

# A healthy prison strategy for HMP Bristol

Analysis, Outcomes and Recommendations  
from a Scoping Exercise January-March 2009

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Commissioned by NHS Bristol



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## 1.0 INTRODUCTION

This report summarises progress in establishing a Healthy Prison strategy for HMP Bristol. It follows a period of consultancy with the prison commissioned by NHS Bristol, and carried out as follow-up to a 2007-8 Health Needs Assessment (HNA) conducted at the prison. The aims of this work were to: [1] assess and build commitment within the prison for a 'healthy prison' strategy; [2] produce a realistic and feasible plan for developing the strategy; [3] create a strategy group to lead and drive the project; and [4] form and publish key performance standards for the prison. A period of consultation preceded publication of this report, which involved interviews and meetings with a range of Prison Service and NHS stakeholders and close scrutiny of relevant reports and publications. It should be noted that work on this strategy is ongoing and now forms part of the core business of HMP Bristol.

It is hoped that this report will be useful to other prisons and primary care trusts endeavouring to integrate public health into their healthcare delivery plans and to undertake needs assessments.

The 2007-8 health needs assessment for HMP Bristol identified four objectives that have directly informed this work:

- To establish a system-wide approach to commissioning and providing prison health and social care services at HMP Bristol;
- To build an integrated health and social care service that is responsive and appropriate to the needs of offenders passing through the offender management system;
- To develop a proactive approach towards disease prevention and health improvement;
- To establish a strategic partnership group to develop the health improvement plan for the prison.

## 2.0 THE HEALTHY PRISON APPROACH

The World Health Organisation (WHO 2007) introduced the concept of a 'healthy prison' in 1994. It is based on the 'healthy settings' philosophy, which was developed in the early 1990s as a whole-systems approach towards improving health through developing healthy, supportive environments (WHO 1991). The settings approach to health promotion (or 'healthy settings approach') aims to facilitate action on all determinants of health and illness, rather than solely managing, treating and preventing disease. It recognizes that health is a product of individual, cultural, social, environmental, political and economic factors, and that healthy choices and health behaviour are consequences of multiple determinants. The goal for prisons, therefore, is to create a 'whole climate' for improving health (WHO, 1996, p. 1), where safety, personal fulfilment and dignity are valued as important prerequisites for health (WHO, 1998a). The UK government is committed to a public health approach based on the WHO settings philosophy (DH 2005), which underpins current health and offender partnership arrangements and the work of the Prisons Inspectorate. WHO (2007) defines the approach in the following terms:

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

Prison settings provide an excellent opportunity for improving health and tackling inequalities. The Healthy Prison approach, sometimes termed the *health promoting prison approach*, involves all levels of prison 'life', from personal and social domains through to organisational factors and the physical environment. It strives to engage with prisoners and prison personnel at all levels of decision-making and seniority, the full range of service providers, and prisoners' families, friends and the surrounding local community. It draws upon resources from across the whole prison, recognising the interdependence of all aspects of prison life. Specifically, a healthy prison approach should include:

- personal and social education and skills development, focused on health education, disease prevention, and health improvement;
- development of policies and practices that have positive health impacts, are health promoting and that actively involve staff and prisoners;



- creation of an environment and infrastructure conducive to positive health, health improvement, health protection and effective healthcare, where wider social, organisational and structural determinants of health are considered;
- measures that facilitate decency and respect within prisons, where the rights and status of offenders and service personnel are fully supported;
- efforts to support and facilitate health improvement of prison personnel, with the objectives of reducing sickness absence, improving productivity and performance, increasing safety and reducing occupation-related ill-health.

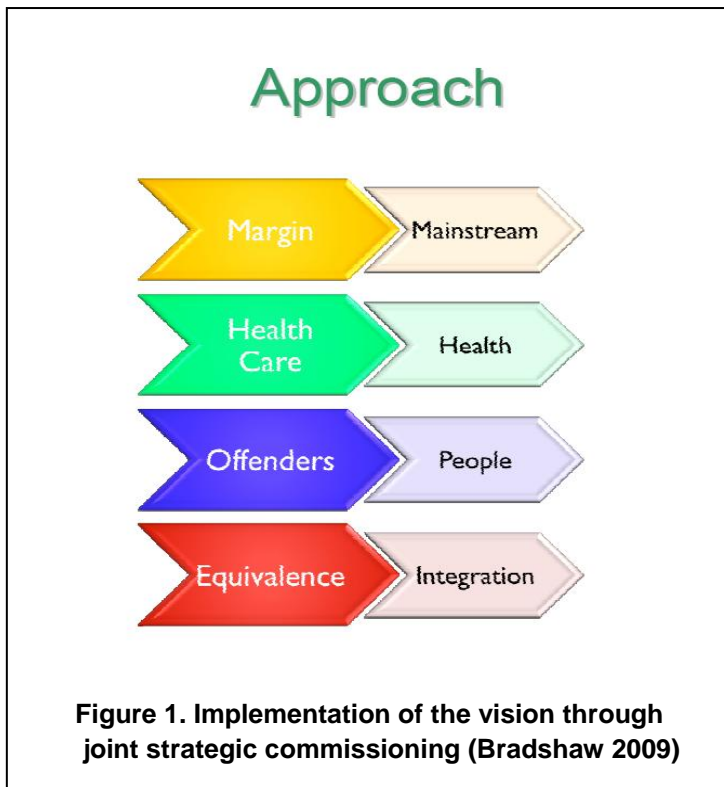
The European Prison Rules, published by the Council of Europe, include standards for healthcare services within European prisons, which emphasise the principle of human dignity, where prison administrations have a duty to provide humane and positive treatment, through effective management and organisation (Council of Europe 1987). Her Majesty's Inspectorate for England and Wales identifies four criteria against which to evaluate healthy prison performance – safety, respect, purposeful activity and resettlement, which reflect a systemic approach towards health within prisons. The WHO suggests that for a prison to become a healthy setting, it must have commitment from prison personnel, especially senior managers who are able to shape the ethos and goals for their institution. This way, health improvement can shift from single-issue projects to system wide change and development, which is sustainable, effective and complements the core business of the prison. For this to happen, the WHO (2007) recommends that prisons have strong and effective leadership and foster positive public identities, as public services providing for societal needs for safety, punishment, public health, tackling disadvantage and reducing social exclusion. Furthermore, prison health services should be governed by the following principles:

- **equivalence** – prisoners have the same right to healthcare as the general public; in this regard, prison health policy and practice should be equivalent to and integrated with national health policy and practice;
- **duty of care** – criminal justice settings must provide appropriate and effective health and social care for prisoners, that include measures to support and improve health and well-being;
- **respect** – healthcare services must support prisoners principally as patients/clients rather than as offenders;
- **professional autonomy** – prison-based healthcare personnel should have professional independence and autonomy equivalent to their peers within other non-custody settings;

- **holistic** – offender health services should embrace the full range of goals and interventions, including public health, social care and healthcare;

The Bradley Report (2009) recommended that commissioning partnerships between Primary Care Trusts and Criminal Justice agencies should aim to collectively reduce re-offending and tackle inequalities and social exclusion. The key recommendations of the report, summarised in figure 1, emphasise:

- early intervention to reduce offending and reoffending;
- better health information sharing across Criminal Justice agencies;
- continuity of care across the criminal justice pathway;
- national leadership via a Health and Criminal Justice Programme Board and a National Advisory Group to implement, through Local Area Agreements (LAAs), Joint Strategic Needs Assessment, commissioning, and sound financial investments.



Diverting offenders with mental health needs and learning disabilities from the courts to settings other than prison could, in turn, reduce the pressure on the prison estate and significantly reduce re-offending rates. World Class Commissioning is the mechanism available to local PCTs, where they may be able to impact on reducing prisoner numbers

and release scarce resources within prisons (Lord Carter of Coles, 2007; Bradley, 2009; Bradshaw, 2009; Healthcare Commission, 2009).

Criminal Justice health and social care policy is developing apace in the wake of the Bradley Report, the Carter Review of Prisons, the Darzi Report on high quality healthcare, and the Health Care Commission's report on healthcare in prisons (Lord Carter of Coles, 2007; Lord Darzi, 2008; Bradley, 2009; Bradshaw, 2009; Healthcare Commission, 2009). The consistent message within these reports is efforts to improve health and wellbeing of offenders, or of those at risk of offending, can reduce re-offending, inequality and social exclusion. Moreover, health and social care services for detainees and offenders should be equivalent to those of the general population and be integrated (part of and not separate from) services available to the general population. It is acknowledged (DH 2007, SEU 2003) that detainees are generally exposed to high levels of social inequality, have unaddressed mental healthcare and learning disability needs, lack access to appropriate primary healthcare and social care services in custody settings, which manifests in high levels of re-offending and overcapacity in custody settings. Commissioning health and social care across criminal justice settings is therefore likely to prove a costly investment in the short -term, given the range of possible innovations required to achieve these ambitious goals. Through World Class Commissioning, there is potential to release resources that could have positive impact on both health and offending. Lord Carter's Review considered options for improving the balance between the supply and demand of prison places, which not only included expansion of prison capacity, but reforming the approach to sentencing and reviewing the way prisons are structured, managed and organised (Lord Carter of Coles, 2007).

The Healthcare Commission (2009:7) has argued that PCTs can be instrumental in improving the health and wellbeing of people in the criminal justice system, through their responsibilities for prison healthcare, as follows:

- conducting regular prison healthcare needs assessments;
- prioritising resources for prison healthcare;
- assessing prison healthcare performance against community-based healthcare performance;
- promoting use of electronic record keeping to improve clinical audit;
- providing appropriate training for prison healthcare staff;

- ensuring prisoners have equal / fair access to healthcare services;
- identifying more accurately the healthcare needs of BME groups;
- regularly evaluating prisoners' views of healthcare services;
- implementing Integrated Drug Treatment Systems;
- ensuring effective and appropriate liaison, transfer and release of prisoners.

Prisons can play an important role in improving the health of some of the most disadvantaged or underprivileged groups in society, enabling access to potentially marginalised or excluded individuals. Commitment to the settings approach in the UK was signalled within *Health Promoting Prisons: A Shared Approach* (DH, 2002), which was followed in 2003 with the development of *Prison Service Order 3200*, establishing performance standards for health promotion. Many different health promotion interventions have been employed in prisons, designed to address unmet health needs. The healthy prisons approach in England and Wales tends to follow three lines of action: [1] developing health promoting policies (e.g. smoking cessation); [2] developing a supportive environment for health (e.g. the Decency Agenda); [3] developing health programmes aimed at prevention, education or protection (e.g. cognitive health behaviour change programmes). PSO 3200 recommends health promotion action in the areas of mental health and well-being, smoking, diet and nutrition, lifestyles including sex, relationships and active living, and drugs and substance misuse. Health promotion is also a key area within Prison Health Delivery Plans.

## **A Public Health Approach**

Public health within the context of offender health is an evolving field. Conventionally, it plays an important role in terms of health protection, especially in relation to communicable disease. Health improvement interventions within prisons have tended to be focused primarily on providing health education to individuals, in line with PSO 3200. However, public health has the potential to provide an expanded, systemic function, based on the WHO settings approach where the valuable role of health promotion in its wider sense is fully appreciated. This perspective is illustrated through Dahlgren and Whitehead's (1992) schematic representation of the determinants of health and well being. In their view, public health is uniquely positioned to tackle inequalities through action at multiple levels,

focusing on socio-economic, cultural and environmental conditions; living and working conditions (the physical environment); social and community influences (the socio-economic environment); Individual lifestyle factors; and biological factors, including age and sex.

The role of public health within the context of offender health is therefore to provide strategic leadership in terms of supporting criminal justice institutions in developing the appropriate conditions for health. Essentially, this involves forging partnerships that engender commitment to systemic change, where the outcome is health improvement. A public health approach, based on the settings philosophy, implies a multi-levelled approach to health improvement. Criminal justice settings should therefore be able to support detainees and offenders in terms of:

- learning to adjust to criminal justice environments, regimes and cultures;
- managing their early transition into CJ settings (e.g. reception, induction);
- managing disruption to domestic, family or social relationships;
- accessing support and beneficial interventions within CJ settings;
- providing access to purposeful roles and activities to make productive use of time;
- coping with the social environment of a closed institution;
- accessing social care services and support;
- preparing adequately for release or transfer;
- maintaining good health and wellbeing.

## **3.0 SCOPING EXERCISE**

### **3.1 Methodology**

This scoping exercise, carried out to inform the development of a healthy prison strategy for HMP Bristol, used two approaches to collect data – qualitative interviews with key stakeholder and analysis of recent relevant national and local policies and guidance. More comprehensive primary data collection was not required given that this study was drawing on data recently compiled through a health needs assessment and two recent Inspectorate reports. The purpose of this exercise was to revisit data already acquired, explore issues raised within these sources with stakeholders, and develop an action plan for the prison and commissioning PCT. The objectives were as follows:

- Identify key public health performance criteria / standards for HMP Bristol, based on recognized standards and competencies.
- Produce a realistic, practicable and evidence-based action plan upon which to base a public health strategy for the prison.
- Engage the senior management team (SMT) and the wider workforce in the development of a public health strategy for the prison.
- Draw up appropriate terms of reference for a public health / healthy prison strategy group for the prison, with SMT representation and ownership.
- Support the strategy team in developing performance criteria / indicators for the prison.

The exercise took place in two phases. The first phase, October to December 2008, involved informal interviews with key stakeholders. Participants included mid-level and senior level managers from the Prison Service, services affiliated with the prison, and NHS commissioners and providers. The purpose of the interviews was to elicit participant's values, perceptions and understandings of the healthy prison approach, and their views on how it should develop. Participants were asked questions about the following issues: their views on what could make the prison a healthier environment; what the "healthy prison" concept conveyed to them; what they considered a realistic aim to be for the prison; what health promotion interventions or projects were already in place; how the prison could effectively reduce health inequalities and social exclusion; whether there could be scope to work better with external partners / agencies; and the feasibility of creating a caring /

supportive custody environment. During this phase, a review of key documentation was carried out to clarify the policy, commissioning and practice contexts, and to guide the development of the strategy. An interim report of findings was published and presented to the prison's Senior Management Team and PCT commissioner.

The second phase, January to April 2009, involved meetings and discussions with the prison's SMT and NHS Bristol to build the membership and develop terms of reference for the public health / healthy prison strategy group, and to agree short, medium and longer term priorities for the prison in the format of a work plan with performance criteria.

A Healthy Prison Group has been established, facilitated by the Head of Safety & Decency, HMP Bristol and, and following the publication of this report, an action plan developed.

## **3.2 Key Issues**

### ***ISSUE 1: SHORT TERM AGENDAS***

#### ***Stakeholder Feedback***

Most prisoners held at HMP Bristol either are serving short sentences or are on remand awaiting court appearances. The average period of remand is six weeks and, for sentenced prisoners (excluding lifers), is between six months and two years. The challenge for the prison is to deliver services suited to short-stay prisoners and to work with other health and offender management sectors to ensure a seamless delivery of services, as prisoners move from one setting to the next.

Working with short-stay prisoners is a challenge for most providers within the prison. The CARAT team typically experiences this, where prisoners are commonly transferred before completing a programme. At the national level, up to two thirds of sentenced prisoners registered with CARATs are serving less than one year, while the optimum period for stabilising most drug users (to get them off drugs and participating in education or employment) is six weeks; so this can be interrupted if prisoners leave prison part-way through a programme.

## ***Options for Change***

Managing offenders within relatively short time frames creates challenges for developing effective health, welfare and offender management schemes.

Under an ideal scenario, transfers or discharges should be planned to correspond with education, treatment and resettlement objectives. Likewise, sentencing and remand should be consistent with such objectives.

## ***ISSUE 2: REACTIVE HEALTH SERVICES***

### ***Stakeholder Feedback***

A high quality health service currently operates at the prison, as indicated in the most recent HMIP Inspections (HMIP 2005; HMIP 2008).

At present, the prison healthcare service essentially operates 'reactively', responding primarily to prisoners' medical and psychiatric healthcare needs. The service historically has been a secondary healthcare service, with some primary care provision. The challenge for HMP Bristol, and the improvement process being led by the Prison Partnership Board is to shift from an acute, reactive and opportunistic (biomedical) approach to a more sustainable, progressive, public health approach, which embraces a full repertoire of health, welfare and social care delivery. There is currently limited capacity to engage in primary and tertiary care, prevention, health promotion or social care. The following issues illustrate some of the constraints on the current service, in terms of developing a health improvement approach:

Prisoners were not interviewed for this report, but feedback from some stakeholders suggested that some healthcare staff were perceived to lack empathy towards prisoners (as 'patients') or commitment towards caring for them (as 'vulnerable' adults). This could be due to a range of factors, including periods of high staff turnover (recruitment and retention problems), the austerity of the healthcare environment, the custody/care paradox for staff working with prisoners, characteristics of the client group, the staff skills mix, or



limited opportunities for career development. Essentially, if the healthcare service is always busy, while threatened with staff attrition or under-capacity, then it is difficult for it to adapt and take on extended roles and responsibilities.

As mentioned in [1], the healthcare service is primarily oriented around prisoners' acute healthcare needs and does not have the capacity, resources nor skill mix to develop its full 'public health' function, and engage with offenders in case-work that reaches beyond clinical need to deeper-seated emotional, psychological or social health and social need. This is, moreover, probably an unreasonable expectation of a healthcare service.

Healthcare providers endeavour to process prisoners with acute healthcare needs as efficiently as possible, and to provide effective primary and secondary services in particular areas of perceived health need (e.g. blood borne virus treatment and screening, harm reduction, sexual health, etc.). Most offenders, though, will not encounter healthcare providers unless they have an acute healthcare need and are motivated to self-refer themselves; significant health or social need may therefore go undetected. Furthermore, prisoners not perceived (through reception screening) to have a healthcare problem may then be less able to access other allied health or social care agencies through referral, unless this occurs via sentence management planning or education. Likewise, the CARAT team works with offenders who are addicted to drugs, but it does not work with non-drug users who might benefit from involvement in health and wellbeing programmes it is able to offer to drug users. So prisoners who access support offered by Third Sector agencies will probably have been referred to them by front-line services within the prison, with whom they have become involved on account of their health status. In this regard, it would be useful to know the proportion of prisoners who do not encounter front-line health services within the prison, yet who might benefit from, but do not have the opportunity to, access (via referral) other health, social care or Third Sector services.

The effectiveness of healthcare services within HMP Bristol is partly dependent upon the contractual and commissioning relationships between NHS Bristol and the external health service providers (Bristol Community Health, AWP and APMS [Alternative Provider Medical Services]) to whom prisoners may be referred or transferred. Financial and practical constraints on external providers can mean they deliver services to a limited specification or budget. For AWP, pressure to reduce beds in the community and to receive transfers of prisoners with mental health problems within the designated

Department of Health 14-day transfer window may reduce efficiency and effectiveness in terms of responding to prisoners' healthcare needs.

An on-going priority for the Prison Service is to reduce prevalence of suicide, self-harm and injury or deaths associated with other forms of violence or abuse. This is under constant review at HMP Bristol with regular evaluations of policies and procedures to manage risk of suicide, self-harm, bullying and violence.

Reception health screening aims primarily to detect new prisoners' primary and secondary healthcare needs, and does not routinely identify deeper-seated health or social needs. Moreover, current health screening does not actively evaluate the impact imprisonment will bring to the prisoner, and it is unclear what level or quality of health screening is undertaken with offenders before they are sentenced or remanded. A consideration for the healthcare commissioner could be to pilot an assessment tool which takes a proactive approach, probably involving the police custody and the courts services. Currently, the most comprehensive healthcare assessments are undertaken at prison reception, whereas effective liaison, diversion and referral would require pre-prison assessments, in line with Bradley's (2009) recommendations

A perception aired by some healthcare professionals was that short-term clinical objectives sometimes superseded longer term plans to address prisoners' healthcare needs. This statement does not seek to discredit clinicians or in any way suggest contravention of guidelines, procedures or codes of conduct; indeed, there was no evidence to suggest this. The perception of some respondents was, nonetheless, that it was often difficult to provide effectively for prisoners beyond prescribing treatment. An example cited during interview with one respondent was the case of prisoners prescribed sleeping tablets but without other care, support or counselling to address the underlying causes associated with their sleep problem. This is anecdotal, but possibly suggests that the healthcare service lacks the capacity to manage underlying emotional and psychological needs of prisoners.

### ***Options for Change***

There is extensive evidence showing that prisoners experience high levels of psychiatric morbidity and social need compared with the general population. In relative terms, they experience higher levels of health inequality and social exclusion, and are likely to have

significant unmet health needs. Determinants of health, wellbeing, illness or disability are intrinsic or specific to particular individuals but also externally or systemically derived. Measures to improve health of prisoners should therefore include interventions at personal, social, institutional and environmental levels. *Most* prisoners would probably benefit from measures to improve their health and wellbeing, which should include non-medical approaches that complement existing healthcare strategies. Effective interventions might involve introducing more empathic and therapeutic conditions to the prison environment that actively improve mental health on the wings.

Safer Custody measures to reduce prevalence of suicide, self-harm and injury or deaths associated with other forms of violence or abuse should be proactive as well as reactive. While safer cells should be widely available in all prisons and should be used to hold at-risk prisoners, “they should be used alongside, and not as a substitute for, other suicide prevention strategies such as comprehensive mental health care, good staff-prisoner relationships, comprehensive risk assessments and provision of support through Psychology, the Samaritans or Listeners.” (Joint Committee on Human Rights 2004). Social and environmental interventions should complement appropriate mental health treatment and care, having preventive and protective effects in terms of reducing the potentially detrimental impacts of imprisonment on health and wellbeing. These should continue to be reviewed on a regular basis, acknowledging the potential impacts of the physical, institutional and social environments on prisoners’ mental health.

In relation to the health impact of prison on prisoners, existing Health Impact Assessment and Health Equity Audit methodologies could be considered by the healthcare commissioner for use in preparing health delivery plans for the prison.

In summary, the prison healthcare service must operate within clear workable boundaries. It is currently a primary and secondary care provider, its latter function primarily to manage patients in the Inpatient Unit who are awaiting transfer to secure psychiatric facilities. The capacity of a healthcare function to improve the health of the whole prison population is limited; therefore responsibility for health improvement and health promotion should rest with the prison as a whole rather than the healthcare service.

## **ISSUE 3: INTERDISCIPLINARY HEALTH & SOCIAL CARE**

### ***Stakeholder Feedback***

A common concern of stakeholders was the need to better 'join up' services for offenders, across the offender management pathway or field. Essentially, there are frustrations among different professional groups about linking prisoners to services, agencies, schemes or programmes and ensuring continuity of care, treatment and education through effective referral and transfer. Some prisoners have better 'journeys' than others, depending on which services they become locked into and the nature of their sentence. An on-going frustration for some service managers within the prison is poor communications with outside / referral agencies, especially their ability to link prisoners to follow-on services. The CARAT team, for instance, commonly encountered difficulties referring prisoners to an appropriate mental health service. They sometimes found it difficult to track prisoners who had been discharged and who subsequently returned to prison. These kinds of problems illustrate how services can operate in a 'silo' fashion, especially when commissioning and contractual relationships are fragmented.

### ***Options for Change***

A holistic approach to offender management should embrace a wider portfolio of health, education, employment and social welfare services for all offenders that run across the criminal justice system, where all agencies responsible for managing offenders (the police, the courts, prisons, probation services and youth justice services) collectively recognise their roles and responsibilities as 'care' organisations. This proactive and somewhat controversial approach may enable a more 'bespoke' approach to offender management planning, with increasing involvement of non-custody statutory, Third Sector and independent sector providers. Many Third Sector agencies can provide great opportunities for offenders, but referrals often occur on an ad hoc, inconsistent basis and are not always known to mainstream service providers or commissioners. A bespoke approach could enable commissioning to become sufficiently flexible to provide user need-driven programmes of care management; then offenders' health, social, educational, employment and offending needs could be assessed and managed in an integrated way to correspond with their offender 'pathway'. This might be one way of ensuring the offender's 'journey'

through the system is meaningful and progressive (especially with prolific/repeat offenders).

## **ISSUE 4: RIGHTS AND STATUS OF OFFENDERS**

### **2008 Inspectorate Feedback**

The following themes raised in the 2008 Inspectorate Report were also reflected in conversations with stakeholders as being key issues relating to the rights and status of offenders. Work on these areas is ongoing and is currently being progressed by the Prison and by the Partnership Board. The following summary is presented to highlight the importance of these key areas in relation to the Healthy Prison agenda.

#### Diversity

In the past, attempts to introduce diversity to practices and procedures within the prison were perceived as somewhat tokenistic. This was reflected in the 2008 Inspectorate report (HMIP 2008), where efforts to be consultative with specific representative groups of prisoners were perceived as weak or uncoordinated. More recently, improvements have been introduced, with the publication of the Diversity Strategy of the Avon and Somerset Criminal Justice Board and with appointments within the Senior Management Team. At the time of this review, there were areas where further progress could be made. For example, in relation to disability rights and opportunities, the focus has traditionally been on ensuring that physical access needs are met for registered disabled prisoners and on increasing opportunities and access to services for those prisoners with registered or self-reported disabilities.

#### Healthy Literacy

A related issue is the need to promote health literacy among prisoners. This is essentially an equal opportunities issue that refers to the degree to which prisoners can individually obtain, process, and understand basic health information and services needed to make appropriate health decisions. This includes the skills they need to, for instance, communicate appropriately and effectively with healthcare providers.

### Purposeful Activity

The Inspectorate's test criterion of 'purposeful activity' is another area of controversy. HMIP identified this as an area where the prison was not performing sufficiently well. The most recent Inspectorate report stated that there was insufficient purposeful activity to occupy all prisoners, with 64% of prisoners engaged in activities on a daily basis and up to 45% of the population locked in their cells during the core day (HMIP 2008). The challenge of increasing the hours, variety and quality of purposeful activity has evidently been affected by the reduction to the core day introduced by the Ministry of Justice in 2007. This means that prisoners spend long hours locked in their cells, increasingly the level of sedentary activity, with potential for increased physical and psychiatric morbidity. It should be noted that average time out of cell per day is 8-10 hours, in line with key performance indicators.

### Offender Management Assessments

According to HMIP (2008), 60% of prisoners at the prison were not receiving Offender Management Assessments and a much larger proportion have not encountered the Education or Health services. Significantly, the Inspectorate noted shortfalls in the quality of sentence management planning, where sentenced prisoners who did not meet the offender management criteria did not have structured offender assessments, remand prisoners received no custody planning, and life-sentenced prisoners experienced long delays in sentence planning. Overall, 50% of prisoners are employed, in textiles, IT, joinery, recycling, industrial cleaning, PE, kitchen/catering, reception, or as wing orderlies, and more employment and training opportunities are needed. This is likely to impact differentially on prisoners and will likely continue to create economic inequalities within the prison population, with significant negative repercussions such as bullying, exploitative behavior and illicit trade of legal and illegal 'goods'.

### Maintaining Relationships

Another area of concern relates to the systems that enable prisoners to maintain relationships with relatives and significant others outside prison. The visits system, as highlighted in the recent Inspectorate reports, is not conducive to re-building relationships,

especially given that, as reported, dignity and privacy are compromised due to security measures and concerns. Consequently, visitors can feel criminalised or ostracised, and the value of the system as a mechanism for rebuilding families and relationships is lost.

### ***Options for Change***

The Prison Service and the NHS, as public services, are expected 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. Furthermore, the service user perspective should be reflected and represented at all levels of policy and practice, and diversity should be a core theme that is integral to prison policies and practices. The McPherson Report on institutional racism emphasized that service providers should not take a passive stance towards equal opportunities where socially marginalized or disadvantaged groups are involved; since inequality exists in society, treating everyone the same does not necessarily mean fairness of treatment. The provision of equality of opportunity must be combined with social justice principles to provide substantive equality to marginalised groups. Social justice provides equitable outcomes to marginalised groups by recognising past disadvantage and existence of structural barriers embedded in the social, economic and political system that perpetuate systemic discrimination. A socially just public service therefore recognises situations where application of same rules to unequal groups can generate unequal results. Where potential inequalities of opportunity are likely, therefore, remedial actions should be taken.

A progressive approach to Diversity, supported by the Prison Reform Trust, would be to develop a broader, more integrated and inclusive approach to assessing and managing 'disability', through further developing reception screening and health assessment procedures to more effectively detect and respond to prisoners' non-registered or unreported needs, such as learning disability or learning difficulty. In this respect, Diversity policies and practices (relating to the full range of 'needs', including Respect, Decency, Equal Opportunities, GALIPS, Bullying, etc.) should be developed in an integrated way to enable consistency.

The institution must continue to ensure that it safeguards basic ethical standards of care or practice, as identified by the Tavistock Group (Smith et al 1999), considered essential to the delivery of healthcare practice, where:

- healthcare is considered a human right;
- care of individuals is central to healthcare delivery but must be viewed and practised within the overall context of generating greatest possible health gain for groups and populations;
- healthcare responsibilities include illness prevention and alleviation of disability;
- cooperation between professionals and with clients is essential for effective healthcare delivery; and
- all involved in healthcare, commissioners and providers, have continuing responsibility to improve quality.

The Prisons Inspectorate bases its prison inspections of four key tests, all of which have ethical dimensions: safety (particularly for the most vulnerable), respect (for prisoners' human dignity), purposeful activity (that brings personal benefit), and resettlement (to prepare for release). However, issues of confidentiality, consent, privacy, anonymity, respect and safety may be compromised in the prison where the substandard facilities limit the degree to which these can be guaranteed during professional-client consultations.

One area that would be worth investigating further is the system of prisoner management that underpins the regime, the Incentives and Earned Privileges Scheme (IEPS). This is an established system used across prisons in England and Wales that has direct impact on purposeful activity in terms of the incentives or opportunities prisoners can access through good order and discipline. Under the IEPS, prisoners can earn privileges through good behaviour, but can lose these if they misbehave. Privileges affect a prisoner's daily life in prison, and can include increased hours permitted out of cell, increased numbers of visits above the minimum requirement, access to more of their own money to spend (on top of their prison wages) in the prison shop (canteen) or on phone calls, opportunity to wear their own clothes or to prepare their own food, or the chance to have a television in their cell. Good behaviour and increased (employment) productivity are rewarded, essentially, with greater economic freedom (through increased wages and more spending power). Personal responsibility of prisoners is undeniably a common goal of offender management, yet the IEPS rewards good behaviour through economic incentive, which can create certain disincentives (e.g. education and skills development, on a lower rate of



pay) and may create inequalities between prisoners through the opportunity for entrepreneurial or exploitative behaviour. An employment system underpinned by the IEPS represents a 'market economy' model of rehabilitation, but has the potential to disadvantage, exclude and disempower some prisoners, most likely those 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.

User involvement in the planning, delivery and evaluation of services is recognized as a key principle of health service management, and is endorsed by WHO as a key objective for a healthy prison. It should therefore be possible to extend prisoner representation into decision making structures, enabling them to engage as role models, representatives or advocates for others, for instance with disabilities, health, welfare or special needs. This already occurs through the Listener and Insider schemes and via the Patient Advice and Liaison Service (PALS) and could be extended to include such initiatives as the Expert Patient programme, Health Trainer projects and other peer-led models of practice orientated towards counselling, buddying, pastoral support, mentoring and health education.

## **ISSUE 5: WORKFORCE DEVELOPMENT**

### ***Stakeholder Feedback***

A number of different themes arose concerning the effectiveness and character of the workforce. Essentially, the prison setting is served by an increasingly mixed, multi-agency workforce, which, for the purpose of developing a healthy prison strategy, needs to work effectively towards common goals and aspirations.

A key theme concerns workforce capacity in terms of delivering the NHS health agenda. Prison healthcare staff must feel recognised and acknowledged as part of the wider NHS workforce. Despite developments within prison healthcare since 2005, with the transfer of healthcare commissioning and provision to the NHS, there remains a relatively rapid turnover of nursing staff across the prison estate. The offender healthcare sector is, on the whole, poorly understood and recognised by the broader NHS workforce. For increased

recruitment and retention of the offender healthcare workforce to occur (nurses, GPs, dentists, allied health professionals, etc.), there must be greater integration with the NHS, especially in terms of workforce development and training. Moreover, equivalent developments are necessary within social care and public health to create the potential for multidisciplinary team approaches to offender health.

A second theme relates to the core values of the prison workforce. The current workforce is represented by two core institutions, with their somewhat contrasting sets of values and practices – those of the Prison Service and those of the NHS. Equally, other institutions are represented within the prison workforce that bring their own sets of values to the prison setting.

From an offender management perspective, it appears that across the Prison Service generally the need for security outweighs the goal of reducing re-offending and promoting prisoner welfare. Where priority is afforded to welfare issues, this tends to be in the high visibility areas of bullying, suicide and self-harm, whereas the health and welfare needs of the majority take a low priority. The contrasting values and priorities of custodians, offender managers and health professionals can be problematic in that it is then difficult to deliver an effective or supportive service for the prisoner population.

Various stakeholders identified examples where NHS or Prison Service staff could potentially fulfil valuable extended roles, if professional boundaries were a little less rigid. For example, it was suggested that Prison Service employed Health Care Officers, who are gradually being replaced by NHS employees, can perform a pivotal role in bridging professional relations between Prison Service and NHS staff. Senior Prison Officers were also perceived to be key in terms of influencing new developments, and should therefore be supported as facilitators in the forging of inter-disciplinary relationships across the prison. It was suggested that allied health professionals could be supported to develop more proactive and opportunistic roles with prisoners. For example, the Pharmacy White Paper, 'Pharmacy in the Community', recommends that pharmacists should engage in opportunistic health promotion with clients. In HMP Bristol, the pharmacy team already runs the smoking cessation service and there is potential to develop a respiratory clinic for those with chronic respiratory disorders. Pharmacists are also able to qualify as 'non-medical' prescribers, enabling them to treat patients more holistically.

A prevailing view among Prison Service personnel is that health services are the domain and responsibility of healthcare providers, implying that prison officers have little direct involvement with health issues. However, the Duty of Care of the Prison Service is consistent with the aims of the WHO healthy prison approach, and wing officers can and often do perform an important welfare role via their Personal Officer responsibilities. This function could be developed further as part of the process of evolving a multidisciplinary health and social care environment, particularly in terms of providing effective liaison and diversion. The Inspectorate recommended that the Personal Officer Scheme be improved and developed, noting under-recording of contacts between staff and prisoners. Staff-prisoner relationships were reported as good, although prisoners from minority backgrounds were perceived to be more alienated from staff than others (HMIP 2008: 2.56-2.57). Since the 2008 inspection, personal officers have been required to maintain weekly reports.

### ***Options for Change***

One measure could be to develop a regional workforce development plan for offender health services, where measures to recruit and retain healthcare staff are the core aim (primarily nursing teams). One objective could be to build relationships with local training institutions (e.g. University of the West of England) to develop a specialist 'offender health' career pathway for health and social care professionals.

Retention of healthcare staff depends upon factors such as job satisfaction, self-efficacy, self esteem, staff support, development and appraisal, staffing levels, access to resources to effectively deliver the service, the work environment, and professional relationships. These are all workforce development issues that should be prioritised by the prison's senior management team.

One goal for a healthy prison is to develop effective, multi-agency partnership working where the institution is organised around a common agenda based on collective goals and objectives. An important priority for the prison's management is therefore to consider how to best create an institutional culture and environment that engenders common goals, thereby fusing the health agenda with the custody agenda.

Related to the issue of professional boundaries, an important goal for the institution is to create the conditions for all professionals, whatever their status or background, that enable them to feel accepted as partners within the organisation. How non-custody staff feel when

they enter and work in different parts of the prison has an important bearing on the degree of change needed to improve working conditions and conditions for prisoners. Professional acceptance (particularly custody staff of non-custody personnel) is an important influence on staff retention. Creating a supportive environment is at the heart of the WHO settings approach, which should apply equally to the workforce as to prisoners. This means developing effective and appropriate support structures for staff – occupational health and welfare services, pleasant work and break spaces, a safe environment, positive professional relations based on respect, and career development and appraisal opportunities.

One solution to reconciling professional differences within the prison may be to actively build a new inter-disciplinary culture across the workforce, with the objective of reducing the polarisation of values (between 'custody' and 'care'). Training and workforce development could include measures to (re)socialise staff in terms of developing values, attitudes and practices or customs that serve common goals: reducing re-offending, improving health, tackling exclusion. This would require work across the various professional boundaries inside and outside the prison.

A further development could be to consider extending the role and culture of the nurse-led healthcare service from an acute nursing / medical oriented specialism to a more integrated system of health and social care, oriented around health and social needs of offenders.

Staff are important role models for prisoners. To enable them to have a positive and empowering role, they need to be fully supported and empowered. This may mean building an interdisciplinary culture across the prison to shift the traditional Prison Service prioritisation of custody above care, and that of health providers from a primarily acute secondary care focus towards one that is integrated, preventive and more oriented towards health improvement. Alternative ways to integrate allied health and social care providers into the healthcare team should be sought to enable development of joint multi-professional programmes and services for prisoners. The 2008 Inspection highlighted the need to develop the skills mix of healthcare providers and enable non-nursing health professionals to extend their roles (HMIP 2008: 2.107- 2.120). There is clearly potential to create a more integrated and interdisciplinary health service, although this does depend on appropriate allocation of resources.

## **ISSUE 6: REORIENTED PRISON ENVIRONMENT**

### **Stakeholder Feedback**

An issue raised by several stakeholders was that the prison environment does not constitute a health environment, not just in terms of delivering effective health services but more so in terms of improving and supporting the health of prisoners and staff. As a physical environment, HMP Bristol is an intimidating establishment, with its austere Victorian architecture and institutional décor, which limits scope to develop a healthy environment. The Inspectorate commented on the physical environment of the prison in 2008 with regard to safety and respect. It was noted that more than 300 prisoners enter the prison each week, yet the reception building has holding rooms with no natural light and limited private space for confidential interviews or consultations. Some cells within the residential wings were found to have no internal sanitation and the frequency that prisoners could have showers was limited. Despite this, there is potential to develop further the social environment of the prison to enable it to be supportive and empowering for prisoners.

Several stakeholders spoke about limitations the new core day has brought in terms of providing time and space in a prisoner's sentence for purposeful activity. The prison offers a range of offending behaviour and vocational programmes for sentenced prisoners, in line with key performance indicators. However, core day and short length of stay restrict scope for developing new programmes or completing existing programmes with prisoners. The limiting core day means prisoners cannot access the library at weekends or in the evenings. The working week is restricted to core day hours, interrupted by lock-down periods, with up to 10 hours of activity per day, Monday to Thursday, up to 8½ hours on Fridays, and 8 hours on weekend days. In reality, this is restricted further due to the time it takes to move prisoners between wings and the availability of staff during 'off-peak' hours (e.g. weekends). The amount of supervised time available to work with prisoners during the working week is therefore limited, particularly given that, outside the core day hours, staff capacity is reduced as the civilian workforce is off duty and prison officers are employed on the residential wings to maintain security. Lock-down times therefore represent periods of 'stagnation' for prisoners, whose individual motivations and wellbeing can sap, especially at weekends or in the evenings. Ideally, the working day should reflect

that of the working/college day in the community, with recreation time in the evenings. However, the new core day was introduced by the Ministry of Justice as a cost-saving initiative, so any extensions to the working week would impact heavily on staffing levels and costs; for instance, one hour of extra supervised time across the whole establishment would cost the prison an estimated £200,000.

Staff acknowledged that poor relations between themselves and the prisoner population can have detrimental effects on their ability to maintain good order and discipline, which, coupled with deteriorating environmental variables, can impact on efforts to ensure decency, respect, safety and health improvement. Security measures, likewise, can have a negative impact on prisoners' relationships with their families outside prison, through control over visiting and use of phones.

### ***Options for Change***

The custody ethos of the prison can prevent it from being supportive or empowering. This is no different for any other prison where the main purpose of imprisonment is to deprive offenders of their liberty. The challenge is therefore to reconcile health goals – to create supportive environments via participation and empowerment – with offender management goals.

Prisons employ a range of personnel – civilian and uniformed staff – to serve a range of roles and functions. However, uniformed prison officers perform a 'front-line' role and therefore have the most contact and interaction with prisoners. As mentioned, the prevailing culture of the prison is established upon core values of security, discipline and control. Relations between staff and prisoners, and responsibility of uniformed staff for developing and upholding prisoners rights and welfare via their duty of care and the Decency and Respect agendas, may be compromised by a number of key limiting factors. These may include the low staff-to-prisoner ratios, large wing populations with shared association spaces, the authoritarian persona of the prison officer (uniform & keys identity), the disruption caused by the need to move prisoners around the prison, episodes of scheduled lock-down, and the relatively inflexible core day.

It may be feasible to forge alternative ways of managing the social environment, so that security imperatives, along with other environmental constraints, have a lesser impact on

health and wellbeing. For example, new developments could include introducing mixed (inter-disciplinary) teams of staff (some non-uniform) to the 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.

The prison environment, for prisoners and staff alike, should be 'receptive' and hospitable as this is likely to have a bearing on health, wellbeing and rehabilitation. Being a Local Prison means that for many offenders this may be their first encounter with the prison system. Despite experiencing loss of liberty, their time in prison must be a dignified one, where human rights are upheld and prisoners perceive the experience as supportive and productive. Staff recruitment and retention also depend upon the work environment being supportive and empowering.

## ***ISSUE 7: APPROPRIATE COMMISSIONING***

### ***Stakeholder Feedback***

NHS Commissioning has enabled the prison to link into a wide range of health and social care services that traditionally were beyond the reach of the Prison Service. NHS Bristol is uniquely located in strategic terms in being able to link the prison into other services, agencies and specialists, as an NHS commissioner. There is huge potential to develop stronger joint arrangements with Bristol City Council and to link the prison into services within the community (local authority, Third Sector, independent sector and other NHS providers).

NHS Bristol is required to deliver on an ambitious health and social care policy agenda, which includes tackling health inequalities and contributing to measures to reduce social exclusion. This is a principle of World Class Commissioning (DH 2007) NHS commissioners are expected to honour, and the offender population presents as one of the most excluded and vulnerable populations (DH 2005). NHS commissioners can only realistically begin to commission services to achieve the aims of this agenda through a

wider focus on offenders' health and social care needs across the criminal justice system. For NHS Bristol, this means working in partnership with other commissioners and providers across the Bristol catchment area, especially Bristol City Council, to plan and deliver services.

An important issue for NHS Bristol, as the commissioner of health services to HMP Bristol, concerns the quality and range of services it can secure from current providers. For example, mental health services are commissioned to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). AWP has recognised and respected competence in the areas of mental health and drug misuse, for people in the community and within criminal justice settings. AWP provides mental health in-reach services, CARAT services and the CARS (Court Assessment & Referral Service, e.g. Court Diversion plus). An Integrated Drug Treatment Service (IDTS) is provided in the prison, with the purpose of integrating prison and community treatment and preventing damaging interruptions either on reception into custody or on release back home. AWP also provides local, community-based mental health teams, including in-patient beds, which enables relatively efficient transfer of mentally ill prisoners under the Mental Health Act, within the 14-day national waiting time limit. The quality and range of services available to prisoners is important in terms of meeting their diverse health and welfare needs. NHS Bristol's commissioning relationship with AWP is a good example of where integrated services can be developed and delivered. There is also much potential to develop other health and social care partnerships, with greater involvement of Third Sector agencies and local authority providers.

### ***Options for Change***

Given the movement of offenders through the catchment, NHS Bristol must consider how it can best work with neighbouring prisons; for example, HMP Bristol has long-established working relations other local and training prisons in the region, given its function as a local prison. Given NHS organisations' commissioning boundaries, it is therefore essential that they are able to work in partnership with neighbouring NHS and LA commissioners, to enable the effective transfer of offenders across local boundaries. HMP Bristol, for instance, is regularly involved in prisoner transfers to and from HMP Gloucester, whose health services are commissioned by NHS South Gloucestershire. There are many other prisons within the region with whom HMP Bristol must participate.



## **ISSUE 8: HEALTH IMPROVEMENT**

### **Stakeholder Feedback**

A range of themes arose from discussions with stakeholders, which were perceived to have potential value in terms of developing health improvement interventions or measures. There was a general sense that isolated 'lifestyle' programmes were limited in their effectiveness with prisoners, for example smoking cessation and other forms of lifestyle advice or education. In this sense, health promotion initiatives were generally viewed as 'short-lived' and unsustainable, especially given the transience of the prisoner population and the fact that many prisoners have very deep seated health or social needs.

It was suggested that best way to develop a health strategy for the prison would be to develop an integrated approach, which aimed to effectively link up health, welfare and offender management (resettlement) priorities and agendas. It was noted that there are currently too many isolated initiatives and programmes that operate in parallel but do not cross over. For example, for there is currently a separate lead for each of the seven NOMS reducing re-offending pathways, plus a quite rapid turnover of senior staff with lead roles and responsibilities. The NOMS National Reducing Re-offending Delivery Plan (NOMS 2006) emphasises the important function of partnership working and that delivery should therefore aim to:

- establish cross-agency effective partnerships at national, regional and local levels;
- establish alliances with the corporate, civic, and voluntary/faith sectors;
- prioritise information sharing and joint ownership of outcomes;
- develop innovative provision at local level alongside nationally-sponsored initiatives;
- plan and put in place the building blocks for future delivery, including developing the evidence base of what works.

The Delivery Plan identifies seven pathways for action, which all resonate with the aims for developing a healthy prison strategy: [1] Accommodation; [2] Education, Training and Employment; [3] Health; [4] Drugs and Alcohol; [5] Finance, Benefit and Debt; [6] Children and Families; and [7] Attitudes, Thinking and Behaviour. In some ways, these pathways are underdeveloped within the Delivery Plan, yet from a public health perspective, there is much that can be done to develop and reinterpret these pathways

as healthy prison goals. One advantage of such an approach is that it does not bring additional change to the institution.

### ***Options for Change***

A core objective underpinning the WHO philosophy for public health and health promotion is 'enablement', which is defined in terms of "enabling people to increase control over and improve their health" (WHO 1986), achieved through empowerment and collective action. Essentially, the issue of 'responsibility' is central to this, whereby individuals can become empowered to take personal responsibility for their health under supportive conditions; a supportive (empowering) environment is a prerequisite for promoting personal responsibility. This is consistent with the aims of the Prison Service, NOMS and the YJS in terms of facilitating the 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. There are good examples of initiatives from other settings (e.g. schools), where initiatives could be replicated within the prison setting, such as the use of peer education, mentoring, group learning and team building, plus initiatives geared towards reorienting policy and provision, such as developing a Healthy Food standard.

Health behaviour change is difficult to achieve with most groups, and evidence overwhelmingly suggests that change is usually only likely with highly motivated individuals. It is important, therefore, that health education initiatives with prisoners are appropriate and realistic, given the limitations of the prison environment, average lengths of sentence, life circumstances of offenders, and their likely future prospects and opportunities on release. For example, as suggested by some stakeholders, a smoking cessation policy should be realistic and appropriate to the needs of the prisoner population. Currently, for instance, the in-patient facility is designated a non-smoking environment, which has proven problematic given that it invariably holds distressed prisoners, whose smoking behaviour may be the lowest immediate priority. Smoking policy should be sensitive to the needs of the population, which means considering how best to phase out smoking, with consideration of the full range of individual, cultural, social and environmental factors that influence smoking prevalence. Health behaviour change programmes should therefore aim to enable offenders to make lasting changes in their lives, in terms of health improvement, reintegration into society and reduced likelihood of

re-offending. Programmes should be appropriate to ex-offenders' social and economic circumstances in terms of managing their finances, job seeking and reintegrating with their families. There are already many good education and skills initiatives and some that need further development and support. Key issues that are perhaps most relevant to prisoners include drug and alcohol treatment, rehabilitation and prevention; health and educational literacy, safety (in custody), violence, exploitation and bullying, mental and emotional health problems, unhealthy or risky lifestyles, family relationships, sexual health and relationships, and issues of inclusion associated with diversity and equality. The status of education relative to other forms of purposeful activity, however, continues to mean that it remains a less attractive option for many prisoners, especially given the higher wages that can be earned through other forms of employment.

## **4.0 RECOMMENDATIONS**

Drawing on the stakeholder interviews, the associated research and the health needs assessment ten key areas have been identified to guide the development of HMP Bristol's healthy prison strategy. Much progress has already been made as a result of the Health Needs Assessment and Action Plan and through the newly formed healthy prison strategy group. Many of the issues and recommendations raised in this report are therefore already being addressed. Progress in the longer term will depend upon continuing commitment and ownership of the strategy, with leadership from the Prison's Senior Management Team and involvement of professional groups across the prison, prisoners and commissioners and other local and regional criminal justice and health organisations. A partnership approach is probably the best approach, where energy is directed at building on existing initiatives in an integrated and systemic way. These recommendations are expressed as a series of aims and objectives:

### **Represent and involve prisoners**

Consider how to involve prisoners as users or representatives in decision-making concerning the planning and delivery of health, welfare and social care services. A range of options are possible here, which include developing the Health Trainer function, developing buddying or mentoring projects, and employing ex-offenders within the prison.

### **Develop a multidisciplinary health service**

Consider developing and extending the traditional prison health service as a multidisciplinary system of health, welfare and social care.

Engage the full range of health, welfare and social care professionals and agencies in health improvement programmes and initiatives (e.g. sexual health, respiratory health, smoking cessation, etc.), involving allied health professionals (pharmacists, occupational therapists, physiotherapists, health visitors, social workers, public health specialist, etc.).

### **Empower the workforce**

Prison staff are important role models for prisoners. To enable them to have a positive and empowering role, they need to be fully supported and empowered.

Engage Senior Officer level custody staff as 'champions' of new developments in the residential environment, given their potential to influence cultural change.

Evaluate the experiences of different staff groups in terms of their roles, functions and responsibilities as professionals working within a custody/security prison culture, how they adapt and cope with the prison environment, and how they work alongside colleagues and prisoners.

Consider potential barriers that may currently exist in terms of developing relations between prison staff and prisoners (as well as between staff groups themselves and prisoners themselves).

### **Create a supportive residential environment**

Explore measures for developing empathic and therapeutic conditions on the residential wings to support prisoners with emotional, psychological or social problems.

Consider further development and innovation of peer support systems to meet the social, emotional and empowerment needs of prisoners.

Keep developing and evaluating the Personal Officer scheme to ensure liaison, support and diversion are optimised.

### **Commission services that are responsive to health and social need**

Health needs assessments at reception should be sufficiently sensitive to detect prisoners' physical, mental, emotional and social needs, to enable appropriate care planning and referral to medical or non-medical agencies and services.

Services should be commissioned that are accessible and receptive to the full range of health and social needs of prisoners, irrespective of their custody or offending status.

Screening and assessment should be able to determine the proportion of prisoners who do not come into contact with front-line health services in the prison who might otherwise benefit from access or referral, for instance to social care or third sector services.

Prisoners at risk of harming themselves or others should receive an appropriate care package where their immediate emotional, psychological and mental health needs have equal importance to security and safety issues (i.e. the use of monitoring and surveillance should not further provoke deterioration in their health status).

Continue to review the ACCT (Assessment, Care in Custody, and Teamwork) system of self harm assessment used with all new prisoners to ensure their Care Maps are effective in planning and responding to individuals' needs.

A needs assessment approach should be piloted to evaluate, in an integrated way, offenders' health, social, educational, employment and offending needs.

### **Create an ethical and humane system of care**

The institution, through its duty of care, should be able to accommodate services that can provide ethical standards of care and practice, in terms of confidentiality, consent, privacy, respect and decency.

Review the mechanisms available to prisoners to maintain contact with families and significant others and consider alternatives to the conventional systems.

## **Develop a system of bespoke offender care management**

Evolve a proactive, bespoke approach to offender care planning, linking up more effectively with appropriate statutory, third and independent sector agencies.

Enable flexible commissioning that is able to forge (and contract) bespoke user need-driven programmes of care.

## **Reorient institutional priorities**

Provide or continue to provide in-service training for all 'front-line' prison staff in communication and listening skills to enable them to engage effectively with the Decency agenda. This is currently being developed under the 'Decency Project', and a DVD has been produced by staff at HMP Bristol for staff that explores the concept of decency.

Re-consider the preferred role, conduct and identity of front-line, uniformed staff, exploring possible alternatives to their role, function and conduct with prisoners.

Evaluate impacts of physical, institutional and social environments on the residential wings impact on prisoners and staff.

Conduct a feasibility study to establish how to reduce institutional barriers that obscure efforts to build a supportive and empowering institution (e.g. staff and prisoner uniform codes; staff-to-prisoner ratios; large wing populations; large shared association spaces; disruption caused by prisoner movements; the core day; etc.).

Explore innovative ways of using the core day to prioritise activities for prisoners that maximise their health, welfare and social care potentials. Commission resources to extend the core day for some prisoners, perhaps in terms of delivering health or social care programmes outside standard core hours.

Research the value that purposeful activity currently brings to prisoners in terms of reducing reoffending and improving health and wellbeing.

## **Commission for offender health, welfare and social care**

Harness NHS Bristol's Commissioning role in establishing a portfolio of health, welfare and social care for offenders, engaging with Local Authority, Third Sector and other health providers.

Commission an integrated health, social care and offender management strategy for the local offender population that is oriented towards and funded to deliver services that effectively meet the health and social needs of offenders and tackle the core issues of inequality and social exclusion.

NHS Bristol should explore possibilities for joint commissioning offender health services in partnership with neighbouring commissioning NHS Organisations.

Ensure that the Joint Strategic Needs Assessment to reflects accurate intelligence on the health, welfare and social needs of offenders in the Bristol area.

## **Develop the public health function**

Acknowledge that health improvement of the offender population is the responsibility of all professionals and agencies involved in the care and management of prisoners and that a joined up approach is required to tackle health and social inequalities, social exclusion and offending.

Enable the local public health team to provide strategic leadership on offender and prison health, and to provide research and intelligence expertise relating to the health, welfare and social needs of the local offender population.

Develop, as cross cutting initiatives, new health development programmes that reflect evidenced effective strategies in other sectors (e.g. the Healthy Schools Awards). For instance, a healthy diet and nutrition strategy could be introduced improve the nutritional quality of food across the prison (with a 5-a-day policy)

The local public health team and health commissioner (NHS Bristol) should work in partnership with local criminal justice agencies and the regional Offender Health Management Board to develop as far as is practicable the 'community prison' model for HMP Bristol. The model was developed by former Home Secretary, Charles Clarke, and was suggested for prisoners serving short terms of imprisonment.

## **5.0 ACTION PLANNING**

### **5.1 Developing a healthy prison strategy**

In developing this strategy advice was sought from colleagues at the Healthy Settings Development Unit at University of Central Lancashire (UCLan), which is a collaborating centre for the WHO Health in Prisons Project and currently hosts a regional health and wellbeing programme for offenders, funded by Big Lottery.

Experience from the north-west region suggests that before beginning a health promoting prison initiative, an advisory group representing a variety of sectors should be established. The role of the advisory group is to share experience, skills and expertise in working towards development, implementation and evaluation of the initiative. This process can take between two and three years. The following stages are recognized as key to developing a healthy prison strategy:

#### **1. Build awareness and commitment**

Involves acquiring commitment from the senior management team to the process and then raising awareness and understanding amongst staff and prisoners as to why the prison is becoming involved in this initiative.

Progress at HMP Bristol:

- Senior Management leads the Healthy Prison Strategy from the Prison and reports to the Prison Partnership Board.
- A communication and staff training programme is in development

#### **2. Set up a health promoting prison team**

The team should include representatives from all relevant areas of the prison to ensure shared ownership. Its role is to help develop, drive and communicate activities within the health promoting prison programme.

Progress at HMP Bristol:

- A Healthy Prison Group has been established.



### **3. Carry out a Health Needs Assessment.**

This has three parts:

- An *organisational health assessment* (Health Impact Assessment) to identify policies, procedures, systems and facilities that impact on health and wellbeing.
- A *staff needs assessment* to identify needs over a range of issues and to provide personal feedback on opportunities for change.
- A *prisoner needs assessment* to identify needs in relation to the whole range of factors (or determinants) that can impact on health. This can incorporate a healthcare needs assessment.

Progress at HMP Bristol:

- A Prisoner Health Needs Assessment has been carried out
- This report begins to address the organisational health needs assessment

### **4. Carry out a prison self-appraisal**

Results from the HNA will reveal strengths and areas of opportunity for health improvement, which are then compared against the quality criteria for a health promoting prison.

Progress at HMP Bristol:

- To be included in the action plan

### **5. Develop a Health Action Plan**

The areas of opportunity identified in the HNA are prioritised and translated into a Health Action Plan. How actions are to be evaluated is agreed at this stage.

Progress at HMP Bristol:

- Action Plan in place

### **6. Implement the Health Action Plan**

The health action plan is implemented over a time bound period (e.g. 12 months), during which time progress is monitored, reviewed and communicated by the health promoting prison team.

Progress at HMP Bristol:

- Action plan is regularly monitored and reviewed

## **7. Evaluation and review**

Staff and prisoner needs assessments are repeated after 12 months to review progress and develop the next Health Action Plan. Actions from the Health Action Plan and the overall process are evaluated, and successes and opportunities are identified.

Progress at HMP Bristol:

- Health Needs Assessments and Action Plan are repeated and reviewed annually

### **5.2 HMP Bristol Healthy Prison Action Plan**

The plan detailed in the following table has been developed by the Healthy Prison Strategy Group in response to the recommendations in this report. The stated aim of the plan is to “create a healthy environment and culture where safety, personal fulfillment and dignity are valued as important prerequisites for health”. The group currently comprises members of the prison’s Senior Management Team, plus representatives from NHS Bristol, Public Health and the University of the West of England. Leadership of the group resides with the SMT, under the direction of the Governor and the Head of Safety and Decency. Key personnel have been named against particular tasks (omitted from this report); progress against the targets will be reviewed at regular intervals by the group. It should be noted that this action plan is under continuous review and therefore only reflects the situation at the time that this report was published.

<b>OBJECTIVE</b>	<b>ACTION</b>	<b>PROGRESS</b>	<b>TARGET DATE</b>
INNOVATIONS	Increase unlock time in in-patient wing		Sept 09
	Pilot recordable audio letter for prisoners	Funding Application for Evaluation	Sept 09
WORKFORCE DEVELOPMENT	Develop Healthy Prison Training for all staff	Pilot organised Full Implementation	Nov 09 Apr 10
	Develop & extend public health roles across the prison		Apr 10
SUPPORTING HEALTH THROUGHOUT THE OFFENDER PATHWAY	Test efficacy of MH pathway across offender pathway		Oct 09
	Develop working matrix for clients with complex needs		Oct 09
CREATING A HEALTHY ENVIRONMENT	Identify indicators in existing Key Performance Indicators relevant to the prison environment		Nov 09
STAFF WELL BEING	Achieve programme of staff vaccinations as per Prison Service Order		Oct 09
RIGHTS AND STATUS OF OFFENDERS – personal fulfilment and dignity	Actively support prisoners to develop and maintain positive relationships and support networks (Families Pathway)		Nov 09

.../CONTINUED	Ensure incentive scheme is gold standard. Conduct Equity Audit on IEPS	EA on IEP completed and awarded green rating; all actions completed	Dec 09
	Develop anti-bullying strategy	Violence reduction strategy comprehensively reviewed and published. Multi- disciplinary approach adopted, with significant input from Psychology. Anti- Social Behaviour Program implemented for victims and perpetrators	July 09
	Provide support to those who open ACCT  Develop training for ACCT assessors	Completed and monitored continually	Oct 09
SUPPORTING HEALTH IMPROVEMENT	Stop Smoking – ensure same level of service as outlined in LES will be delivered within the Prison	Pharmacy runs chronic condition clinics and offers advice and referral  Stop Smoking advice provided  Visitor / prisoner road show to be investigated	Oct 09   Jan 10
	Healthy Eating - HMP Bristol to increase the availability of healthy food. To achieve Heart Award standard.	Prison Kitchen to attend Bristol Food and Health Strategy Group  Work towards award is well advanced	Nov 09
	Develop exercise on prescription	Investigate Coronary Heart Care & Rehabilitation training	Dec 09
	Gym Staff to provide a range of activities in out-of -cell time		July 09

.../CONTINUED	Building resilience for wellbeing - deliver lifestyle awareness through prison education programmes		Dec 09
	Focus on prevention and early intervention for mental health	Increasing capacity of out-reach	Oct 09
	Explore IAPT for prison population		Oct 09
	Actively support VCS in-reach		Nov 09
	Act on findings of psychology research into self harm across prison establishment		Nov 09
HEALTH PROMOTING HEALTHCARE	Develop stronger links with social care	This will be undertaken via needs led referral	Nov 09
	Map chronic health needs for population	Green on performance indicators	Jul 09
	Undertake wing health profiles to support proactive health care	Green on performance indicators	Jul 09
	Re-decorate inpatient wing	On-going painting program	Jul 09
	Re-design exercise area in inpatient wing	Area jointly shared with segregation	Nov 09
	Maintain group rooms as therapeutic space	On-going	Nov 09

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