

INFORMING THE DEVELOPMENT AND IMPLEMENTATION OF A HEALTH-RELATED PEER ROLE IN THE NORTH EAST PRISONS

This report contains the findings from a qualitative study conducted across four of the North East prisons, collaboratively funded by NHS England; Health and Justice North East and Northumbria University. This study is part of a wider research project and this report has been written for the attention of those involved with the commissioning, developing and implementing of the health-related peer role in the North East region.

*A summary of
findings with
practice
suggestions*



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The key supporting documents for this report include the 2015 North East Health Needs Assessment for each of the four locations

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Executive Summary

Key learning from existing 'health trainer' service in the High Security setting:

- Importance of effective partnership working with other departments and providers including a designated point of contact in each.
- The gym is a key resource – 'health trainers' are coordinated and supervised by Gym Officers.

Common health concerns across all prison sites:

- **Smoking**; specifically in relation to going Smoke Free – prisoners asked for more information and access to smoking cessation services and support; concerns about the potential impact of a smoking ban on mental health without this.
- **Mental health issues**; including lack of awareness
- **Diet and exercise**; support to make changes such as alternatives to the gym, information about which are the healthy choices for diet and having healthy recipes that match to the ingredients available.
- **Spice (male prisons)**; seen as a problem by all prisoners involved in the focus groups and suggested a health-related peer role could be used to raise awareness of the risk, supporting an organisational approach to tackling this issue.

Key issues for successful implementation and sustainability across all prison sites:

- **Effective partnership working**; particularly with the gym.
- **Involving the prisoners** in the design and development.
- **Integration**; creating awareness and relevance from Governor level to prisoners also including the health promotion strategy and local health and wellbeing boards.
- **Standards are essential**; including recording and monitoring processes, clear job description and recruitment process, confidentiality agreement, pathways for reporting issues and seeking support, training and access to resources (e.g. leaflets, etc.)

High Security; develop effective working relationships particularly between the gym and healthcare, involve the 'health trainers' and Gym Officers in the improvement of the service.

Category C: introduce alongside the existing social care peer role introduced by healthcare and link up with the older prisoner community centre. Existing Peer Mentors were enthusiastic about the role.

Female Closed; a combined peer role using the existing PID workers is suggested and linking with prisoner engagement activities such as the Prisoner Consultation Committee.

Category D Open; a model involving shorter training due to employment aspect, the role may particularly benefit the healthcare function in this setting due to the part time working hours.

Wider implications: Support the recommendations from the HNAs, PSO 3200, and an increase of purposeful activity, education and training.

Purpose and aims

The purpose of this report is to provide information to support the development of a health-related peer role in the North East prisons, which is part of the current healthcare provider contract. The research has been undertaken as part of a PhD jointly commissioned by NHS England; Health and Justice North East and Northumbria University. The research is qualitative and the methods used were semi-structured interviews with staff and focus groups with prisoners in four of the prisons; High Security, Category C, Female Closed and Category D Open. A summary of the establishment specific main findings are presented, including; health concerns, barriers and enabling factors for the implementation of a health-related peer role, key learning points and suggestions, and relevance to the Health Needs Assessment findings.

Health-related peer role

A 'health trainer' is a peer role that was introduced in the 2004 White Paper; *Choosing Health, Making Healthy Choices Easier* and there is standardised training for this role through the Royal Society of Public Health (RSPH) and City & Guilds. A 'health trainer champion' is the step before 'health trainer'. Other training options such as a mentoring route are possible to create a similar peer role with 'on the job' training specific to the location. Possible training options are discussed on page 21. To be a 'health trainer' the standardised training must be completed. It is suggested a health-related peer role with other training could be called a 'health peer' or a 'health mentor'. The key values associated with a health-related peer role are: empowerment, encouragement, support, confidence building, choice and participation. The ways in which a trained health-related peer could provide support and engage others include; one-to-one work, goal setting, bridging between professionals or services and other prisoners, information giving, signposting, raising awareness and group work. It would be essential for the health-related peers to be properly trained in the skills required to do this work.

Methodology

A literature review was conducted, examining the previous research on 'health trainers' and peer interventions in the prison setting. The findings from the literature review informed the development of the topic areas to be discussed during the interviews and focus groups. The main approach used was qualitative semi-structured interviews with staff and semi-structured focus group with prisoners for each of the four prisons focused on for the purpose of this research. The interviews and focus groups were conducted between July – December 2015

Prisoners:

Five focus group sessions were held with a total of 28 prisoners across the four settings. Prisoners were provided with full information prior to the focus group and informed consent was gained; all of the prisoners that took part in the focus groups were in existing peer roles within the prisons or currently in training. This meant the prisoners had some knowledge about peer roles and were able to understand the questions that were asked.

Staff:

Sixteen semi-structured interviews were conducted with staff from each of the four locations, this included Heads of Healthcare/Healthcare Managers, Governor grade, Prison Officer and Gym Officers. Three of the interviews were conducted with another member of staff present at the request of the individual, therefore a total of 18 staff members were involved.

Supplementary consultation:

Discussions by email, telephone or in person also took place for the purpose of information gathering with other relevant individuals including regional providers, prison staff, Local Authority commissioners currently and previously involved with health trainers/ peer roles, prisons outside of the region (North West Female Closed, North West High Security and Yorkshire and Humber region), Public Health England, academics and community organisations.

High Security prison

The High Security prison differs from the other settings as a ‘health trainer’ initiative is currently in place. This allowed for exploration into what is in place and how things work which has provided some valuable learning points that can inform the development of a health-related peer role across the region. The prisoners who took part in the focus group were all ‘health trainers’.

Table 1: Health concerns and behaviours identified during prisoner focus group and staff interviews in the High Security setting.

Staff (n=4)	Prisoners (n=8)
Diabetes (older)	Drugs
Cardiovascular Disease (older)	Diet (Health trainer distribute leaflets about healthy cooking, use diet sheets and food diaries)
Asthma (younger)	Smoking cessation
Fitness/exercise (younger)	Mental health issues
Smoking	Assist with healthcare complaints
Diet	Exercise
Wellbeing	Health trainers found there are deeper issues that the presenting ones linked to emotions and coping.
Health promotion follows NHS national calendar	Health trainers found they engage more of the younger population and recognised that more awareness raising/ engagement strategies need to take place with the older population.
More focus needed on long term conditions with a jointed up approach	

Description of existing service:

The current ‘health trainer’ service in this High Security prison has been in place for around 5 years and was introduced through a pilot scheme run by the Local Authority who had the public health contract at that time. The initiative appears to have been co-created by staff and prisoners involved at the time in order to come to an agreement on issues such as confidentiality, expectations and links with other services and departments within the prison. The existing service is reported to be around 17 ‘health trainers’ including VPs and it is supervised and managed through the gym, with two gym officers in particular providing support and supervision for the ‘health trainers’; the gym is also used

as a base. The 'health trainers' have weekly meetings, every Friday morning, in a classroom in the gym where the 'health trainers' bring a data collection sheet currently used and this is photocopied by the Gym Officer and a copy stored in a locked filing cabinet in the gym. The sheet is kept by the 'health trainer' and stored in a locked cupboard in his cell. The data sheet is anonymised by using the initials of the 'client' and basic information recorded. The 'health trainers' also approach the Gym Officer for advice and support with the role on a one-to-one ad-hoc basis. The 'health trainers' have a good working relationship with the Gym Officers. Frustration was expressed by both prisoners and Gym Officers about the deterioration of links with healthcare since the introduction of the 'health trainer' initiative 5 years ago and a general lack of awareness of the role; this was linked to the change from Local Authority to current arrangements for providing public health within the prison setting.

Table 2: Establishment specific barriers and enabling factors for the High Security prison.

Barriers	Enabling factors
<p>Lack of awareness of the role.</p> <p>Lack of established links between departments e.g. healthcare.</p> <p>Lack of acknowledgement of the 'health trainer' as a legitimate peer role.</p> <p>Employment allocation and structure made it difficult for 'health trainers' to see prisoners they were supporting.</p> <p>Staff shortages in healthcare so at full capacity dealing with the basics.</p> <p>Lack of monitoring processes in place to capture health outcomes.</p> <p>Waiting list for gym induction.</p> <p>An established connection between 'health trainer' and 'client' was lost if either was moved wing.</p>	<p>Current 'health trainer' initiative has been in place for 5 years.</p> <p>Established 'workforce' of enthusiastic and committed 'health trainers' due the static nature of the prison.</p> <p>Enthusiasm and dedication from the Gym Officers involved.</p> <p>Healthcare and the gym have effectively worked together previously; e.g. cardiac rehab which started disjointed but worked.</p> <p>'Health trainer presence and access in the gym setting.</p> <p>Established rapport between Gym Officers and prisoners.</p> <p>Recent HNA reports health promotion video to be put on a loop on in cell TVs</p> <p>Some prisoners cook their own food/are involved with a 'food boat'.</p> <p>Dietary management through kitchen and healthcare partnership working.</p> <p>The kitchen choices have been assessed by a dietician and there are healthy choices available.</p>

**'Health trainer'
experiences of the
role:**

- Main aspect of the role is to set SMART objectives with the 'client' – to support goal achievement and review progress.
- Word of mouth is a valuable engagement strategy.
- Typical period of contact in this prison is 10 months.
- It was felt the 'health trainer' should have experienced the issues themselves, for example an ex-smoker supporting with smoking cessation.
- Being familiar and associating with other prisoners is seen as beneficial.
- There was a lack of engagement/ interest when the role was introduced because of an assumed link to the Listener role and distrust issues.
- There is a potential for over-dependency from the 'client' and this has to be managed by the 'health trainer'.
- Important to stress the financial benefits of changing lifestyle as a hook (e.g. smoking costs).
- The 'health trainers' worked well as a team and shared relevant information, for example they would share learning if they had dealt with an issue (whilst maintaining confidentiality).
- Two of the 'health trainers' assisted non English speaking 'clients' by translating health-related information and providing support in their first language.

Key learning points:

- Importance of effective relationships between departments and avoiding working in silos; necessity for a point of contact in each area/department.
- The Gym is a key resource and the current service is established through the gym; joint working is essential otherwise this could have a negative impact on what is already in place.
- Raising the profile of the role and ensuring it is seen as 'legitimate' by all levels of staff and prisoners.
- The importance of training and induction of 'health trainers'/ health-related peer role to enable them to support others to make positive changes but also around issues such as dependency.
- Monitoring processes need to be introduced to capture impact (i.e. health outcomes as specified in the contract)

Relevant HNA concerns/links:

- Sedentary lifestyle is an issue with the highest proportion of obese/overweight prisoners in the region; *a health peer role could be used to raise awareness of the gym, provide information about alternatives such as in-cell exercises and dietary advice.*
- 62% of the population reported as smokers and 21 weeks waiting list for smoking cessation services; *a health peer role could work alongside healthcare to support the smoking cessation function.*
- There is a high level of need for health promotion work (specifically weight and smoking related), which is only partly met; *the existing 'health trainers' could be used to support this work and independently raise awareness/ provide information and support.*

Category C (contracted)

The prisoners who took part in the focus group were all substance misuse peer mentors or in training for the role.

Table 3: Health concerns and behaviours identified during prisoner focus group and staff interviews in the Category C prison.

Staff (n=4)	Prisoners (n=5)
Smoking cessation	Smoking; links with boredom and delays with smoking cessation services.
Spice/drug issues	Diet
Diet	Spice; issues with 'Spice challenge' whereby prisoners are offered free Spice by drug dealers if they are able to smoke £25 worth.
Fitness / exercise	Mental health issues; especially anxiety and depression.
Long Term Conditions	Exercise
Social Care	Particularly liked groups that were run by a peer and when as part of that a personal story was shared as they found it inspiring and motivating – positive role model.
Older prisoners	Stated a support structure is needed in the wider prison environment to support an intervention of this nature, e.g. availability of smoking cessation services and reduction of drugs in the establishment.
Bowel and chlamydia screening	Health promotion would be better conducted at a wing level.
Lifestyle change	

Table 4: Establishment specific barriers and enabling factors in the Category C setting.

Barriers	Enabling factors
Lack of health promotion resources.	Prisoners currently attend a health promotion meeting and future plans to develop this.
Staffing levels; gym specifically mentioned.	Six new Gym Officers expected to start in 2016.
Servery food is not ideal for healthy eating.	Healthcare support workers have a focus on health promotion.
Concerns about whether the 'health trainer' qualifications are the most useful to the prisoner on release.	Prisoners report to healthcare that they want more support groups.
Bullying always potentially an issue with a peer role, especially VPs – important to acknowledge	Introduction of a social care peer role; a health peer role would fit alongside this.

<p>the role could be used to collect debts and deal drugs.</p> <p>May be a challenge to implement on less stable wings.</p>	<p>It will be a legitimate job in the prison.</p> <p>Seen as a support for the healthcare function.</p> <p>Healthcare point of contact in place.</p> <p>Positive attitude towards the role; ideas about how the role can work in the establishment and can see the organisational benefit (education, supporting healthcare function, purposeful activity).</p> <p>Healthcare eager to work with the gym.</p> <p>Successful health promotion reported to have previously run through the gym.</p> <p>Existing rapport between Gym Officer and prisoners – make sure this is added to main.</p> <p>Gym reps currently have monthly/bi-monthly meetings.</p> <p>An older prisoner’s community centre is currently being established.</p> <p>Fewer barriers between mentors and prisoners than with staff.</p>
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Key points/suggestions:

- Processes are already in place with prisoners attending health promotion meetings and plans to develop.
- The gym is a key resource.
- Links should be made with the resources being established with the older prisoner population, e.g. older prisoner’s community centre.
- The work established with the social care peer role should benefit the implementation of a health-related peer role.

Relevant HNA concerns/links:

- Suggested a peer support role for smoking should be introduced; *a health peer could be trained to provide support for those quitting smoking and leading up to going smoke free.*
- A peer role for mental health however concerns about stigma – recommendation about breaking down the stigma; *a health peer role could be used to increase awareness.*
- Introduction of the health improvement strategy, led by the Category C prison; *the health peer role is a key aspects of this strategy for each prison.*

Female Closed

The prisoners who took part in the focus group were all PID workers and/or gym orderlies at the Female Closed prison.

Table 5: Health concerns and behaviours identified during prisoner focus group and staff interviews in the Female Closed prisons setting.

Staff (n=5)	Prisoners (n=6)
Screening; cervical and breast – improving referrals.	Smoking; women suggested it would be useful for quitting information to come with the e-cigarettes, along with user instructions.
Gynaecology clinic – improving referrals.	Diet/weight; access to a dietician called ‘fat club’ by the women. Health pack available but not a great variety of fruit and veg and it arrives in a bad state. Recipe folders including healthy recipes that match to the ingredients available would be useful.
NHS Health checks – improving referrals.	Teeth
Smoking cessation	Optician
Diabetes awareness	Mental health issues; it can be a long wait for appointments.
Hep B and C awareness	Support with; Hep C advice
Healthy lifestyle	Awareness of expected waiting times would be useful and reduce fear, e.g. Hep C treatment and abnormal smear test results.
	Exercise; like the variety of new classes.
	Medication; stated this is not appropriate to address through a peer worker.
	General MOT wanted.
	Holding cell in healthcare is smoky, dirty and unpleasant.
	Felt a holistic peer health role would work best, e.g. combined with the existing PID worker role.

Table 6: Establishment specific barriers and enabling factors for the Female Closed prison:

Barriers	Enabling factors
Apprehension about the intervention not being appropriate for the establishment.	Gym is a good resource and staff keen to be involved – already providing health lifestyle courses.
Health trainer qualification may not be useful on the outside.	Gym and healthcare already have some links in place including through the healthcare referral to the gym.

<p>Potential bullying or misuse of the role (e.g. misuse of PIDs role of some try to gain medication through it).</p> <p>Pressure in a peer role to overcome the issues described above.</p> <p>Confidentiality as the current space use for PIDs work is not private.</p> <p>Prisoners reported some gym staff wolf-whistling at them in the gym and this put them off wanting to go.</p> <p>Long waiting times for smoking cessation; however peer role could support this function.</p> <p>Smaller population = smaller pool of suitable prisoners.</p> <p>Some wings are more unstable and introducing the role there could be a challenge – the women also suggested that the role could be predominately information giving and signposting in more challenging areas, with one-to-one support in more settled locations.</p> <p>Lack of awareness of PID works role with staff and prisoners.</p>	<p>The women liked the new gym classes that had been introduced – good variety.</p> <p>Current PIDs role well placed to be developed/expanded to include health-related aspects.</p> <p>The existing Prisoner Consultation Committee (PCC) as a means of prisoner engagement.</p> <p>Health promotion materials available and displayed in the healthcare foyer.</p> <p>The PIDs workers were keen to get involved, particularly if a qualification was offered.</p> <p>The kitchen always includes a healthy option.</p> <p>There is a wing rep meeting on the first Tuesday of the month.</p> <p>Vegetable boxes are provided by the gardens seasonally.</p>
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Key points/suggestions:

- A health-related peer role, the PIDs role and gym peer role may work well together; a combined/holistic role may assist with the issue of having a small pool of suitable prisoners.
- A 'launch' of a health-related peer role may create initial awareness and interest (with staff and prisoners); it could be used to raise awareness of also of the PID worker role.
- The gym is a key resource.
- Existing processes and structures can be used to develop the initiative; PCC, PIDs role, wing rep meetings, the gym.

Relevant HNA concerns/links:

- Indicated that substance misuse and mental health issues were the most pressing concerns; *a health-related peer role could signpost to relevant services or raise awareness of issues.*
- Identified a clear need to public health services and health promotion; *a health-related peer role could support this by providing health promotion, support and signposting/awareness about relevant services.*

Category D Open

The prisoners who took part in the focus group were all in an existing peer role; gym orderly, peer mentor and/or a Listener.

Table 7: Health concerns and behaviours identified during prisoner focus group and staff interviews at the Category D Open prison.

Staff (n=5)	Prisoners (n=9)
Social care awareness (linked to providing information to prisoners about their rights/assessments, etc.)	Hygiene – toilet and kitchen areas.
Smoking.	Spice – prisoners requested first aid training related to experiencing others overdosing.
Lifestyle improvement/wellbeing	Mental health issues – particularly awareness around depression and anxiety.
Long Term Conditions	Smoking cessation (and also linked to hygiene – cigarette butts in sinks, etc.)
Drug awareness / misuse – Spice	Weight / diet – underweight and poor nutrition as well as overweight
Diet	Exercise
Exercise	
Older prisoners	

Table 8: Establishment specific barriers and enabling factors for the Category D Open prison.

Barriers	Enabling factors
<p>Lack of 'work' for Listeners.</p> <p>Most prisoners will be out at work after the first 12 weeks and therefore trained individuals could be 'lost' – potential lack of cost effectiveness and sustainability.</p> <p>Small population and therefore pool of suitable prisoners.</p> <p>Low staff numbers and part time working.</p> <p>Difficult to prioritise health promotion in high pressure environment with staff shortages.</p>	<p>The gym is a good resource and staff keen to be involved – healthy lifestyle promotion is done through the gym at present.</p> <p>The Gym Officers work full time.</p> <p>Free movement and lack of escorts required.</p> <p>Prisoners assessed as low risk to be in open conditions.</p> <p>Gym orderlies can do 'body stats' – BMI, BP, etc.</p> <p>Access to outdoors.</p>

<p>Prisoners access peer support groups in the community.</p> <p>Extra work for the gym staff</p> <p>Talking to another prisoner about personal issues can lead to bullying.</p> <p>Lack of health promotional materials available.</p>	<p>Prisoners can produce spreadsheets/ use a computer – this may assist with the monitoring aspect.</p> <p>Existing processes; Governor questions time and patient forums.</p> <p>Community visits are allowed – potential for accessing training in the community.</p> <p>Wellbeing days currently held.</p> <p>No duplication with existing health promotion.</p>
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Key points/suggestions:

- A shorter training option may fit best for the Category D Open prison due to employment commitments, e.g. first aid course, smoking cessation training, etc. Longer training options may not be cost effective.
- The gym staff and gym orderlies are a good resource.
- Mental health awareness would be worthwhile; particularly around more common conditions such as depression and anxiety (links to point below).
- Health peer could be particularly supportive of healthcare function in this setting due to part time staffing hours and health promotion need.
- Prisoners were keen to use a health peer role to help address issues such as hygiene, mental health awareness and Spice particularly.

Relevant HNA concerns/links:

- Indicated mental health needs are low but anecdotal evidence to suggest this had increased – mental health issues came out as a concern for the prisoners as part of this research. It was indicated that prisoners did not report mental health concerns due to fear of being ‘shipped out’ to closed conditions. *A health peer role could be used to raise awareness of mental health issues; awareness may also be beneficial for prison staff to ensure consistent messages*
- Spice indicated as a problem; this was a main concern for staff and prisoners as part of the research and prisoner felt awareness could be raised through the use of a peer role, they also requested first aid training so they were equipped to deal with overdoses during evenings/weekends. *Health peers could be trained in first aid at this location and raise awareness about the risks*
- 50% of prisoners identified as overweight and 20% obese. *Health peers could provide health promotion for this including alternatives to accessing the gym*
- Some prisoners did not know how to access mental health services; *links to point above about raising awareness/ providing information and signposting which could be done through a peer role.*
- 42% of HNA respondents stated their health had deteriorated since being in prison; *a health peer could provide health promotion support and potentially provide information about community based services for a ‘through the gate’ focus*

Across all settings:

This section summarises the common themes and aspects across the four settings.

Common health concerns:

- **Smoking**; specifically in relation to going Smoke Free – prisoners asked for more information and access to smoking cessation services and support; concerns about the potential impact of a smoking ban on mental health without this.
- **Mental health issues**; including lack of awareness
- **Diet**; information about which are the healthy choices for diet and having healthy recipes that match to the ingredients available.
- **Exercise**; including alternatives to the gym and in-cell exercises.
- **Spice (in the male prisons)**; seen as a problem by all prisoners involved in the focus groups and suggested a health-related peer role could be used to raise awareness of the risk, supporting an organisational approach to tackling this issue.

Table 9: Common issues from the four settings.

Barriers	Enabling factors
Security issues.	Health promotion need and supporting role of the health peer
Waiting lists and availability of services.	
Initial cost and time implications.	'Health trainer' role has established and running in high security setting for 5 years which shows it is possible to establish and maintain.
Potential misuse of role/ bullying.	
Managing confidentiality.	The gym – including the positive relationship prisoners often have with Gym Officers.
Setting up processes and structure; initial challenges.	A health-related peer initiative, in partnership with other peer roles can increase the pro-social community within the prison setting.
More challenging to implement on less stable wings/populations.	The role can be tailored to fit the local context, for example with the older prisoner population.

Common themes and key learning points:

- **Involving the prisoners** in the development of the intervention to establish interest and making it relevant – also include an assessment of skills, knowledge and experience, e.g. if a health mentor model is chosen this could include identifying a pool as individuals who already have the mentoring qualification.
- Establishing **effective working relationships** across department/providers (gym, healthcare, mental health, substance misuse, etc.) and not working in silos, for example; having a point of contact accessible by prisoners and staff.
- **Integration of the role on every level**; awareness and acceptance of the role by Governors and every other level, including prisoners and linking to existing processes e.g. the sentence plan.
- Importance of **standards** including but not limited to; job description (clear expectations and limits), data capture processes/monitoring/evaluation built in, recruitment and retention (selection criteria clear), support and supervision, use of a confidentiality agreement between peer and 'client' (expectations/limitations/data storage/reporting potential harm to self or others), specified process/pathway for reporting immediate issues such as suicide risk, training and access to resources (e.g. health promotion information and leaflets): aiming to minimise misuse of the role/bullying and establishing as legitimate role that can be evaluated.
- A health peer role as a **'bridging' function between staff/services** and other prisoners; e.g. raising awareness about the impact of DNAs, signposting to relevant services, attending health promotion meetings and taking the messages back to the wing.

‘Smoke free’ relevant findings:

Specific information has been provided about the link of a health-related peer role to smoking cessation following from attendance at the regional ‘Reducing smoking in prisons’ group March 2016 and it also stood out as a pertinent issue in the findings because of the awareness of the upcoming prison smoking ban with the staff and prisoners. The health-related peer role is also relevant for the other areas indicated within the report.

- The public health aspects of the reducing smoking in prisons initiative are wide reaching and fit well with the introduction of a health-related peer; a jointed up approach is suggested as part of the health promotion strategy, with aspects such as activities to alleviate boredom with the aim of supporting prisoners to quit smoking (e.g. exercise equipment in locations others than the gym, engaging older prisoners in activities of interest to them like carpet bowls).
- Smoking was highlighted as a health concern for during every interview and focus group.
- There was a specific interest from prisoners as they were aware of the smoke free legislation and had concerns about current waiting times for smoking cessation services, by the time they got access to services they has lost the momentum.
- The women in the Female Closed prison suggested health promotion quitting information should come with the e-cigarettes and also information on how to use them correctly as they reported the experience of smoking them to be very different from tobacco and were unsure how much they should be smoking. They also indicated that because they didn’t feel like they were getting ‘the hit’ they associated the tobacco, some would smoke both.
- Prisoners reported the e-cigarettes to be more expensive than tobacco and therefore less attractive.
- Prisoners expressed concern (particularly in Female Closed) about potential impact of the smoking ban on mental health issues and suggested self-harm may increase. The women in the focus group were overall quite positive about the smoke free initiative but felt there was not currently enough support or preparation for those who wanted to quit.
- The health peer role was indicated as something they would access alongside professional support/ NRT and as an interim between deciding to quit and waiting for access to smoking cessation services.
- Current healthcare support staff could be trained by Regional Reducing smoking in prison Lead, if smoking cessation training is required – this learning could then be disseminated to

health-related peers and/or prisoners could be directly involved in the training for both professional and peer approach.

Training options

The training should be tailored for each location; for example including an induction process specific to the regime, supported ‘on the job’ experience and specific training if required such as smoking cessation.

Table 10: Possible training options for a health-related peer role (prisoners)

Role	Required training	Additional training required	May be suitable in
Health trainer champion	RSPH level 2 ‘Understanding health improvement’: minimum 7 hours study with face to face learning plus 45 minute multiple choice exam.	Induction into role, location and responsibilities. Specific topic training where and as required, e.g. smoking cessation support.	All locations as ‘short’ route.
Health trainer	Above plus City & Guilds Level 3 health trainer certificate: up to six months to complete with face to face learning.	As above	More static locations; High Security, potentially Category C (contracted)
Health peer/mentor	Mentoring training as provided by current education providers Novus (can be tailored for specific area)	As above	All locations – High Security, Category C (contracted), Female Closed. With caution in Category D Open prison due to employment commitments.

Options including staff, particularly healthcare support staff may also be considered and may involve training provided through Education provider (contact made with provider regarding all possible options and correspondence shared with healthcare providers).

Benefits and disadvantages

Health trainer:

Benefits

- Tiered route; can stop at 'health trainer champions' or have the possibility of progressing to 'health trainers' if possible (funding for training, practicality of implementation i.e. length of training).
- Standardised training based on national standards and competencies
- Already 'health trainers' in High Security setting so consistency of role across region.
- Distinguishes this peer role from other roles such as peer mentor, etc.

Disadvantages -

- The usefulness of the qualification on release; it may not be possible for individuals to gain a role on the outside as a health trainer
- Cost implications – for implementation and ongoing, would it be sustainable?
- Length of time to train for full 'health trainer' qualification which may not be suitable, particularly in some settings e.g. Category D Open setting.

Health peer/mentor:

Benefits

- A mentoring qualification could be used in a different setting/ area either on release or in the prison setting – may be more useful for resettlement.
- The mentoring training is included in the education provider contract, the training is familiar organisationally and can be tailored to be 'health-related' e.g. health mentor including health promotion for physical health/wellbeing, specific mentors e.g. smoking cessation – perhaps more likely to be sustainable.
- Standardised training.
- Already mentors in different areas, e.g. 'peer mentors' for substance misuse, therefore individuals could potentially have multiple roles with 'add-on' training and structure – this may partly alleviate the issue of all providers trying to access the same pool of prisoners, still the same prisoners and training but different focus; makes the most of skills and qualified individuals in each setting.
- May be able to access individuals already trained as mentors and add health promotion/lifestyle change aspect, linked to above.

Disadvantages

- Risk of role duplication
- There are already 'health trainers' in the High Security setting therefore roles may not be consistent across the region however static population in that setting which is why they still exist 5 years on.

References

Cairns, C. (2015) *North East Prisons Health and Wellbeing Needs Assessment*. Internal report. Unpublished.

Department of Health, (2004) *Choosing health: Making healthy choices easier*.

Hamoodi, A. and Christie, A. (2015) *HMP Northumberland Health Needs Assessment*. Internal report. Unpublished.

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