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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.

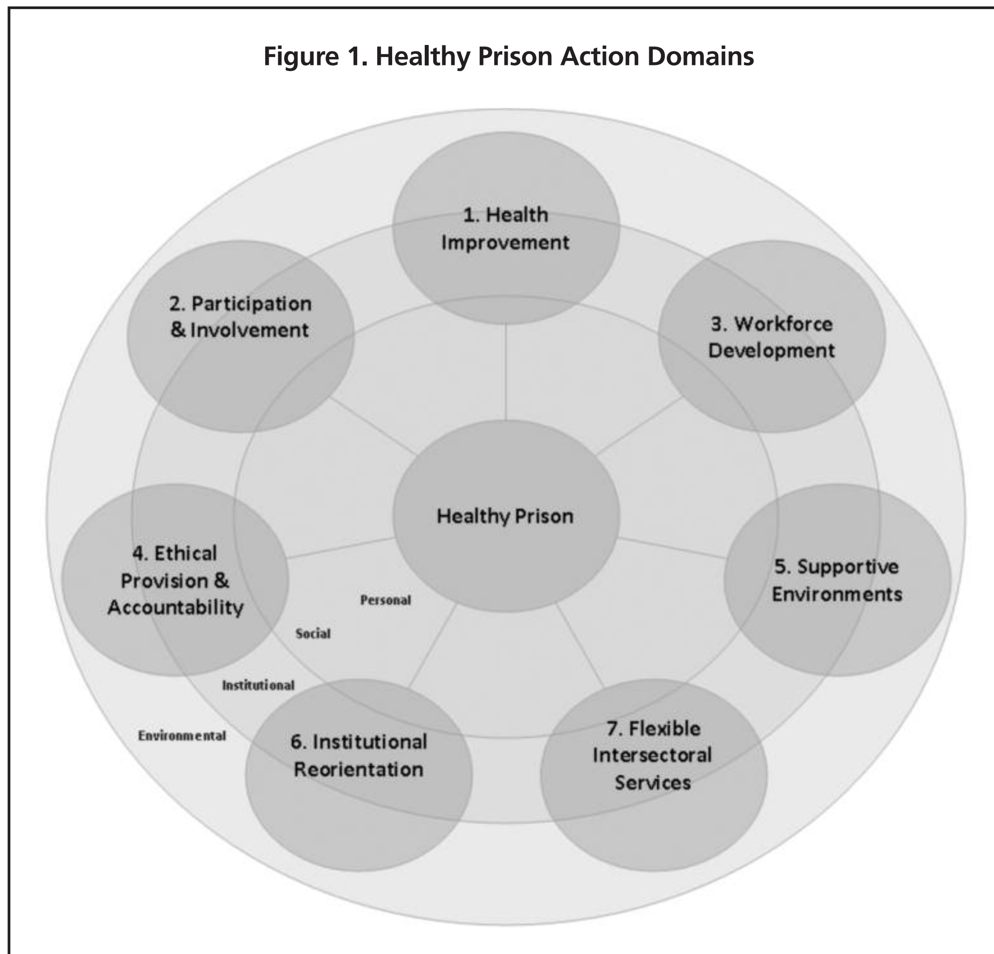
Consultation with mid- and senior level prison-based staff elicited perceptions and beliefs about the healthy prison approach, including how the strategy should be developed, what could constitute realistic objectives, how the prison environment could be improved, the nature of existing health promotion 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*

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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.