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Are health promoting prisons an impossibility? Lessons from England and Wales.

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Abstract

This research investigated current health promotion activities in 1999/2000 in prisons in England and Wales. It involved the use of a number of methods, a questionnaire to all prisons in England and Wales, interviews, case studies and interviews with health promotion and public health staff in health authorities with prisons in their area. This research documents the range and quality of health promotion occurring in prisons against which future activity might be measured.

The findings indicated that health promotion is under-resourced and the concept and practice poorly understood. Secondary and tertiary care activities were often interpreted as health promotion. For example the early detection and isolation of those with mental health problems was interpreted as health promotion, but the advancement of positive mental well-being is not seen as important. Health needs assessment tended to be analysis of and for health care services, and -except in a minority of cases - did not include consultation with staff, prisoners or their families. Where responsibility is shared and the work based on multi-disciplinary approaches it seems more likely to be reported accurately as health promotion activity. The official policy of healthy settings/whole prison approach was not understood by many and its application was limited.

The findings have informed the development of a new health promotion strategy for the Prison Service in England and Wales.

Key words prisons, healthy settings, needs analysis.

Introduction

There's a town somewhere in England and Wales that is not on any map, consisting of 70,000 people it is bigger, for example, than Gosport in Hampshire, near Portsmouth. The 'residents' of this 'town' are mainly men (90%), over represented by those from lower socio-economic groups. Their health status is lower than that of the general population, between 70-90% smoke. This town is among the fastest growing in the UK. This 'town' is made up of the prison population and is in fact distributed among 134 institutions spread across England and Wales (based on an idea by Baum 2000). This incarcerated population is known to have a disproportionately higher incidence of mental health, suicide and drug misuse and the level of suicide is the highest among any social group (Bridgwood and Malbon 1994).

The rate of imprisonment in England and Wales is approximately 125/100K of the population. This places it fourth in international terms, with only the US (690/100K), Russia (678/100K) and Iran (155/100K) having higher rates (White, Cullen and Minchin 2000). Within the European region the policy approach to prisons and incarceration is deeply divided with the Scandinavian countries place more emphasis on rehabilitation than incarceration than say Ireland, the UK or Germany and the Mediterranean countries operating a more open policy with regards to imprisonment (O'Mahony 2000).

Health promotion policy and prisons

Recent policy initiatives in England and Wales (HM Prisons Service and NHS Executive 1999) and the WHO (Europe) Health in Prisons Project (World Health Organization 1998), have called for a greater focus on health, health promotion and primary care. The former document noted an over reliance on healthcare beds within prisons and a medicalised model of care, the report went on to say:

We would encourage the developments already taking place with regard to health promotion and recommend that health care and health more generally, form an appropriate and integral part of prisoners' regimes, taking a proactive approach to the services provided in the light of assessed prisoner health needs. While prisoners had good access to primary care this did not always meet their needs in terms of health promotion and disease prevention. (HM Prisons Service and NHS Executive 1999, p 27).

In the past, health care provision in the prison setting have been funded and managed by individual prisons from within their overall prison budget leading to variations in standards. The demands of the total institution became the reason d'être for many health care workers in the prison system (Goffman 1961). Despite this, some institutions have managed to develop health-promoting environments that have tackled issues such as bullying (Waplington 1993, Bird et al 1999, Caraher, Bird and Hayton, 2000, Caraher, Hayton and Bird 2000). The joint report from Her Majesty's Prison Service and the National Health Service Executive (HM Prisons Service and NHS Executive 1999) places responsibility for health care with both the Department of Health and the Home Office to help effect some of the above changes but management of health care within prisons remains the responsibility of the latter department. At a local level each Primary Care Trust is obliged to represent prisons within the local planning process as set out in the Health Improvement Programme (HImP).

The case for health promotion in prisons

A health promotion policy based on self-determination and self-esteem, faces obvious problems. For example, there are reports of prisoners being locked up 23 hours a day, prisoners not having access to 'across the counter' medicines, bullying, attempted suicide, suicide and violence, all of which are indicators of underlying mental health problems (Bird 1997, Howard League for Prison Reform 1997). All of this makes it hard to move from a concern with illness and 'containment' to promoting well-being. On the other hand, such a situation presents an opportunity to provide education, support and treatment within a contained environment (Perkins 1999, Burgess 1999). The World Health Organisation (Europe) Health in Prisons Project recognises these

issues and is keen to develop prisons as one of the settings to promote health and tackle inequalities (World Health Organization 1998).

Methodology

The brief from the Prison Health Policy Unit at the Department of Health required a baseline of health promotion activity to be established against which future activity could be measured. The objectives of the research were as follows:

- To assess the range and quality of health promotion initiatives currently operating in prisons in England and Wales.
- To explore the understanding of the concepts and terminology related to health promotion in prisons in England and Wales.
- To assess the training needs of appropriate staff by analysing the existing training of staff.

The research was carried out between November 1999 and April 2000. It involved use of the following four interwoven methods.

1. A questionnaire sent to all 135 prison governors in England and Wales focussing on: who was responsible for health promotion; their qualifications; what health promotion was taking place; what resources were available both within and outside the establishment; and attitudes to and perceptions of health promotion.
2. Twenty semi-structured interviews conducted by telephone with a sub-set of 20 prisons. The sample was purposive and based on analysis of the questionnaire responses and chosen to represent a range of institutions, at different stages of development. The survey typology was designed to pick up on the quality issues and gathered examples of good practice by focusing on training, education and the involvement of outside agencies in prison health promotion activities. The aim was to gather perspectives on health promotion that could not be easily gained in the questionnaire.
3. The development of six case studies to produce an in-depth picture of health promotion in practice to fill in and understand the operational gaps from the other data

gathering methods. The institutions chosen ranged from those who were actively engaged to those only beginning to contemplate initiating health promotion activities. The procedure involved shadowing of staff, analysis of documentation, perusal of whole institution procedures and policies, focus groups/interviews with staff, prisoners and other interested parties such as local health promotion or drug agency staff involved in prison health promotion activities.

4. Semi-structured interviews with health promotion or public health staff in the health authorities with prisons in their areas. Sixty six health authorities (out of a total of 107 in England and Wales) have prisons in their areas. Many of these have more than one prison within their area. Where possible copies of plans, annual reports and related documents were also obtained.

Results

After a single reminder the response rates from the questionnaires was 92%, with 120 out of a possible 135 being returned, successful contact and an interview with an individual within Health Authorities with responsibility for prisons was made with 58 out of a possible 66 (87%).

The results are presented under three main headings. The first looks at the state of needs assessment and includes data on the level of consultation with staff and prisoners, the dilemmas between traditional individual and population needs assessment, and explores what staff and prisoners consider to be priorities for health promotion. Under the second heading the data on the state of current health promotion co-ordination and activity is dealt with. It looks at who co-ordinates/manages and carries out health promotion, and details policy development and health promotion planning groups. Finally the health promotion successes and failures identified by the respondents are set out in order that lessons can be learned from the barriers to successful implementation of health promotion initiatives. It is important to note that the results from the different research methods are merged to present a perspective on the various aspects.

The state of needs assessment

There were many reports of needs assessment although analysis showed that the majority had little or no health promotion element and could best be described as health care needs assessment based on epidemiological data, required to plan health services in the prison. The process of needs assessment was lead and dominated by public health specialists to the exclusion of other staff such as drug workers, health promotion staff and even prison staff or the prisoners themselves. Many public health prison leads we interviewed, felt that there was little need for health promotion and other specialists to be involved at a strategic level in the needs assessment process.

There were a small number of examples (7.5%, n=9) of practice involving public health and health promotion specialists along with prison service authorities working together to carry out needs assessments. These can be classified under the following three categories:

- The secondment of a health promotion specialist to a prison or group of prisons on either a part-time or full time basis (n = 6).
- The use of external health promotion specialists/academics to carry out a health promotion needs assessment (n =2).
- A project based on a settings approach, which involved a link worker between the health authority and the prisons being seconded one day a week to the prisons. This started in 1997, and so has now become embedded in the culture of the prison (n=1).

A number of those we interviewed reported having the input of a health promotion specialist gave a different interpretation of health needs. The following quote points out the mismatch between health needs assessment based on secondary care and that incorporate a primary prevention or healthy settings approach:

The prisons have audits, I look at them and think 'why do they do that, they have clinics for this and that, for example asthma and one or two percent of the [prison] population have asthma, it's not necessary or representative. The health needs assessment that we're doing now will help sort out the mismatch and create clinics

which might be more needed such as dyslexia, speech therapy all of those. For example, it's a basic right, in legislation, that if you are a non-smoker you should not be put with a smoker, with cases of overcrowding this frequently happens.

In some instances the needs assessment process floundered when neither the health promotion nor the public health staff possessed a knowledge or cultural understanding of prisons.

Consulting with staff and prisoners

We found that the views of prisoners and/or the prison officers and health care staff were rarely built into the needs assessment process. For the latter group we found that this resulted in them expressing dissatisfaction and scepticism with the needs assessment exercise. For a number of health authority staff the reasons given for not dealing directly with prisoners were 'fear' and safety. The manager of a health promotion unit based on the outskirts of London said '*there are members of the health promotion team who say they will not go into the prison, it is very isolated and I will not force them as I am responsible for their safety.*'

Many prisons indicated that the promotion of health was best tackled in tandem the health needs of staff and prisoners. This was justified on the basis that prison officers were the '*custodians of the inmates*' welfare and their health was also poor, due to stress etc. Despite this we found only 8 examples (13%) of health authorities carrying out needs assessment which included the staff as part of the process and only one example of assessment which included the needs of the families of prisoners.

Individual versus population needs assessment

Figures on sickness, immunisation rates and the use of health care facilities formed the basis of most public health needs assessment. In response to the question 'does each individual prisoner have their health promotion needs assessed?', 44.2% of prisons indicated that they did. A further respondent said that this was done on request; and three more said that such assessments were planned or about to be started. Sixty one establishments supplied details of when these assessments took place. In the vast

majority (52/61) the assessments took place at reception. Clinics were the next most popular place for assessments - in 18 of the 61 establishments supplying details. The collation of this information into an overview was rarely attempted. The prison service did not hold evidence of any systematic assessment of population health and the use of public health skills were not evident.

Staff priorities for health promotion

As prison staff are gatekeepers to the prisoners we gathered their views of health promotion priorities. The questionnaire sent to the prisons asked for their priorities with respect to eleven areas of prison health promotion. They were asked to supply a rating from: 'definitely should not do' to 'definitely should do', for each of the topic areas. The percentage reporting that each activity should *definitely* be covered are shown in Table 1. Health promotion relating to substance misuse gets the highest priority, healthy eating, physical and parenting education get the lowest.

Table 1 also shows that here are some disparities between expressed priorities (measured as the percentage agreeing that health promotion 'definitely should do') compared with the levels of current health promotion activity as indicated by the respondents. Four areas have levels of activity less than one would expect from the expressed priorities. These are mental and social well-being, staff health, dental health, and global approaches to health.

Table 1 Priorities for health promotion (expressed as a percentage of those saying definitely should do health promotion) compared with reported existing activities

Topic area	Percent saying "should definitely do health promotion (and rank)	Rank based on actual level of activity
Health promotion with reference to substance misuse, including Hep B and C	75% (1)	(1)
Mental and social well being	60% (2)	(6th equal)
Smoking	56% (3rd equal)	(2)
Whole prison approach	56% (3rd equal)	(6th equal)

Staff health promotion	50% (4)	(10)
Cancer prevention	44% (5)	(7)
Sexual health	36% (6)	(3)
Dental health promotion	27% (7)	(8)
Healthy eating	23% (8)	(5)
Physical activity	23% (8)	(4)
Parenting education	15% (9)	(9)

The high priority given to substance misuse and mental health may not derive from an interest in health promotion *per se*, but from a concern with control and a need for early detection and problem isolation of individual cases. The discrepancy between the high level of support for the whole prison approach and its actual level of activity is also worth nothing.

Attitudes to health promotion were explored with a modified subset of the questions used in the Rawson and Grigg (1988) survey of health education officers. Respondents were asked to indicate the priorities that should be attached to eleven tasks. The item receiving most positive endorsements states that those responsible for health promotion in prisons should seek to help individual prisoners to take responsibility for their own health: 61.3% said this definitely should be done. Three other items were almost as strongly supported: to recognise the social, cultural and political dimensions of the causes and solutions of illness; to set-up multi-disciplinary working parties; and to support local policies to create a healthier environment. Yet these items/areas received little attention in practice.

A factor analysis of the responses to the eleven items recording attitudes to health promotion grouped the items into two sets. The main point of interest is that one of these sets contains eight items concerned with more general approaches to prison health promotion, such as people should help empower individual prisoners to take responsibility for their own health; the other contains just three items entirely concerned with the processes associated with specific health promotion activities: giving talks,

running groups and initiating fitness programmes. The survey detected small differences between the attitudes of groups of staff, measured by their scores on these two factors.

Current health promotion activity and co-ordination in the prison setting

Some form of prisoner involvement in carrying out health promotion was noted in 96 establishments (79.3%). In the majority of cases (n=87 establishments, 72.5% of responses) it took the form of participation in peer support, peer education (such as befriender schemes) and self-help groups (in 18 prisons). In at least five establishments, prisoners were involved in the preparation and distribution of health promotion materials. Evidence of involvement of prisoners as active participants in the needs assessment process was minimal.

The questionnaire sent to all the prisons asked what types of health promotion activities were currently undertaken in ten areas of health concerns and whether there were any activities which adopted a whole prison or 'settings' approach. Three main categories were used to describe the level of health promotion activity:

Continuous - that which is run regularly and is relatively visible - such as groups which meet weekly or health promotion interventions which are provided every time an prisoner receives related health care.

Periodic - refers to groups that meet much less frequently or high profile one-off events, such as health fairs and activities linked to national/world health topic days.

Opportunistic - provided if a prisoner requested it, or if a meeting, or more typically a medical consultation, was already taking place on a related topic.

The numbers of establishments delivering health promotion at these levels are shown in Table 2. An approximate ranking of the total activity in each area can be gleaned from the far right column in the table. For example, the most frequently mentioned topic, substance misuse, is covered in all but 8% of establishments; the other four topics with widespread coverage are smoking, sexual health, healthy eating and physical activity.

Table 2 Reported health promotion activities

% of establishments reporting this type of activity on each of these areas for health promotion - only one activity coded per area								
	Continuous service	Periodic	In planning stage	Posters	Opportunistic	Leaflets	Other	None/No response
Healthy eating	49	14	1	3	3	10	1	19
Dental health	23	16	3	3	11	10	3	31
Physical activity	65	8	1	1	3	3	2	17
Cancer prevention & early detection	19	31	3	1	4	13	2	27
Substance misuse Including Hep B & C	46	25	2	1	12	3	3	8
Parenting	12	26	3	0	3	2	3	51
Mental & social well-being	30	24	3	0	12	3	2	26
Sexual health	28	29	2	1	8	15	1	16
Whole prison approach	9	9	7	3	0	3	23	46
Smoking	31	28	1	3	5	13	4	15
Staff health	29	22	9	0	7	2	5	26

Parenting education was a feature of young offenders institutions and of women's prisons.

Only six establishments assign the responsibility for health promotion to a health promotion specialist; and the most common model - in 60 cases, is for the health care

manager to oversee health promotion. In a further 43 establishments, the responsibility lay with someone else in the health care unit: 37 of whom described themselves as either doctors or nurses and 31 gave their prison service grade as their job title. e.g. principal Health Care Officer. In 12 establishments, responsibility for health promotion was taken by someone outside of the health centre (see Table 3).

Table 3 - Unit allegiances of those with principal responsibility for health promotion.

	N	%
Health care – doctors	12	10.0
Health care – nurses	25	20.8
Health care - health prom specialists	6	5.0
Health care - general (e.g. HCO, health care manager)	60	50.0
Catering	1	0.8
Administration including personnel	4	3.3
Education, art, library, activities	3	2.5
Discipline & general prison staff	3	2.5
Rehabilitation & (prison) probation	1	0.8
Unspecified	5	4.2
Totals	120	100.0

In terms of who managed/co-ordinated and actually carried out health promotion, responses were split between the 44% who were only involved in its management and co-ordination and the 13.4% of respondents who delivered health promotion but had no management or co-ordination role. (Table 4).

Table 4 Respondents' role in relation to health promotion

	N	%
Co-ordinate only	24	20.0
Co-ordinate and carry-out	9	7.5
Co-ordinate and manage	6	5.0

Co-ordinate, carry-out and manage	28	23.3
Carry-out only	16	13.4
Manage and carry-out	8	6.7
Manage	23	19.2
None of these	6	5.0

That 44% of those who co-ordinated or were responsible for health promotion were not carrying-out health promotion is not entirely surprising when one considers the time they had for these activities. Nearly half were spending less than two hours per week on all their health promotion responsibilities and a further 22.5% were only spending between 2 and 5 hours.

Over half of the respondents (57.9%) reported that they did not have sole responsibility for health promotion. Most of these gave details of the 76 people with whom the responsibility was shared. The roles of these 76 people who shared the responsibility were similar to those of the respondents, though a smaller proportion (26.9%) were involved in delivering health promotion. Rather more, 32.8%, were engaged in management and supervision and a good few of these seemed to be more senior than those who completed the questionnaire. In establishments with joint responsibility 10.4% helped to co-ordinate the internal prison health promotion efforts; 13.4% liaised with outside bodies on health promotion matters. However, persons with joint responsibility were also rather more likely than the original respondents to be based outside of the health care unit, for example in an administrative or educational function.

In contrast to the management of health promotion, nurses were most often identified as those responsible for carrying out health promotion - in 88.3% of establishments, and they are widely supported by other non-medically qualified members of the health care teams (health care officers, other health care workers and professions allied to medicine). Staff from prison education units, libraries etc. were involved in health promotion in 41 establishments while physical education staff were involved in health promotion in 30.9% of prisons.

Health promotion groups

A 'health promotion group' existed in 35 (28.9%) establishments, though their titles, such as Health at Work Committee and Occupational Health Committee, suggest that prisoner health promotion might not always be their prime aim. Five respondents did not know whether such a group existed in their prison.

The composition of these groups shows a part of their membership drawn from outside the prison health care staff:

79.4% of groups included someone from prison management

47.1% someone from education, libraries and related activities

29.4% from the local NHS

23.5 from prison drugs team

29.4% from residential wing staff

50% from physical education

20.6% from probation

38.2% from discipline and general prison staff.

Groups with responsibility for health promotion were more likely to be found in establishments where responsibility for health promotion was shared - (28) 40.6% of those where there is joint responsibility already have a committee or one is planned, compared with 9 (19.6%) of committees where there is no joint responsibility. Details of the composition of groups were provided by 34 establishments and are summarised in Table 5. Fifteen of the groups included a representative from one or more external agencies. Feedback from interviews with a subset of prisons indicated that this outside representation was due to the lack of expertise existing within the prison.

The remaining 19 were entirely composed of representatives from units within the prisons, though one of these also included someone from the Prison Officers Association and another someone from the Board of Visitors.

There is a marked contrast between the levels of prisoner involvement in day-to-day delivery of health promotion activity and their involvement in groups responsible for co-ordinating and planning health promotion. Only one of the 35 groups mentioned by respondents was reported as including a prisoner representative, this same prison group also included representatives from outside agencies and the Prison Officers Association.

Table 5 shows by row the type of group structure - and the numbers on the right are the numbers of groups conforming to each type - not the numbers of groups containing each type of representative. The table doesn't show how many contain each type of representative, for example, the third row represents groups made up of only representatives of units within the prison and the Prison Officer Association - and there are three groups of this type amongst the 34 of which we have details. Table 5 also highlights that half the groups do not have external representation and almost all do not have prisoners represented on them.

Table 5 Composition of Health Promotion Groups - whether outside groups are represented

Group composition						
Representation from one internal unit.	Representation from 2 or more internal units.	Representation from one or more	Representation from Prison Officer Association (trade union)	Representation from Board of Visitors	Prisoner representation	No. of groups with this composition
X						1
	X					14
	X		X			3
	X			X		1
X		X				2
	X	X				11
	X	X		X		1
	X	X	X		X	1

The existence of a written prison health promotion plan or strategy was another marker of a co-ordinated approach. Such plans were reported in 18 (15%) establishments, but 9.2% of (11) respondents did not know if such a plan existed.

Successes and failures

The questionnaire asked respondents to describe one success and one failure amongst the health promotion activities in their establishment and 131 successes and 43 failures were nominated. Whether these judgements were based on systematic criteria is unclear

as very little detail was supplied on the local mechanisms for evaluating health promotion. One of the more formal and widespread procedures was the distribution of feedback questionnaires at health fairs, one of the less formal evaluations estimated the success of a leaflet campaign by the numbers of obviously discarded leaflets. A rather cavalier attitude to evaluating health promotion emerged in some of the qualitative interviews with prison staff. One medical director said '*I am constantly evaluating what I do - that's part of my job*'. He then went on to say in the next sentence:

There is no formal evaluation of health promotion within the prison. The inmates were asked about the changes in diet and opinions were collected but nothing happened to the data.

In the reporting of successes and failures, there may be more chance of something being described as a success if it is open to simple monitoring or outcome measurement. This may explain the high proportion of screening, immunisation and vaccination programmes amongst the successes. HIV and hepatitis clinics including an element of screening and vaccination were most often reported as successes (in 15 institutions); drug treatment, rehabilitation and harm minimisation programmes were success for 13 establishments; and screening, immunisation and vaccination programmes (for diseases other than HIV and hepatitis) were mentioned by 8 respondents. The success was often judged to be the establishment of the clinic (process outcome) as opposed to any impact or outcome measures. Other successful areas were health fairs, well person clinics and various mental health initiatives - mentioned by nine respondents.

Far fewer failures than successes were reported and these referred to structural and resourcing problems that limited the capacity to deliver health promotion, rather than specific activities which had failed. An example of the latter was provided by the example of smoking reduction and cessation programmes, which were reported from 18 establishments. Five gave no reasons for the failure, but six thought there would be greater chance of success if nicotine patches were available free or on prescription. Four

noted that activities were hampered by lack of support from by staff, or were not reinforced by management and concluded that support was needed at governor level.

The organisational and structural issues raised in these examples of failed activities were often mentioned elsewhere in the questionnaires. A common theme was the failure or decline of initiatives, either because they relied on the time and enthusiasm of individual staff members who subsequently left or were transferred, or because they lacked recurring funding to continue or expand. Such failures seemed particularly damaging because of the previously raised expectations and subsequent disappointment.

Discussion

As a general caveat, this research showed a ‘snapshot’ from the year 2000, and the results have already begun to influence policy and practice in the Prison Service. This can be seen in the new national strategy for prisons in England and Wales *Health Promoting Prisons: a shared approach*, available at www.doh.gov.uk/prisonhealth

The findings show a situation where health promotion in prisons is under-resourced, with few prisons having dedicated budgets, for health promotion, and the concept and the practice poorly understood. Secondary and tertiary care activities are often seen or interpreted as health promotion activities. For example the early detection and isolation of those with mental health problems is seen as health promotion, but the advancement of positive mental well-being is not seen as an issue of prime importance (Bird et al 1999, Caraher, Bird and Hayton 2000, Caraher, Hayton, and Bird 2000). Health needs assessment, except in a minority of cases, was not undertaken as a collaborative exercise, or based on multi-disciplinary work, using multiple methods. The emphasis was on health care as opposed to health needs assessment, thus missing the potential of the Health Improvement Plans (HImPs) (Department of Health 1999) to tackle the determinants of health and to reduce inequalities. The health promotion agenda is influenced by a mechanistic approach to health and a concern with the very real dangers of issues such as self-harm and the prevention of suicide. If health promotion is to be developed the advantages of prevention and the promotion of positive well-being need

to be promoted with the staff and balanced with the requirements of staff to prevent suicide and the incidence of self-harm. Approaches to needs assessment also need to be multi-disciplinary and involve different groups to guard against an overly medicalised approach becoming dominant.

Although a national needs assessment exercise is underway and provides a key entry to health promotion activities (Marshall, Simpson and Stevens 1999), there is a danger of this becoming a technical exercise and thus neglects the views of prisoners, their families and staff. A review of the situation by Marshall, Simpson and Stevens (2001) says that *'local surveys of the health status of prisoners are time consuming and rarely add to information estimated from published data. However, if they are necessary to inform specific decisions they are useful'*. The opportunity to promote health in its broadest sense is being lost if the local HImPs are not used to address issues of health and the broader determinants that influence health. There is an urgency not to miss specific issues raised by prisoners in favour of a so-called 'objective' needs analysis approach which is the position reflected in official guidance as noted above in the formal guidance given by Marshall, Simpson and Stevens (2001) (see also <http://www.doh.gov.uk/prisonhealth/toolkit.htm>). For example, adequate access by families to prisoners including the quality of the experience of family visits are issues identified by prisoners as important in influencing health (The Devon Prisons Project 2000, The Office for Public Health in Scotland 1999). The lay beliefs of prisoners from ethnic minority backgrounds or foreign nationals need to be considered in the delivery of programmes and the promotion of health (Hayton, Caraher and Parkes 2001).

Most health promotion in prisons was co-ordinated and carried out by staff in health care who were seen by other staff—such as prison officers— as the appropriate group to lead on this. Health promotion was also seen as an activity separate from other daily activities and something to do when time was available. This is akin to the situation in hospitals where nurses view health promotion as a separate activity from proper nursing (McBride 1994, Benson and Latter 1998). While health care staff have an obvious role and expertise in health promotion it needs to be acknowledged that health promotion is

everybody's responsibility and a way needs to be found of developing it as part of the work of every member of prison staff and not an activity that is identified with health care or the running of education groups. This also raises the issue of what is health promotion for the various interested parties. There is the potential conflict between the needs of prison officers on the wings and the guidance as laid out in the Future Organisation of Health Care and the World Health Organisation in the moves towards a healthy promoting environment (HM Prisons Service and NHS Executive 1999, World Health Organization 1998),).

There are discrepancies between the actual health promotion work reported and the expressed priorities of the staff. It was heartening that staff identified the whole prison/settings approach as important, but less so that the activity/process was not discernible or understood in practice. The focus on the creation of a climate for promoting health should be the responsibility of all who live and work in prisons but the lead responsibility for creating the supportive environment within which health promotion can flourish lies with management. The focus needs therefore to shift from the current emphasis on health education activities with its emphasis on topic specific agendas to one that is balanced with health promotion and the creation of supportive environments. One way to start this process is by the development of written prison health promotion plans or strategy documents which were reported in 15% of establishments. Those prisons with such a document/policy were more likely to be engaged in health promotion activities.

Much health promotion work is being attempted in the prison setting albeit on a occasional or opportunistic basis. Many of the lessons from this work are being lost due to patchy monitoring and evaluation. Consideration needs to be given to the establishment of a number of pilot intervention projects that monitor and evaluate outcomes. The priority and lack of success of stop-smoking policies may be a fruitful area for research.

The absence of clear central policy guidance and social agreement on the purpose of prison and imprisonment runs the danger of being measured by inappropriate outcomes. As Handy (1997) says:

It is not clear, for instance how the outcome of a prison should be measured, partly because we haven't made up our minds, whether the purpose of a prison is to punish, to deter or to rehabilitate the inmates. Unless and until we work out what the purpose is we can't measure the results. Without a clear definition of desired results, any market for prison management would have to focus on the one thing that can be measured: the costs or the inputs. But competing on costs does not necessarily guarantee the best outputs. (p 19).

Current health promotion practice is targeted at the symptoms of the problem rather than the problem itself. A future comprehensive health promotion policy should tackle the determinants of ill health and offending behaviour. There is a need for the health of prisoners to be addressed within prisons but also for issues to be addressed as part of a wider health promotion policy which tackles the determinants of anti-social behaviour and ill-health (Wilkinson 2000). The policy enigma for health promotion in prisons is one of the level of the intervention (McKinlay and Marceu 2000). An upstream policy focus will mean an emphasis on changing the structures, such as the architecture and other factors that determine health and maybe even the whole approach to prisons including a more fundamental review of the role of prisons and sentencing policy. The determinants of health are related to poverty and social exclusion, factors over-represented among the prison population. O'Mahony (2000) argues that a penal system

which selectively enforces laws in society and does not genuinely struggle to correct its own structural inequalities, is not merely illegitimate but is itself a major source of social injustice. (p 79)

While the current research was driven by the existence of the joint policy document on the future of health care in prisons the work has come full circle with the findings from this work feeding into the soon to be released policy document 'Health Promoting Prisons: a shared approach' which recommends the development of health promoting

systems and a whole prison approach as the way to improve the health status of prisoners.

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