisoners, it is appropriate therefore to frame this within the parameters of biological factors, psychological factors and social factors. Only by taking account of the interconnectedness of these factors on the wellbeing of the person as a whole can we hope to gain a truly holistic understanding of the issues which affect the mental health of this prisoner group.

Biological Factors — Physical Health and Wellbeing in Custody and Beyond

Standard one of the National Service Framework for older people[9] (a set of standards set out by the Department of Health to provide clear quality standards in health and social care) states that *'NHS services will be provided, regardless of age, on the basis of clinical need alone.'* This has obvious implications for elderly people in the prison setting for who issues of both provision and access might stand in the way of them receiving the healthcare interventions they require. Furthermore, standard two of the same document advocates the individual being able to make choices about the care they are receiving. Again, within the prison walls, choice may be very limited or even non-existent.

Older prisoners with physical health problems may find that there are significant difficulties in accessing facilities within the prison. The Prison Reform Trust's paper *Doing Time*[10] highlights that of the 92 prisons they sampled in England, two had no access to the healthcare department. This has obvious implications for the ability for healthcare needs to be assessed and met in a timely and equitable manner.

Nacro and the Department of Health[11] rightly point out that *'growing older is inevitable, but being in poor health as one grows older is not'*. However, some studies[12] suggest that there is a direct correlation between coming into custody and deterioration in physical health.

7. Kakoullis, Le Mesurier, Kingston (2010) see n.2.
8. ngel GL. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science*. 196; 4286; pp129-136.
9. DoH. (2001). *National Service Framework for Older People*. DoH; London.
10. See n.6.
11. NACRO, DoH. (2009). *A Resource Pack for Working with Older Prisoners*. NACRO; London.
12. Colsher PL, Wallace RB, Loeffelholz PL, Sales M. (1992). Health status of older male prisoners: A comprehensive survey. *American Journal of Public Health*. 82; 6; pp881-84 and Aday RH. (1994). Aging in prison: A case study of new elderly offenders. *International Journal of Offender Therapy and Comparative Criminology*. 38; 1; pp79-91.

There is evidence that the physical health of older prisoners is worse than that of their counterparts outwith the prison walls. It has been suggested that the average older prisoner has the physical health and condition of someone ten years older than them in the community, giving the average 60 year old prisoner the same state of health as someone aged 70 in the community[13]. The relationship between poor physical health and poor mental health is well evidenced[14].

It can reasonably be expected that due to lack of choice and opportunity in terms of diet exercise and other lifestyle choices, the physical health of older inmates will deteriorate more rapidly than a younger person or someone of a similar age in the community, and this is likely to lead to decreased mental wellbeing or mental illness such as anxiety and depression.

Furthermore from a healthcare perspective arrangements around the provision of palliative care may be an important consideration in the treatment and management of those who will end their lives in the prison environment. In addition to this there is also an issue around the management of organic mental health problems such as dementia amongst an aging prison population, although exploration of this is beyond the limited scope of this work.

It has been suggested that the average older prisoner has the physical health and condition of someone ten years older than them in the community . . .

It might be fair to draw the following conclusions. Firstly, there is a marked difference between the elderly prison population and the elderly general population in terms of physical health condition, namely that the elderly people in custody experience poorer physical health than their peers in the community.

Secondly, this factor raises issues for the delivery of healthcare interventions and treatments for the elderly in custody. Opportunities for timely treatment of physical healthcare needs and for health promotion activities are available in the prison setting and need to follow prisoners out into the community on release to enable a successful outcome in their resettlement[15]. However, as the HMIP report of 2008[16] states, often effective management and treatment of chronic physical health problems can be disrupted by prisoners being moved from one establishment to another.

Thirdly the issue of end of life treatment choices and palliative care options within the prison system warrants further exploration and debate.

Fourthly, deterioration in physical health is very likely to have implications for the emotional and mental health and wellbeing of this population group within the prison setting. It is this which this author will now attempt to explore further.

Psychological Factors — Psychiatric Morbidity, Suicidality and Risk

The HMIP Thematic Review of 2008(14) highlights a lack of training amongst staff to spot the signs of mental health difficulties amongst older prisoners, and cites this as an area of concern *'especially in light of the elevated levels of depression among the older age group'*. It goes on to point out that *'of those with mental health problems, 78 per cent were experiencing depression, or reactive depression as a result of imprisonment'*.

The report suggests that the NSF standards for the care of older people are not uniformly implemented within the prison system, with only pockets of good practice being identified. This may be due to the lack of a national prison service policy or protocol on the treatment of mental health problems in older prisoners. The report goes on to highlight the gap that exists within prisons in the treatment of mild to moderate primary mental health problems due to the role and criteria of Mental Health Inreach Teams (MHIT) to treat severe and enduring mental health problems[17]. However, this report dates from 2008, and this author would suggest from practical experience, that this gap is rapidly closing.

Standard seven of the NSF for older people clearly states that *'older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and*

13. Kakoullis, Le Mesurier, Kingston (2010) see n.2.
14. CSIP. (2006). *Improving Primary Care Mental Health Services: A Practical Guide*. DoH; London.
15. Crawley E. (2004). *Release and resettlement: the perspectives of older prisoners. CJM.* 56; summer 2004; pp32-33.
16. HMIP. (2008). *Older Prisoners in England and Wales: A Follow-up to the 2004 Thematic Review by HM Chief Inspector of Prisons*. HMIP; London.
17. DoH/HMPS. (2001ii). *Changing the Outlook: A strategy for developing and modernising mental health services in prisons*. London; Department of Health & HM Prison Service.

their carers.'[18] It points to the fact that mental health problems in the elderly population commonly go undetected, or are simply attributed to the natural ageing process and are untreatable. The document highlights three key interventions, namely the promotion of mental health, early recognition and management of mental health problems and access to specialist care. HMIP[19] reports very little indication that any of these guidelines are being applied in a widespread and consistent manner across the prison estate.

It is far more likely for older prisoners to suffer from depression than any severe or enduring mental health problem, or drug-related problem[20]. It is clear from this fact, and those presented above, that primary mental health care plays a central role in meeting the health and social care needs of this particular prisoner group.

Social Factors — Isolation, Social Exclusion and Reduced Social Capital:

On entering prison in later life, many people are leaving behind families, jobs, friends and hobbies, often with little prospect of ever returning to them, and due to the mobility of the prison population may be held in prisons far away from home, reducing the likelihood of continuity of important and significant relationships and support networks. This has implications in terms of adjustment, affect, anxiety, stress, social isolation and suicidality.

The Department of Health's *A Pathway to Care for Older Offenders*[21] raises a number of key questions and recommendations relating to the NSF for Older People standard two. It indicates the frequent lack of compatibility between the prison regimen and the health and social needs of older prisoners. The often rigid and inflexible nature of the prison regimen and the negative impact this can have on older prisoners is described in detail elsewhere[22].

The document highlights three key interventions, namely the promotion of mental health, early recognition and management of mental health problems and access to specialist care.

The prison environment itself is likely to have an impact on the mental health and wellbeing of older prisoners. An HMCIP report made in 2004[(4)] states that *'Prisons are, in the main, built for young, able-bodied prisoners'*, with very few prisons having purpose-built or specially adapted facilities for elderly or disabled prisoners. Similarly the regimen within prisons tends to be biased towards younger men of working age and good physical health.

A combination of inaccessibility within the fabric of the environment and the restrictions, limitations and inflexibility of the regimen contribute to what Crawley[23] describes as 'institutional thoughtlessness.' An example to highlight what this means in reality might be that older prisoners may have to negotiate stairs to access medication, meals or educational and work opportunities. It may also mean that older prisoners find it hard to utilise facilities within the wing setting such as showers, either because they cannot reach them or because they are intimidated or put off by younger, more boisterous inmates accessing them at the same time. Exercise periods might become impossible for older prisoners to manage due to lack of access to toilet facilities or seating in the exercise yard, and the fact that they are unable to re-enter the building for the duration of the exercise period (usually one hour).

It is clear then that institutional thoughtlessness can have a significant impact on the mental health and wellbeing of older prisoners, contributing to low mood, stress and anxiety.

By its nature and purpose, prison is an excluding experience[24]. Statistics show that many elderly prisoners have been convicted late in life for an offence committed years or even decades earlier, and find themselves entering custody for the first time at this late stage in their lives[25]. This has been described as 'prison shock.'[26] It describes the experience of older

18. DoH. (2001) see n.9.
19. See n.16.
20. Le Mesurier N, Kingston P, Heath L, Wardle S. (2010). *A Critical Analysis of the Mental Health of Older Prisoners: Final Report*. Centre for Age and Ageing, South Staffs NHS PCT, Staffs University.
21. DoH. (2007). *A pathway to care for older offenders: A toolkit for good practice*. DoH; London.
22. Crawley E. (2005). Institutional thoughtlessness in prisons and its impacts on the day-to-day prison lives of elderly men. *Journal of Contemporary Criminal Justice*. 21; 4; pp350-63 and Crawley E, Sparks R. (2005). Hidden Injuries? Researching the experiences of older men in English prisons. *The Howard Journal*. 44; 4; pp345-56.
23. Ibid.
24. Caie J. (2011). Social inclusion and the prison population. *Mental Health Practice*. 14; 6; pp24-27.
25. Prison Reform Trust. (2003). *Growing Old in Prison: A Scoping Survey on Older Prisoners*. Prison Reform Trust.
26. Aday (1994) see n.12.

prisoners as they try to come to terms not just with the prison environment, but also with their crimes, and points to *'depression, guilt and psychological stress'* as being prevalent in this study group.

It might be argued that one of the characteristics of the prison population is its transient nature. As well as endangering family and existing social ties on entering custody, the older person becomes part of a system where they and others are moved from one establishment to another on a reasonably regular basis.

Friendships and ties formed in one prison are likely to be short-lived as people move on or are released. On top of this comes the fact that amongst the older prison population, as is the case outside prison, death is a natural variant in the changing and shifting of social networks.

Social networks are then unstable and temporary within the prison walls. This author is not aware of any studies in existence which look at the likely impact that this would have on the emotional and mental wellbeing of older prisoners, however based on what this review has already discussed, it might be a fair assumption that it would be highly unsettling and unhelpful.

A Sure Start to Later Life, a document produced jointly by the Department of Health, the Department of Work and Pensions and the Social Exclusion Unit[27] states that *'Many older people find it very difficult to access intermediate care services as they do not have an appropriate discharge address'*. It goes on to highlight the fact that *'older homeless people are likely to have a greater need for care than younger people.'*

Clearly there is a link between entering prison and a worsening of physical health complaints. Often on admission to custody older males are already experiencing poor physical health and the conditions within prison worsen this.

Biopsychosocial Opportunities

In summary, the review of the literature has showed the interconnectedness of biological, psychological and social factors in the onset or worsening of primary mental health problems amongst older male prisoners.

Clearly there is a link between entering prison and a worsening of physical health complaints. Often on admission to custody older males are already experiencing poor physical health and the conditions within prison worsen this. This however provides an opportunity for commissioners and providers of prison healthcare to offer both health promotion activities and to effectively diagnose and treat physical health problems which the individual are in essence a 'captive audience'. There are also opportunities arising to ensure that the interfaces between prison and community healthcare provision and between healthcare departments of individual

prison establishments is smooth, atuned to the needs of the individuals accessing it and equitable in order to provide continuity of care and treatment.

Psychologically, the research has shown that the standards set out under the NSF for older people are not uniformly met within the prison service, and that there is a lack of access to specialist services. In addition, diagnosis and risk assessment are not always accurately carried out in a timely manner. This again highlights an opportunity for prison health services to improve and develop specialist services for older people within the prison setting and to effectively diagnose, treat and monitor the mental health of older people.

Difficulties arising out of the social aspect of the biopsychosocial model are harder to address in custody, but their impact on older people in prison is easy to see.

There are compelling arguments for the timely and effective treatment of physical and mental health problems amongst the elderly prison population, not least of all financial considerations. Whilst no accurate figures are available for the treatment of older people within the UK prison system, data from the United States suggests that medical costs associated with older prisoners are around three times higher than those of their younger counterparts[28].

There are clearly a number of effective biopsychosocial interventions ranging from work and education to exercise, access to psychological interventions and medication which could be utilised to

27. Social Exclusion Unit. (2006). *A Sure Start to Later Life: Ending Inequalities for Older People*. Office of the Deputy Prime Minister; London.
28. Wahidin A, Aday R. (2005). The Needs of Older Men and Women in the Criminal Justice System: An International Perspective. *Prison Service Journal*. 160; pp13-22.

a greater extent within the prison environment. This too provides both prison managers and healthcare commissioners with an opportunity to look at flexible, cost-effective and creative ways of improving the treatment choices available to older people in prisons.

The introduction of the Improving Access to Psychological Therapies (IAPT) programme in 2006[29] brought about a shift in the healthcare economy. With the aim of reducing the benefits bill and getting people back to work, IAPT is widely available in communities across the UK. It is not so widely available within prison communities however, and must surely be considered as a means of reducing spending on healthcare within prisons, as well as a means of empowering elderly prisoners to engage in some kind of meaningful occupation and activity which will improve their quality of life.

Practice, Policy and Research Implications

Surprisingly, and perhaps shockingly, there is no national policy within the Prison Service as to how elderly prisoners should be treated and dealt with. This appears to have led to inconsistency in approach and in the provision of facilities and appropriate regimen across prisons in England and Wales. Effectively this author sees this as meaning something of a 'postcode lottery' for older prisoners, and can surely only lead to an unsettling experience, the effects of which may lead to the onset of mental health problems as well as inconsistent treatment and exacerbation of existing physical and mental health difficulties. Without such a policy it is doubtful as to whether both the prisons and their healthcare commissioners and providers will be able to grasp the opportunities highlighted in the section above.

Surprisingly, and perhaps shockingly, there is no national policy within the Prison Service as to how elderly prisoners should be treated and dealt with.

Further research into the experience of older prisoners and the treatment of their mental health needs may raise the profile of this group and spur the prison service on to provide a policy which will ensure consistency, consideration and fair treatment of the elderly prison population. Such research will surely also be of significant value to healthcare professionals responsible for the provision of care and support to older prisoners, and may also highlight the need for NHS Trusts to ensure the input of specialist practitioners to work with this client group.

There is a clear need for staff within the prison walls to receive training so that they can be aware of the problems and distress caused to older prisoners by a fixed and rigid application of the standard regimen. Staff working within the prison service also need to find a way of ensuring that the prison population is not viewed homogenously, but as a diverse group. Whilst this is perhaps beginning to happen in the case of ethnic, cultural and religious groups, the issue of older age as a separate group under the diversity banner is perhaps not so readily recognised. Again, a specific policy would help to bring this to the fore and identify the elderly as a specialist group within the population.

In the face of the evidence, it can be argued that such an overarching policy ought to include guidance to staff on the nature of the difficulties likely to be experienced by older prisoners, and the impact these factors may have on their mental health and ability to cope with their incarceration.

Training on mental health and the management of challenging behaviour already exists, and is in actual fact mandatory for staff working in some areas of the prison estate such as in Discrete Units (Segregation Units, Category A units, Closed Supervision Centres etc) where prisoners held present with complex, dangerous and challenging behaviours and difficulties[30]. However this mandatory training need has not been identified, and does not extend to other groups of prisoners with unique needs, such as older prisoners. It could be argued that as a prisoner group with unique and often complex biopsychosocial needs, specialist training should also be available to, and mandatory for, prison staff working with older prisoners in order to better understand and meet the needs which these prisoners have.

A national policy could also allow for flexibility in the regimen which establishments could tailor to their own needs, or preferably recommend a completely separate regimen, perhaps in separate accommodation, for the elderly population of the prison. Such a policy should take into account the different needs of elderly prisoners, such as the need for meaningful occupation and activity after retirement age; the longer length of

29. Layard R. (2006). *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London; London School of Economics and Political Science, Centre for Economic Performance.
30. Wellbeing Strategy. (2011). *Working With Challenging Behaviour Training*. High Security Prisons Group; HMPS

time which older people may need in order to carry out their daily living activities; the need for more integrated working between prison staff and healthcare and mental health staff; and the accessibility of the accommodation and other facilities provided. In addition to these more abstract needs should be addressed in policy. Needs such as the rights of the elderly to feel safe on the wing and not to be intimidated and bullied by younger prisoners, and the need for dignity and at times privacy, which the main regimen seldom affords.

Some establishments such as HMP Wymott offers facilities especially for the over 50s within its population which is run according to the NSF for the Elderly, and on a biopsychosocial model[31]. Other prisons such as HMP Gartree and HMP Hull have strong links with Age Concern in order to provide advocacy and support to elderly prisoners[32].

Pockets of good practice therefore do exist, and the intentions behind setting such projects up are positive and beneficial to the elderly prisoners housed at these establishments. However, for those elderly prisoners not fortunate enough to be housed at one of these prisons, or who have been and have subsequently moved to another establishment where their needs are not so robustly met, there is still much room for development and improvement. We have seen in this paper the impact which incarceration can potentially have on the mental health of elderly prisoners, and it is surely within the power of the prison service to introduce national measures to benefit this group both from the perspectives of their physical and mental health.

As such this must represent some financial benefit in terms of preventing the onset of chronic conditions and the treatment costs associated with these. Prevention is surely better than cure, both in terms of individual quality of life and in financial implications.

Conclusions

The prevention and treatment of primary mental health problems in older male prisoners, is a subject worthy of further investigation and investment. We have seen that the elderly are the fastest growing group within the prison population, and as such there is a need for both researchers and clinicians to address this growing issue within the walls of our prison establishments.

There is a clear need for further research to be carried out in this area to examine the effectiveness of a variety of biopsychosocial interventions in the care and treatment of primary mental health problems in the elderly prison population. The effectiveness of such interventions has been studied within the general elderly population. However this author would suggest that the prison environment is quite alien to the community setting, and presents those elderly people living within it with a different set of challenges and obstacles in having their needs accurately identified and treated. In addition, the day to day difficulties of living in such a setting, and being party to a restrictive regimen, may call for a more innovative approach to the provision of mental healthcare, and further research may assist in informing practitioners in how best to deliver interventions of an equally high standard as those delivered in community settings. In this instance, equity does not perhaps mean equivalence in terms of what is delivered and how, but rather equivalence in terms of outcome, accessibility and acceptability.

In short, further research and investigation is required in order to ensure that the elderly in prison do not become a forgotten group, but that their voices are heard and their mental healthcare needs are effectively met. This will require not only research and study, but a concerted will from both the prison service and healthcare providers to improve how health and social care services are delivered to older prisoners. This finds us standing on the edge of not only a huge challenge but also a great opportunity. It is entirely possible to ensure specialist training to staff, timely detection and treatment of physical and mental health problems, and creative and effective biopsychosocial interventions to older people with primary mental health needs in prisons. Only then can we positively say that older people in prison are 'no problems, old and quiet'.

31. Fry D, Howe D. (2010). Managing Older Prisoners at HMP Wymott. *Prison Service Journal*.
32. Evans C. (2010). Age Concern Leicestershire and Rutland — HMP Gartree Older Prisoners Advocacy and Support Project. *Prison Service Journal*.

Reviews

Book Review

Out of sight, out of mind: why Britain's prisons are failing

John Podmore
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Price: £14.99 (paperback)

Breakfast. Half an ear cocked to Radio Four. A familiar voice talking eminent good sense about prisons. One brimming with frustration about what could have been and enthusiasm as to what could still be. Podmore is a former prison governor, inspector and head of the Anti-corruption Unit and here he has produced a polemical account of today's prisons, their place in criminal justice and much more.

Much of the ground covered will be familiar to those in the criminal justice system. All, in prisons, at one time or another will have dealt with security for its own sake; the balance between politicians' demands and those of the tabloids (and amendments to the former to appease the latter); the forced abandoning of projects to which staff are committed; and box ticking as measures of achievement.

Podmore writes of the prisons and prisoners he has known well, some the public might regard as notorious. A snapshot of prison history melds into consideration of the security implications of holding high risk prisoners, in some cases alongside petty criminals. He does not flinch from the hugely contentious issues sometimes confronting governors, for example, in keeping a highly vulnerable prisoner in custody beyond the expiry of his warrant since there was no place for him in a psychiatric hospital. With a legal background, I ask 'How could that ever be justified?' The author's explanation leaves me thinking 'How could it not?'

I attended a conference in the early 1970s where Shirley Williams MP, who then spoke for the opposition on prisons, told of her satisfaction in holding that brief. It required no political posturing. The major parties' aspirations for penal policy were so close that all that lay between them was dispassionate debate. How different from recent times. Podmore reminds us of the appointment of Michael Howard as Home Secretary and a departure from previous policies informed by academic research. Red meat punishment became order of the day. A new Director General, Derek Lewis, was imported from business to run prisons like any other business. He omits the symbolism of this. Lewis displaced the thoughtful and humane Joe Pilling who would probably have lent a leavening influence over developing populist policies. Sensitive approaches were no longer wanted. Political imperatives led to scapegoating governors. Lewis was sacrificed and Howard's own Minister for Prisons eventually turned against her former boss.

Things were little different under a different administration. The potentially humane Charles Clarke spoke of population reduction and diversion of the mentally ill, only to leave office over the failure to deport foreign ex-prisoners. Along came John Reid, who had hardly stayed in his many previous ministerial seats long enough to get them warm. The rhetoric of 'more prison places' was resurrected. And all the time, governors were to ride the bewildering roundabouts and swings of the varying and conflicting political initiatives of the day. Add Podmore's account of established systems being 'replaced slowly but inexorably by a privatised prison service' and he argues, cogently, that political doctrine is rapidly taking the place of true reform.

A lengthy chapter is devoted to something, Podmore suggests, is one about which the Prison Service has consistently been in denial: corruption. Graphic accounts are given. His Anti-Corruption Unit imparted a systematic approach to the subject but it is a shame that he needs to denigrate the Professional Standards Unit as 'hardly having an impact on anything other than the precise definition of officer's (sic) uniform.' I recall, for example, that my pretty comprehensive 2004 report, arising from brutality at Wormwood Scrubs, was under its aegis. Despite this, the author's comparison of the way the Metropolitan Police handle alleged corruption, and the Prison Service's half-hearted way, is well made.

Taking prisoners' perspectives on corruption is largely achieved through vox pop. This includes dodges like how to groom staff, acquire mobile phones, drugs, launder cash, escape positive drug test results and trade sexual favours for privileges. Podmore gives accounts of very serious offences orchestrated from jails, often using clandestine mobile phones. It is clear that prisoners' sophistication has moved on some since my Askham Grange prisoner, found with heroin in her knickers, innocently asked the searching officers 'How did that get there?' But there is danger in accepting vox pop at face value. I reflected on my Long Lartin days when reading of the ex-prisoner whose dealing 'earned' him £28,000 over a sentence since 'I had a daughter to get through university; I had to buy her a car.' The same man had mates (plural) who made over £100,000 while inside. Published author but then Category A prisoner, Norman Parker, would talk of Long

Lartin as 'the dream factory' from which every tin-pot gangster would be released to his job with Martin Scorsese or to his château in the Dordogne. Sometimes prisoners tell porkies.

In a climate of fiscal austerity the public sector must share the pain but, asks Podmore, how compatible is this with an exploding population? He develops this subject well. Familiar arguments about bail are rehearsed and there is little doubt that, with increasing delays before prosecution many, not needing imprisonment, continue to be remanded at disproportionate cost. Podmore follows this with an equally convincing consideration of the need for more nuanced approaches to the use of the (cheaper) open estate. The 2010 Ford riot does not evidence failure of open prisons. Better management practices are required, rather like the failing Kirkham of 1998 — 2004 which, by 2009, received accolades from the Chief Inspector and public support from the local community.

John Podmore briefly addresses home detention curfew and parole. Of the former he concludes that 'people remain in prison not because the law says they should as part of their punishment but because there is nowhere for them to go. Hardly the best use of expensive incarceration.' There follows a concise explanation of the life sentence and the indeterminate sentence for public protection. He expresses familiar frustration that informed criticism of mandatory life sentences is routinely rejected for fear of politicians appearing soft. The mushrooming of IPPs is noted, also its effect on prisoners and their families, many of whom may have a variety of cognitive limitations, when they cannot be told release dates — or in Podmore's words: 'Computer says ninety-nine years.'

The author laments the lost opportunity to save public money through a professional development of work in establishments. Despite political aspirations to align working conditions with those outside, the average working week for prisoners was only 11.6 hours in 2010. Pay, generally, remains dismally low. Yet there is meaningful work if governors would but seek it out as Podmore did at Swaleside. He had difficult union negotiations but when the result was a contented prisoner workforce with decent pay, a satisfied outside provider and, eventually, a co-operative staff the effort was worth while. Things looked good when Justice Minister, Ken Clarke, put faith in such developments at the 2011 Conservative Party Conference, only to be potentially stymied by the law of unintended consequences under the Prisoners' Earnings Act.

Despite political aspirations to align working conditions with those outside, the average working week for prisoners was only 11.6 hours in 2010. Pay, generally, remains dismally low.

One might anticipate Podmore as being wholly committed to rehabilitative programmes for prisoners and so he is. But not the muddleheaded plethora of questionably validated and unevaluated programmes that have been metaphorically dumped on governors by NOMS. Selection may be 'scatter gun' and, in one prisoners' perceptive view, may be directed at those needing them least — the compliant and not those with behavioural problems. There is even a muddle, it seems, over drug treatment programmes delivered by the third sector. Where the writer is a little off beam is in his criticism of post-detoxification alcohol abuse support. He writes that 'the sorts of support services provided in the community by a range of charitable organisations does not take place in prison.' Alcoholics Anonymous has done sterling work in most prisons over many decades.

It is clear, throughout, that the writer places great faith in the work of trusts and charitable foundations, including arts based ones, and he is an influential participant in the work of several. It is in his account of their interaction with prisons that his frustration is most manifest. The third sector has developed a remarkable range of specialist expertise underpinned by professional practice yet he finds officials' perceptions of them to be of amateur do-gooding. This is where the 'big society' should come into its own yet, repeatedly, their work is damaged or curtailed through knee-jerk NOMS decisions. In one example, a charitable trust with long established footholds in a number of young offender institutions found each of them being re-roled, making their work inappropriate for the new population. They had not been consulted and NOMS' view appeared to be that their disappointed response merely demonstrated their inability to meet Service needs.

Cack-handedness is manifest in charity contributions to staff support too. Take the imaginative scheme under which the Governor of Leeds, the Home Office, Monument Trust and Leeds Metropolitan University combined to provide foundation degree courses for prison officers, some of whom later followed degree and post-graduate studies. Governors and officials moved on and, with them, enthusiasm for the course. Two hundred thousand

pounds down the line, the scheme folded. Something that should have been trumpeted as a model for the Service was abandoned. When a senior executive of Monument met a NOMS director it became clear that there was scant headquarters knowledge of the scheme in the first place. Let us hope nobody in NOMS notices the Cambridge University Master of Studies course.

John Podmore gives many examples of how the bureaucratic leviathan is unequal to maximising the potential of exciting and innovative third sector contributions. Now a new element is introduced. Those who have provided such initiatives over many years will be bidding against other providers, including commercial bodies, for delivery of the same services. So, for example, the selfless former prisoner Branstaff Jacobs, whose tiny charity supports and finds accommodation for the most vulnerable of discharged prisoners, may fall prey to the shareholders of one or another multi-national.

Reading Podmore's account of 'the invisible prison governor', with the diminution of authority and influence of the role, caused me particular disappointment. This, together with 'enforced silence', he argues, has led to their isolation from policy development. The pre-Fresh Start bifurcated hierarchies of governors class 1 to 5 on one hand and chief officer 1 to basic grade officer on the other led to a crude distribution of authority and accountability. Post-Fresh Start, these lines were clarified but a clumsy absorbing of chief officer (caterer) and the like into the then 'governor grades' led to further confusion. Every Tom, Dick and Mary could describe themselves as prison governors. Podmore makes no reference to the aborted Fresh Start Phase Two whereby the Prison Service administration grades were to be absorbed into a coherently structured management whole. Podmore has a fairly jaundiced view of some cross grade postings whereby governor grades moved into headquarters jobs and vice versa. Then he is also somewhat jaundiced, and in my view unfair, in dismissing most headquarters staff as incompetent 'bean counters'. The later ascription of managerialist nomenclature to the governor grades, providing a formula the wider civil service could understand, had drawbacks too. In an extreme example, the person in charge of one of the three prisons in the Sheppey Cluster became sixth in the hierarchy of accountability. Bureaucracy became embedded in the system and 'managerialism had slipped in when no one was watching.'

Managerialism has led to a reduction in, though not eradication of, escapes, riots, controversial deaths in custody, allegations of mistreatment and the like.

Sensing that John Podmore grieves for the freedom of governors to manage their fiefdoms with idiosyncratic zeal (perhaps his own natural style) his analysis of management between 1970 and 1990 is thin. Managerialism has led to a reduction in, though not eradication of, escapes, riots, controversial deaths in custody, allegations of mistreatment and the like. However to dismiss that era in half a page could lead the reader to suspect that such telescoping captures all that characterised prisons in those days. The Treasury may once have offered us an open wallet. But the mid-70s saw the introduction of budgetary control and matters were no longer as simple as suggested.

Clearly there were serious shortcomings and, as Shane Bryans notes in number 200 of this Journal, Professor Alison Liebling challenges 'romantic reflections on the past'. But as Bryans indicates, assistant governors of old were recruited to do a different job from that of their modern counterparts. The rehabilitative ideal was the driver for junior governors in borstals and in training prisons. So, for example, at Long Lartin, governor Jack Williams, who had inherited the ethos instilled by Bill Perrie and Ian Dunbar, refused to jeopardize that. It is too simplistic to espouse the mantra 'pre-1990 bad; post-1990 good'.

Podmore rightly credits Alison Liebling and Ben Crewe for their continuous analysis of managerialism (and now post-managerialism) in the Prison Service. Of concern to me, in Liebling's rough classification of present gubernatorial styles, are those who are 'uncritically focused on performance targets' or 'alienated or complacent.' There are, of course, 'highly skilled operational governors' too. I guess some will be those who have not been leaned against for allowing prisoners to have a party or for hosting a Comedy School course. A former governor of Pentonville told me that he could mount any sort of arts event he liked with his prisoners, provided he gave it a punitive enough sounding name. Research should not underestimate the question of luck in determining whether one is seen as an exemplary governor or a bit of a cowboy.

John Podmore regards the advent of managerialism as a device that keeps governors in their place. There are no longer conferences for middle managers (as there once were for junior governors), for governing governors or even a need to attend the, now abolished, annual Prison Service Conference.

They seldom speak at external venues and their contribution to the media are policed by Press Office. Thus their views seldom inform the wider criminal justice debate. Podmore notes that his own 'elastic interpretation of the rules made me few friends in the Press Office.' Significantly, it never deterred him from developing his own public profile just as others before him (and I think of governors like Bill Driscoll and Ian Dunbar). It was once said that a Wakefield prisoner applied to see 'the number one' (Dunbar) and was told: 'Try Newsnight on Thursday.' If governors generally have become frightened of making intelligent public comment they have themselves to blame. There were always ways of 'interpreting' the rules in my day as I am sure there are now. Perhaps governors are too busy ticking boxes.

A multiplicity of supposed institutional needs militate against effectiveness regarding family ties, securing post-released employment and education. These, John Podmore reminds us, can have a profound effect on life after prison. Yet with family contacts, there are obstacles like different requirements for different booking systems, remote locations, short notice overcrowding drafts, limited access to telephones unless it is the clandestine mobile, 'basic' visiting rights for those who may need visits most; and this is just the start. It all conspires to make what should be a positive experience the very opposite. In this commercial era, the charity Prisoner Advice and Care Trust, having given enduring support for family visits, found the rug pulled from under it by a competing, cheaper, charitable provider. At the stroke of a pen, PACT lost thirty per cent of its funding. Nonetheless, Podmore finds that there are 'flowers in the desert.' The first is emailaprisoner.com, pioneered by Derek Jones, initially with Guys Marsh. Without headquarters support individual governors are slowly joining the scheme. Secondly there is the video scheme Story Book Dads (sic) allowing mothers and fathers in prison to be a constant presence in their children's lives.

About eighty per cent of prisoners will be jobless on release. Podmore is sceptical of any real effort on the part of the Prison Service or other statutory agencies to provide the opportunities they need to rejoin the work force. The Rehabilitation of Offenders Act, as presently enacted, has long periods before ex-prisoners need not admit their convictions. While presently subject to parliamentary consideration, previous proposals to reduce the relevant periods have failed for fear of voter and tabloid hostility.

Podmore notes that his own 'elastic interpretation of the rules made me few friends in the Press Office.'

Podmore briefly addresses education for prisoners, now contracted out to commercial providers often covering many prisons. Education, understandably, tends to be concentrated on basic literacy and numeracy yet recent reports of Ofsted and the Chief Inspector reveal its shortcomings. Podmore forgets that further education is itself experiencing austerity and organisational change. Press accounts of the travails of Manchester College, one of the largest providers, evidences this. The collision of one bureaucracy with another, at a time of simultaneous processes of change, suggests that this is not the best time to be a prisoner intent on learning.

It is not surprising that many of John Podmore's conclusions about today's criminal justice system are somewhat bleak. He notes that the United Kingdom remains a nation of 'incarcerholics'. Northern European decarceraters are 'woolly minded liberals' and we look to the United States to validate locking up ever more. He overlooks the penalogically red necked Texas, now embarking on decarceration for that most ethical of reasons: prison is too expensive.

Podmore's is not an anti-privatisation manifesto. He recognises that privatisation is here and we must accept it. But warnings about its grip across the Atlantic should be heeded. The privateers seek easy pickings and so did not bid for the disgraceful Brixton. But Brixton could be, and was, turned around. It became a 'most improved' prison under Podmore's governorship. This convinces him that 'innovation and rehabilitation must be at the heart of new tenders where there is already competition, as well as in the rest of the prison estate where (for now) there is not.' This is hardly radical thinking but he believes it has escaped politicians and Whitehall mandarins for generations. They mouth the words but seldom deliver.

Unmentioned so far are Podmore's frequent references to prisoners' exclusion from the digital age. Innovation should include them in what, for most, is an essential of daily life. I remember when prisoners were not allowed The Morning Star, or sunglasses, or trainers, or FM radios. And when staff would not wear name badges because of a potentially offensive weapon in the wrong hands: the safety pin. All in the name of security. How quaint it seems now. He invites the Prison Service to introduce prisoners to that alarmingly dangerous future of doing something absolutely normal. Of course, Podmore accepts, there will be security implications but these should be managed and not used as a smokescreen behind which to hide progress.

For all the supposed benefits of the managerialism, Podmore warns against the emergence of a demotivated workforce leading to poor staff-prisoner relations. Various Chief Inspectors' reports support him. Elsewhere, the book gives credit to Ian Dunbar and his elaboration of dynamic security. This should be revisited as it is through positive staff-prisoner interaction that safe environments and sound security can be enhanced. He makes only passing reference to prison officers. Much has been revealed, through appreciative enquiry, showing that they are far from the disengaged dim-wit of old. But that was only ever a lazy stereotype. Most were honest workers doing a good job. Teddy Thomas, in 'The English Prison Officer since 1850' (1972) described eloquently how, whenever elements of officers' jobs became interesting (teaching, welfare etc.), they were handed over to specialist grades. The officer reverted to turnkey. Should the Prison Service hive off more and more services to cheaper outside providers, there is the danger of leaving the officer behind yet again. This, as much as anything, may lead to the demotivated workforce of which Podmore warns.

So, is there anything to be salvaged from Podmore's penal mess? Whereas he is mercilessly critical of parts of the system, he recognises its good bits and his book is written from a perspective of one who cares deeply for that of which he was part for so long. He is convinced that the Prison Service has the potential to be better. It needs releasing from suffocating Whitehall traditions whereby successive bands of civil servants try to satisfy successive Ministers that they can rapidly implement today's new fad in place of yesterday's. Podmore opines that we are good at managing the transition from community to prison and hopeless at managing the chaos of prison to community. The Royal Society of Arts, of which he is a Fellow, proposes RSA Transitions whereby the new model prison would 'provide a physical space where people can properly prepare themselves for life outside prison.' It will be professionally costed and 'informed by hard-nosed financial thinking.' Essentially it will be part college, part social enterprise and part rehabilitative facility offering paid jobs and preparation for work on release. It will embrace the community where it is based and it will be much more too. This, he sees as the promising future.

John Podmore has made a significant contribution to modern debate but his work has a few shortcomings.

Perhaps an argument for another day but relating to John Podmore's, and others', assessment of gubernatorial requirements, it appears to me that if one recruits a cadre of middle managers he describes as 'operationally and emotionally remote' from prisoners, one risks a middle management with a one dimensional appreciation of their organisation. As Podmore notes, prison officers tend to have only rudimentary training. How many of them, like the assistant governors of old, would have an deep knowledge of Prison Rules and Standing Orders (now Prison Service Orders) ensuring prisoners of their entitlements? How many prisoners presently suffer from what a chief officer once told me: 'Standing Orders don't quite have the effect at Durham as they might in other prisons.' Wing assistant governors made sure they did. How many of the new middle managers would even come to know a wing culture whereby there was 'the Prison Service way and the Hollow way'? If they are trained to tick boxes, that is what they will do well.

The Managerialist approach and the discipline of market testing may well have ameliorated the system. I shall not have complete faith in it until I stop reading about trivial matters reaching the Prisons and Probation Ombudsman that should have been sorted at local level. Or when I no longer have concern for the management of women prisoners that I had when working with them beginning some 28 years ago. Or when I stop hearing of slopping out.

Written in an engagingly colloquial, though occasionally hubristic, style this is no dusty penological tract though almost every argument is backed by figures or costings. John Podmore has made a significant contribution to modern debate but his work has a few shortcomings. His arguments are generally persuasive but are punctuated by occasional errors and infelicities.

There were no deaths during the Strangeways riots. Articles submitted to the Prison Service Journal are subject to peer review, not censorship. Martin Narey was no longer Director General in 2005 as asserted, and so on. I am uncomfortable with the side-swipe at the charity Spurgeons. Podmore writes: 'No one had heard of it before and it had no track record of work in prisons.' Spurgeons has 140 years' experience supporting fragile families; it commenced work in Wellingborough in 1999; it now runs nine visitors' centres and works with prisoners at Winchester and Kingston. I feel that the triumphalism of 'The POA has finally been defeated' (a sentiment repeated in Shane Bryans' article noted above) is misplaced. Privatisation may have eroded its former power but since

management has, for years, sought less confrontational relationships with the union, it is unseemly to gloat now it has got it. There is the clichéd gripe about 'fat cat' lawyers, yet no mention of lawyers' contributions to the prisoners' rights agenda that has helped shape modern prison practice.

Further, Podmore has been seriously let down by his editor. One learns more about prison security from the chapter headed 'Spies and Robbers' than the one headed 'Security'. By page 74 we have the third description of the Belmarsh Special Security Unit. On one page, extracts from three separate reports identify Nick Hardwick as Chief Inspector of Prisons. On the very next page, Podmore explains, twice, that Nick Hardwick is the Chief Inspector of Prisons. And when will publishers learn that a computer spell check is not a substitute for proof reading? 'Effect' and 'affect' are not interchangeable. 'Fulfill' and 'instill' are not English. The corrupt acting governor Thorne is later ennobled to 'Throne' and what on earth is an 'apple art'?

These criticisms should not detract from the thrust of Podmore's important book. He writes with gusto and in an accessible form nor does he pulls his punches. Will his words be heeded? I recall a quotation from an unlikely source. In John le Carre's 'Call for the Dead' (1961) he writes:

> *Experience, perception, common sense … were not the organs of fact. Paper was fact; Ministers were fact; Home Secretaries were hard fact. The Department did not concern itself with the impressions of … a single officer when they conflicted with policy.*

John Podmore is a visionary and his thoughts are based on his experience, perception and common sense. My fear is that NOMS, which offered him redundancy, may marginalise his views. If so, it, and the Prison Service will be the losers.

Peter Quinn *is a retired Governor.*

PRISON SERVICE JOURNAL

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The *Prison Service Journal* is a peer reviewed journal published by HM Prison Service of England and Wales. Its purpose is to promote discussion on issues related to the work of the Prison Service, the wider criminal justice system and associated fields. It aims to present reliable information and a range of views about these issues.

The editor is responsible for the style and content of each edition, and for managing production and the Journal's budget. The editor is supported by an editorial board — a body of volunteers all of whom have worked for the Prison Service in various capacities. The editorial board considers all articles submitted and decides the outline and composition of each edition, although the editor retains an over-riding discretion in deciding which articles are published and their precise length and language.

From May 2011 each edition is available electronically from the website of the Centre for Crime and Justice Studies. This is available at http://www.crimeandjustice.org.uk/psj.html

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Six editions of the Journal, printed at HMP Leyhill, are published each year with a circulation of approximately 6,500 per edition. The editor welcomes articles which should be up to c.4,000 words and submitted by email to **jamie.bennett@hmps.gsi.gov.uk** or as hard copy and on disk to *Prison Service Journal*, c/o Print Shop Manager, HMP Leyhill, Wotton-under-Edge, Gloucestershire, GL12 8HL. All other correspondence may also be sent to the Editor at this address or to **jamie.bennett@hmps.gsi.gov.uk**.

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