14 Health promotion and improvement

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Introduction

People in prison and on probation are at risk of premature death compared to people in the general population[1]. Cardiovascular disease, stroke and chronic conditions such as heart failure and chronic obstructive pulmonary disease are among the leading causes of death for people in prison in England and Wales[2]. The average prevalence of chronic illnesses such as cardiovascular disease (CVD), diabetes mellitus, hypertension and cancer is greater than the general population[3 4 5]. The majority of ill health from these causes is driven by risk factors such as obesity and smoking, which are more common in the prison population than the general population[6 7 8]. This premature poor health is therefore preventable. The prison population is getting older and this burden will therefore increase over time.

People in prison should have access to the same health as the general population. However, prisons are generally considered unhealthy places, rather than being able to support and create health[9]. Accessing people in the places where they live their lives and make choices is a key public health approach[10]. Prisons are, therefore, a prime opportunity to address the disproportionate health and social circumstances of people in prison and offer a way of tackling inequalities in health and justice, through promoting health, facilitating community integration and reducing reoffending[11]. While this is not the primary business of prisons, they do provide access to marginalised and disenfranchised groups who would otherwise be classified as 'difficult to reach' in the wider community particularly in terms of primary healthcare and substance use[12]. Improving the health of people in prison not only improves the health of individuals and therefore reduces their need for healthcare, but most people in prison return to the community, with many oscillating repeatedly between prison and community[13]. Prison health is a concern for broader society and public health.

It is also a unique opportunity for all aspects of health promotion, health education and disease prevention, for example:

- developing specific, targeted interventions to address health inequalities
- opportunities to access and address health needs
- reducing the burden of disease and chronic illness (CVD, diabetes) through the prevention of ill-health while people are in prison, especially for long-term people in prison
- an opportunity to promote the health of staff

This chapter sets out the imperative to promote health in prisons to address the priority health needs, and prevention of ill health, of people in prison. The 'settings approach' is used as a framework to illustrate the benefit of working across and engaging with the 'whole prison'. This includes the importance of the environment in determining health outcomes, alongside access to good quality healthcare. The chapter concludes priority areas for health promotion, noting challenges and opportunities of implementation in the prison setting, supported with case study examples of good practice.

A framework for whole prison health promotion

Prisons have potential to make a major contribution to improving the health, wellbeing and life chances of some of the most marginalised and excluded individuals in society[14 15]. However, there are some important challenges to achieving improvements in health in prisons.

Commissioned healthcare provides prison-based primary care services equivalent to those in the community and within this would be usual opportunities for health promotion, for example brief interventions and health education and awareness raising. This is not without challenges, for example, the volume of people in prison and movement within the prison system and competing priorities for individuals such as housing and employment.

Health promotion in prisons tends to follow a medical model, viewing health primarily as the absence of disease and focusing on individual lifestyle choices rather than wider determinants that influence and underpin health[16]. While there are examples of community initiatives such as health coaches being developed in some prisons, there is no outcome data relating to the benefits of such new health promotion approaches. The settings-based health promotion prioritises a 'whole prison' perspective underpinned by key health promotion values of equity and empowerment. It has been widely argued that the settings approach offers opportunities to realise the potential of prisons to embrace health promotion and meaningfully tackle health inequalities[17].

A 'health promoting prison' is one where the whole regime is geared towards promoting the physical, mental and social health and wellbeing of people in prison and staff and should, as far as possible, replicate the environment and services of the community while in a secure setting.

Figure 1: key elements of promoting health in prisons

Source: adapted from Dooris, M and others Dooris, M. and Doherty, S.[18] and Baric, L.[19]

A core principle of a 'whole prison' approach is the notion of decency in prisons and a recognition that health promotion is 'everybody's business', not just the responsibility of healthcare staff[20]. Developing a whole prison approach to health and wellbeing supports equitable access to care for all[21]. Putting this framework into action could therefore comprise the following elements[22]:

- implementation of prison policies that support the health of people in prison and staff (for example, healthier canteen options and menus)
- creating an environment in each prison that is supportive of health and the concept of decency – that is, ensuring that the prison regime supports prisoners' wellbeing
- delivery of disease prevention, health education and other health promotion initiatives that address the health needs in each prison (specifically and more broadly) using engagement methods appropriate for the environment (for example, brief interventions, peer mentoring and/or health coaches) to help them adopt healthier behaviours

Current evidence: the need for health improvement

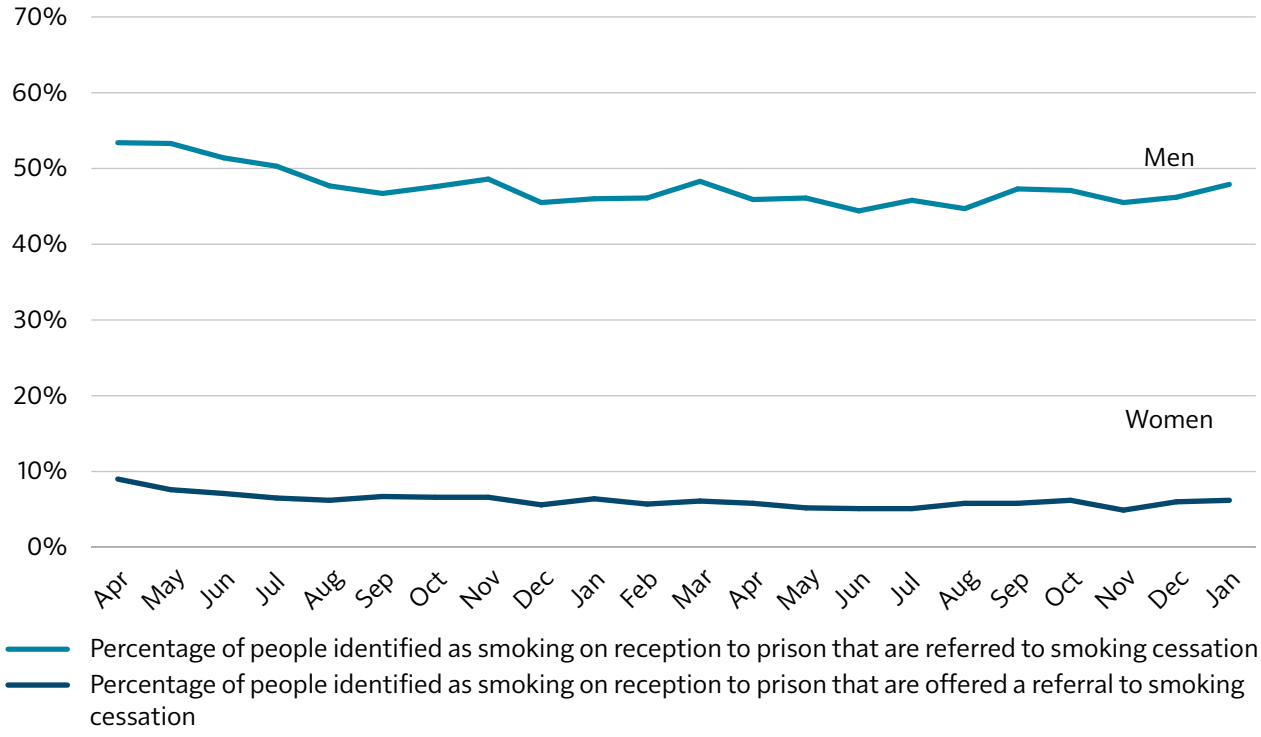
Smoking and vaping

People arriving into prison are 4 times more likely to be smokers in comparison to their peers in the community[23], at around 80% to 83%[24 25 26], compared to 15% in the general population. Since 2007, HM Prison and Probation Service (HMPPS) were working toward smoke-free prisons. Smoke-free prisons was phased across the adult 'open' estate for England and Wales

between November 2015 and September 2018 with all settings being smoke-free since September 2018[27]. In 2015, a partial smoking ban inside all open prisons was introduced. This meant that all staff, people in prison, contractors and visitors were no longer able to smoke inside any open prison buildings, only designated outside areas. During 2016, HMPPS started to implement a smoke-free policy in Wales and commenced implementation at 4 early adopter sites in England. By May 2018, all closed prisons were smoke-free. Research from Scotland identified that the smoking ban in prisons resulted in a 9% reduction in prescribed medications for smoking related illnesses[28].

Healthcare teams continue to be commissioned to provide smoking cessation within prisons and all prison residents who smoke should be offered smoking cessation clinical support. A complete smoking cessation offer, equivalent with the community, should include primary care, pharmacy for nicotine replacement options (NRT) provision and psychosocial support. Data from NHS England shows that the proportion of smokers that are identified on arrival to prison that accept referral to smoking cessation services is low.

Figure 2: proportion of smokers at reception to prison who are offered referral to smoking cessation and accept referral in 2023 to 2024



Source: NHS England Health and Justice

Our engagement for this report identified that smoking cessation support is not available in all prisons. The programme is 8 weeks (compared to 12 weeks in the community) and is more readily available in remand prisons than training prisons. In open prisons (category D) smoking is permitted in designated areas, tobacco products may be available to purchase and people may choose to start smoking again. Some regions have chosen to stop offering smokers packs for sale. Patches can be purchased from the Prison Retail Service (canteen), but these are expensive compared to vapes and still require clinical support to reduce the dose.

The proportion of people in prison who use vapes is not reported, however, vaping has, for many, become the preferred option in prisons. Individuals can purchase e-cigarettes and/or vapes and vape liquid through the Prison Retail Service (canteen). Nicotine vapes are National Institute for Health and Care Excellence (NICE) recommended and can support cessation and enforced abstinence as a harm reduction tool. However, vaping is not risk-free.[29 30] Although anecdotal, an unintended consequence has been the use of vapes as a currency in prison and therefore associated with debt and violence. There is currently no stop vaping support in prisons. Therefore, there is a need to support both those who vape and those who use both tobacco and e-cigarettes and/or vapes, tailoring support accordingly.

Practice example: smoking cessation services within West Midlands prisons

At the beginning of 2024, West Midlands NHS England Health and Justice and HMPPS undertook a joint review into the current provision of smoking cessation services within prisons and to gain views from residents. As well as questionnaires to the 12 heads of healthcare, a questionnaire for residents received 1,749 responses. This identified that:

- many people started vaping in prison with some not having vaped or smoked prior to prison
- there is a high demand for support to stop vaping
- there is a general lack of awareness of smoking cessation services available in prisons
- there are requests that vaping bans are adhered to and that people don't have to share cells with those who vape
- people felt vaping helps with boredom and to combat stress

A recent review of studies published from 2017 to March 2024 found that most prior smokers return to smoking after leaving a smoke-free prison, despite many people hoping or intending to remain smoke-free[31]. There are some regions with joint working between probation, RECONNECT and liaison and diversion and the prison estate to support those who are likely to start smoking on release, for example, through an advisory team in the departure lounge to book appointments and signpost to the service. This is not widely available and the support that is available to people on leaving prison varies between regions. There is a missed opportunity to improve the health of a priority group and to reduce health inequalities.

Substance use treatment and recovery

Substance use within prison populations presents significant and evolving challenges. In recent years, the range of substances and levels of sophistication in the availability and access to illicit drugs has rapidly increased. This creates additional risks to population health, impacting on drug related deaths and instances of intoxication and under the influence presentations[32]. Drug dependence often co-exists with other health disparities such as poor mental health and

homelessness. Some people experience multiple and complex needs, with drug addiction co-occurring with a range of health inequalities such as mental ill-health, homelessness and rough sleeping and contact with the criminal justice system. In England, over a quarter of a million people each year experience at least 2 out of 3 needs across homelessness, substance use disorder and involvement in the criminal justice system and at least 58,000 people have contact with all 3[33]. Drugs and crime are closely linked and drug use does not spontaneously cease upon arrival to prison[34].

In prisons in England and Wales[35 36]:

- 1 in 6 men (17%), and 1 in 7 women (15%) serving a sentence in prison are there for drug offences[37]
- two-thirds of women (66%) and nearly 2 in 5 men in prison (38%) report committing offences to get money to buy drugs[38]
- more than two-thirds of women (68%) and over half of men (55%) said they were under the influence of drugs when they offended[39]. Seven in 10 people in prison with a self-identified alcohol problem (70%) said they had been drinking when they offended[40]
- almost one-third of women entering prison report having a drug issue (30%) compared with just under a quarter of men (23%)[41]
- 1 in 7 women and men (14%) entering prison said they had a problem with alcohol[42]
- in 2023, 3 in 5 people in prison serving less than 12 months (60%) had an identified substance misuse need, and 2 in 5 (39%) had an identified alcohol misuse need[43]

The challenges of substance use in prisons have been extensively explored in the independent review by Dame Carol Black published in 2024[44]. This described a wide range of harm reduction and treatment programmes with notable variations in the programme offer and limited access to data and information evaluating the impact of such recovery-oriented models[45]. The purpose of this section is therefore to describe recent developments in whole prison health promoting approaches.

There are multiple opportunities to engage men and women in prisons with substance use specific health promotion interventions, from diversion from custody through release and resettlement. The building block of a preventative and health promoting approach for people who use substances is being trauma informed, recognising that individuals who experience dependency have often been exposed to trauma which can be a driving factor behind their vulnerability to addiction. In addition, a psychologically safe and supportive environment is proven to help address the root causes of addiction with built in sensitivities to diverse populations.

Therapeutic communities (TCs), Psychologically Informed Planned Environments (PIPES) and Incentivised Substance Free Living Units (ISFLs) are based around a whole prison approach. ISFLs are dedicated wings for people in prison who want to live in a drug-free environment, whether that be free from the consumption of drugs, the violence related to drugs or the culture of drug use[46]. There are 45 ISFLs running in prisons across England and Wales[47] –

supporting people to come off illicit drugs and reducing their reliance on synthetic opiates that are used as part of a treatment regime, like methadone.

ISFLs offer a structured and supported regime with programmes and activities. Peer-led talking therapies, purposeful activities and building supportive relationships have been described as important in supporting recovery and effective in helping people in prison to understand the drivers of their drug use and how to address their mental health needs on ISFLs[48]. Many health and prison staff believe that an ISFL should primarily be a settled environment where people in prison can access help to support their needs, and that a mix of people in prison, with and without histories of drug use, was beneficial in creating this environment. There is some research suggesting merit in parts of these settings, for example, the peer led components, purposeful activities and settled environment. However, there is significant variation in how prisons implement Drug Recovery Wings (DRWs) and ISFLs, and how they relate to NHS England commissioned drug and alcohol teams prison commissioned abstinence recovery programmes and dual diagnosis pathways[49]. Formal evaluations of DRWs and ISFLs are currently in their final stages and due for completion later in 2025. Health promotion for substance use disorder recovery is by its very nature most effective when its collaborative across sectors and between providers including HMPPS working with health, education, lived experience and voluntary, community and social enterprises (VCSE)[50].

At the heart of successful and impactful health promotion for substance use disorder in prisons, is staff who are trauma informed[51] and make every contact count (explored under opportunities) and committed to shift the narrative from a deficits-based conversation to one that recognises and builds on an individuals' inherent resilience and capabilities and their personal assets, where individuals are encouraged to take an active role in their recovery, fostering a sense of ownership and empowerment[52]. Evidence suggests that fundamental to this is peer support, providing education and promoting healthy behaviours which can reduce harm, improve engagement and sustain recovery[53].

Mental health improvement

Over half of surveyed men (54%) and just under two-thirds of women in prison (62%) say they have mental health problems[54]. In surveyed prisons, more than half of patients had previously self-harmed (54%), 2 in 5 had attempted suicide (40%) and a similar proportion had a history of substance use disorder alongside poor mental health (39%). A recent review of interventions to improve health and wellbeing in Scottish prisons concluded that meditation and mindfulness were effective and horticultural and art and creative interventions were promising[55]. The setting factors that influence mental health and opportunities for health promotion are explored in chapter 7.

Practice example: a whole system health and justice intervention – Greener on the Outside for Prisons (GOOP) illustrated with an example from HMP Preston

Greener on the Outside for Prisons (GOOP) is an asset-based health and justice intervention that focuses on nature-based activities and a broad programme of therapeutic horticulture[56]. GOOP is currently established in 26 prisons in England for men, women and children. Using a 'settings-based' approach to health promotion, GOOP takes account of the complex interactions between personal, organisational and wider environmental factors that influence health. It is underpinned by principles of equity, participation, empowerment, sustainability and working in partnership[57].

For example, prison security assesses people to work in prison gardens and usually prohibits people with specific profiles (for example, severe and enduring mental health issues). However, from a health promotion perspective, these are the very people who will benefit the most from being connected with the natural environment[58]. In comparison, people can be referred to GOOP by both prison and healthcare staff, meaning it is available to people who may not otherwise have been able to benefit. The referral pathway is monitored by all who are invested in achieving change at the individual and organisational levels (whole prison engagement).

GOOP has been evaluated since 2008. Data demonstrates a positive impact on mental health and wellbeing. For example, 88.2% of participants feeling more confident to manage their everyday lives, 94.8% experienced increased opportunities for social interaction and 86.1% of participants reported new skills or knowledge gained[59]. In HMP Preston participants have noted the supportive and inclusive space developed by staff:

> "[the staff] got respect for us on here, they talk to me and have time for my mental health issues and everything" Male in prison

Participants and staff have made clear links between participation and positive behaviour change relating to self-harm:

> "I'd be lost without this to be honest. I don't know where I'd be or what I'd be doing. I wouldn't be in a good place I don't think, probably trying to escape or kill myself. I'd have gone off the rails […] Having this […] has just saved me, it's just changed my whole prison experience." Male in prison

Behavioural change of participants with a history of violent and/or disorderly behaviour participating in GOOP is observed:

> "It can help a person that's aggressive […] to come over here, because it's a relaxing job and I've seen people that's come over here and that's been a bit aggressive on the wings that end up loving the job. So it does help. It helps people that can be violent." Male in prison

Physical activity

An independent review of sport in justice in 2018 identified that 8% of boys in young offender institutes went to the gym more than 5 times a week, with a third of children and young people spending up to 22 hours a day in their cell due to the need to restrict movements to prevent conflict with others[60]. In 2018, monthly gym participation averages 56% for men and 29% for women[61] compared to 67% of adults meeting the recommended moderate intensity for at least 150 minutes per week in the general community[62]. This is important because increasing exercise is associated with improved physical and mental health.

Research evidence has identified mostly positive impacts of increased structured physical activity interventions, including yoga on factors such as physical fitness, blood pressure and cholesterol[63 64] and mental health outcomes[65]. When combined with education this can also have positive impacts[66]. Park runs in prisons are now popular, mirroring community engagement for physical health and social wellbeing and with positive impacts on mental and physical health, connection and stability described.[67 68] Royal College of General Practice provide resources for cell-based workouts[69].

Healthier eating and weight management

People in prison are at greater risk of being overweight and obese[70], a risk factor for CVD and many cancers. The exact prevalence of obesity in English prisons is not reported. A study in 1 male prison in Wales found that 81% were overweight or obese[71]. People may arrive in prison overweight and also gain weight in prison as a result consuming excess calories and highly processed foods[72]. This is combined with generally having low levels of physical activity, explored below. Reducing obesity can reduce rates of CVD, which are high in the prison population. The World Health Organization (WHO) cites[73] unhealthy diet as a modifiable factor. As well as helping individuals, preventing non communicable diseases will reduce the burden on healthcare and prison operations in due course.

Research has explored nutritional interventions aimed at improving the availability of a balanced diet and nutritional education through a variety of formats with some positive impacts on dietary choices, body mass index and clinical measures such high blood pressure[74 75 76]. Education programmes and nurse or pharmacy led services for people with diabetes can improve weight and diabetic control[77]. Examples of innovation in prisons that focus on supporting prisons to deliver practical food-based education and promote healthy eating are emerging including the work of Food Behind Bars[78] and Food Matters[79]. HMPPS also has policy in place to support national standards for meals, and a newly formed National Food, Physical Activity and Wellbeing team who are working on nutrition and food education, for example, each menu has a symbol identifying healthy eating options that can be chosen. In the minority of prisons where people in prison are able to access laptops in their cells, there is work underway to enable access to nutrition education. High levels of poor literacy and comprehension in the prisoner population may hinder reaching those most in need. There are also limitations on access to dietician support and nutrition guidance within the team for the people in prison. There is also an opportunity to have a more informed discussion around the canteen provision and more active engagement and championing from catering managers.

While there is evidence for individual interventions, a system-wide response to improving healthier food options and aiding better support for weight management is required.

Practice example: healthy eating initiatives in Thames Valley and London

Historically, food choices from servery and canteen were unhealthy and often ultra-processed, high in salt, saturated fat and sugar[80].

In October 2022, a dietetic service for the Thames Valley Prisons was commissioned. By working with the patient, multidisciplinary team (MDT) and catering, nutritional care plans are created to support patients in meeting specific requirements for their clinical conditions, for example, patients with diabetes at high risk of hypoglycaemia. Supporting these individuals on site facilitates engagement and reduces additional external appointments and prison escorts. By working with prison kitchens, the Regional Dietician supports development of healthier meal options and menu coding to enable these changes. Thames Valley prison menus have been shared by HMPPS as good practice nationally.

One of the healthcare providers in London has employed a regional dietitian who has implemented several initiatives including the following:

- co-chairing a nutritional working group with a prison governor, head chef and head of education to work towards introducing nutrition education into mainstream lessons and the induction booklet, starting cookery classes, commencing a 'cell to 5K' exercise project and improving the menus so that meals are healthier and more balanced
- working with a prison food charity (Food Behind Bars) trained chefs and catering teams to analyse menus and develop nutrition training packages
- expansion of the traffic light system for colour coding the health status of meals on offer and inclusion of one designated 'healthy heart' meal at each mealtime using British Dietetic Association criteria
- running regular dietetic-led group education sessions about conditions related to cardiovascular disease (obesity, type 2 diabetes and high blood pressure) and how a more healthy diet can reduce the risk

Secondary prevention

This chapter has so far described primary prevention opportunities to reduce risk factors and prevent disease. Secondary prevention requires early detection of disease and treatment of risk factors to slow disease progression.

The NHS Health Check is a national programme designed to identify early signs of stroke, heart disease, type 2 diabetes, renal disease or dementia. In the community, it is offered to people aged 45 to 74 years, whereas in prison it can be offered for people aged 35 to 74 years. There is an absence of robust available data to describe the proportion of people that are eligible for an

NHS Health Check in prison that are offered one and therefore evidence for how to improve implementation. In one study of 6 prisons in England, more than 3 out of 4 eligible males took up the opportunity for NHS health checks when offered (compared to 37% in England)[81]. Of these, 12.1% had new significant CVD morbidity, including type 2 diabetes and hypertension. The CVD risk was identified to be similar to the general population, but the prison population screened were 10 years younger, suggesting they had more advanced risk for their age[82]. A recent Care Quality Commission (CQC) Inspection (2023) included notable good practice at HMP Huntercombe through using a 'Health Hub' to screen for CVD risk. For example, men are screened for high blood pressure and when identified are referred onto appropriate care pathways. These men would not ordinarily have attended healthcare as many had no symptoms, but their risk of early death from CVD is now more likely to be averted following appropriate onward referrals.

Dental health, oral health promotion and disease prevention

People in prison often have significantly poorer oral health than the general population due to pre-existing neglect, substance use disorder and limited access to preventive care before imprisonment[83]. Poor oral health can lead to severe pain, infections and systemic health issues, which, if left untreated, may contribute to increased healthcare costs and a higher burden on prison medical services[84]. Additionally, inadequate dental provision can negatively impact people in prison's mental well-being, nutrition and rehabilitation efforts, exacerbating existing health inequalities[85]. While there is limited evidence in prisons, it is plausible that women in prison may have higher levels of untreated dental disease and more complex oral health needs than their male counterparts due to a history of trauma, domestic abuse, and substance misuse, which can contribute to poor dental hygiene and increased dental anxiety. Women are also more likely to suffer from eating disorders, which can have significant oral health implications, including enamel erosion and severe tooth decay[86]. Additionally, pregnant women in prison require specialised dental care, as hormonal changes during pregnancy increase the risk of gum disease.

Current dental services in prison

In the UK, prison dental services are commissioned by NHS England. Unlike NHS general dental services, which operate under the Unit of Dental Activity (UDA) model, prison dental care is commissioned on a sessional basis, reflecting the unique challenges of providing care in a secure environment. All prisoners and individuals in young offender institutions are entitled to NHS dental treatment, including when on day release. They are exempt from NHS dental charges.

Delivering dental services within prisons—essentially "somebody else's house"—presents major difficulties, as clinical priorities must navigate the constraints of security policies, staff shortages, and operational prison regimes. One major issue is "no access" visits, where patients are simply not brought to their dental appointments due to staffing issues or security concerns, leading to missed treatments and longer waiting lists.

Despite clear evidence linking oral health to wider systemic health issues, including CVD, diabetes and oral cancer, dental care is often deprioritised compared to general healthcare within prisons[87]. Dentists play a crucial role in identifying signs of poor nutrition, eating disorders, self-harm, substance abuse and early indicators of oral cancer, yet these insights are rarely integrated into wider prison healthcare planning due to the lack of collaboration between dental and health teams[88]. As with health in prison, frequent transfers, often mid-treatment, means that only urgent care can be provided due to the potential short period of time before transfer or release. This disrupts continuity of care and makes it difficult to complete even routine procedures like fillings, extractions, and regular oral cancer screenings.

The prison dental service operates largely in isolation from the wider primary care dental system, meaning that released individuals face barriers when trying to access community dental care, often having to start treatment plans from scratch. Addressing these issues requires a more integrated and collaborative approach between national dental teams and detained settings commissioners of dental services, including ensuring contracting methodology meets the demands of a secure environment rather than adapting current contracting methods to fit. The ability to transfer dental records electronically, similar to electronic patient health records, would assist with the monitoring of contracts to develop better outcomes for patients through improved oral health prevention programme monitoring and ensuring the clinical setting is fit for purpose.

The current access issues in the community setting to NHS dental care often prove a barrier for continuation of care from release from the secure setting. By ensuring dental services are better embedded within overall prison healthcare strategies and improving continuity of care both inside and outside the secure estate, better patient outcomes can be achieved and better value for the taxpayer attained. This will also foster an integrated care approach.

As with health, the current clinical medical system does not support the collection of detailed dental records, often relying on dental providers making manual data returns which presents a significant challenge in prison dental care, leaving no national overview of the current oral health of the detained population. Unlike general medical records, which are increasingly integrated through shared digital systems, prison dental records are often maintained separately and are not universally linked to NHS dental practices outside the secure estate[89]. This lack of integration results in poor continuity of care, as released individuals frequently struggle to provide their dental history when seeking treatment, leading to duplicated assessments, treatment delays and deteriorating oral health outcomes. Additionally, the absence of comprehensive data collection on prison dental services hinders efforts to assess service effectiveness, identify gaps in provision, and develop improvements. Addressing these challenges requires improved integration between prison healthcare systems and NHS dental services in the community to ensure released individuals can access timely and appropriate dental care without unnecessary barriers.

Perceptions of the service

The perception of dental services among prisoners in the UK is often negative, with many detainees viewing access to treatment as inadequate, slow, and inconsistent, sometimes

leading to patients conducting their own dental work[90]. Long waiting times, sometimes extending for months, lead to frustration, with some prisoners believing they must exaggerate symptoms to receive urgent care. Additionally, there is a culture of mistrust toward prison healthcare services, as many prisoners feel their pain and dental needs are dismissed or deprioritised in comparison to general medical concerns. We should acknowledge that NHS dental services across England are under strain, not just in prisons.

Anxiety about seeing a dentist is also common and is exacerbated by the prison environment, where security constraints, unfamiliarity and a lack of compassionate communication can heighten fear[91]. Confidence in the system is further damaged by frequent appointment cancellations due to staff shortages or operational issues. Furthermore, the lack of integration between dental and general prison healthcare services makes it difficult for prisoners to understand the wider health benefits of oral care, reinforcing the perception that dental treatment is a low priority within the system.

Challenges and opportunities for health improvement in prison settings

Although healthcare in prison should be equitable with the wider community, the acute setting of a prison may not provide adequate opportunity for health promotion. People often enter prison with multiple and complex health needs and if they are in prison for a short time there are often challenges in meeting these complex needs that can sometimes reduce opportunities for wider health promotion work such as promoting healthy weight and smoking cessation. Prisons are generally considered unhealthy places, rather than being able to support and create health[92]. Yet working to prevent premature ill health, by tackling its drivers, benefits the individual as well as reduces operational and healthcare challenges.

At an organisation-level, promoting good health in prisons requires investment in the systems and structures (policies and procedures) of the setting to embed joined up working. Intervening at an individual level in prison settings offers opportunities to address a number of key and often interlinked health issues and topics and reduce health inequalities, improve outcomes and decrease the burden of disease and disability. However, these opportunities are not without challenges.

Challenges to promoting health in prison

The prison environment presents specific challenges when it comes to promoting health[93]. Some of these factors are explored further below.

Environment

The prison environment and regime are determined by governors and HMPPS, not healthcare. The typical prison environment makes it difficult for people in prison to carry out health-promoting behaviours, like smoking cessation, healthy eating or physical activity in fresh air. Being confined to their cells for large periods of time exacerbates boredom and limits

opportunities for people in prison to engage with activities such as using the gym. The fabric of many prisons is poor – prisons were not designed to deliver modern healthcare – are often overcrowded, can reinforce trauma and are challenging for those with neurodiverse needs. Healthcare services are often delivered in physical environments that would not be considered acceptable in the community with little to no ability to drive improvements[94].

Health services, including health promotion activities, compete with other elements of the regime and patients often must choose what they are going to attend (health appointments, work, education or visits). People in prison are paid for each work and education session they complete[95], but are not routinely paid for engaging in health activities. Some of the non-health elements promote healthy living and habits, for example, gym courses or learning new life skills or cooking; often, these activities are not promoted or seen as health promoting activities, rather education or work.

The limits on time in the core prison day reduces when clinics and health promotion engagement can be held. This drives services (health and non-health) to compete for engagement and results in clinical session time being underused.

Prison cultures of violence and bullying affect the personal safety and mental health of both people in prison and staff. The importance of a stable, safe environment and providing activities tailored to the needs of the population was highlighted by interviewees in recent research on ISFLs[96].

Health literacy of people in prison

Health literacy refers to the ability of individuals to gain access to, understand and use information in ways which promote and maintain good health[97]. Health literacy is established as a modifiable determinant of health[98], thus arguably a way to impact on and reduce health inequalities. People in prison often have difficulty accessing health information as they cannot access phones and the internet. When they do, they may have challenges in understanding or applying it. Data from Ministry of Justice states that over 70% of adult people in prison are assessed on entry to prison as having Maths and English at or below GCSE level. Where known, over half (55%) of people in prison who took an initial assessment and then enrolled on a course had a learning difficulty or disability (LDD)[99]. Health information is generally in written form for people who are not in prison with examples for health improvement (activities) that may not be relevant, sufficient, helpful or accessible for people in prison (such as go for a walk, cycle or have a swim). Improving health literacy of people in prisons can help them to make informed decisions including about behaviour and lifestyle changes. Initial contact with education can for some develop self-esteem and self-worth in order to be able to prioritise health promotion.

Lived experience panel: barriers to promoting health in prisons, NHS England Health and Justice Lived Experience Network

For this report, we undertook a workshop with people with lived experience of prison to explore health promotion. The following barriers to promoting health in prison were identified:

- lack of choice to improve health. The benefit of programmes that educate or provide skills is limited when the environment doesn't allow choice to practice this. Food provided is based on volume and is carbohydrate heavy
- lack of knowledge and education to identify health needs. There is sporadic offer of workshops– you might learn a skill but if you can't exercise those skills and information within the regime then you won't retain it. These options may only be open to only some groups
- variable levels of service, for example, a GP might refer to smoking support, but this might not be available consistently in every prison. Governors may not be aware of opportunities and good practice that can be achieved in other estates
- lack of a joined-up approach; prisons as large organisations with complex systems. Siloed working mean beliefs and practice persist

Recruitment, retention and training of staff

Frequently staff (both health and operational staff) may not feel equipped to promote good health in prisons, which requires an understanding of when and how to engage people in prison with their health needs, and where and how to refer. This is compounded by high turnover of staff and multiple competing pressures making training of staff a challenge. This is explored further in chapter 16.

Prison population

There are also factors relating to the population in prison that make it more challenging to promote health through brief interventions that are often used in the community. For example, earlier life experiences, including high levels of adverse childhood experiences, may influence trust and willingness to engage with services. Some people move rapidly through the prison estate or oscillate between the estate and the community reducing opportunity for engagement with good health promotion. This means it is imperative to embed joint working agencies into the structures and processes of the setting to ensure that promoting good prison health is business as usual.

Opportunities for health promotion and improvement in prison

Prisons offer a public health and health promotion opportunity to intervene with a population who are known to have high levels of complex health and social care needs. For some people,

prison can be the first time they have had the opportunity to access healthcare and focus on improving their health and wellbeing. Preventing ill health not only benefits the individual, but reduces operational and healthcare burden in prison, and on release, in the community. Several opportunities to support healthy eating, physical activity, smoking cessation, substance use disorder and mental health have been explored in this chapter. A lived experience group held for this report reflected on the common ways of achieving health promotion.

Lived experience: ways of achieving effective health promotion in prison settings, NHS England Health and Justice Lived Experience Network

The members of the lived experience group identified the following opportunities to promote health of people in prisons:

- increasing trust by enabling lived experience members to be vetted to work within prisons
- reducing the power imbalance between professionals and current and ex-prisoners
- creating a safe space and culture where people feel heard
- offering consistency in a fair approach from all staff – healthcare and operational
- encouraging co-production by consulting with people in prison over health-promoting events
- understanding the effects of post-traumatic stress disorder (PTSD) and how its prevalence can be a barrier to many people in prison
- following through with what is proposed in initial meetings (requires top-down and bottom-up buy-in)

Whole system health improvement

Embedding a whole system approach to care[100] is key to successful resettlement. One way for prisons to work in a more joined up way is to use the non-medical opportunities of socially prescribed activities. Social prescribing is a key component of Universal Personalised Care that connects people to activities, groups and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing[101]. Social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services – for example, arts activities, gardening, cookery, healthy eating advice, sports, volunteering – to support their health and wellbeing[102]. HMPPS have responsibility for wellbeing and key workers could be well placed to identify and link people into social prescribing opportunities. There is also interest in training people in prison as health coaches to deliver health knowledge and reduce the people in prison's high risk health behaviours, while also building capacity in the system and having positive impacts on resettlement through nationally recognised

qualifications. There is evidence of benefit for management of chronic conditions[103], but limited evidence in prisons.

Practice example: social prescribing in Kent prisons with Change, Grow, Live (CGL)

Socially prescribed activities have been robustly implemented across the Kent prisons since April 2024 via Change, Grow, Live (CGL, a recovery services provider). This in part was enabled largely due to adequate resources and immediate buy in from heads of healthcare, security departments and drug strategy governors. The aim was to implement a different intervention bimonthly. These include vision boards, breathwork, yoga, rhymes and reasoning and virtual reality (VR) headsets.

Feedback has been incredibly positive, with the cohort commenting on the combination of new innovations compared with classic group facilitation. Evaluation has identified positive changes including reduction in stress and anxiety and improved sleep. Some of the learning the team have identified, is the need to vary the offer by different categories, for example, people with a long sentence or who were unsure of the immediate future may find it hard to have ongoing engagement with vision boards. Clients now run their own breathwork groups and yoga interventions and are able to apply what they have learnt when spending time in their cell.

Promoting the health and wellbeing of staff

For staff to be able to support a whole system health improvement approach it is vital that their own health and wellbeing is systematically considered and supported. This is explored in chapter 16 on workforce.

Training staff

Being confident and capable in instigating and leading health prevention and promotion conversations making every contact count (MECC) fosters an environment and team mentality whereby health promotion becomes everybody's business. This is vital to underpin the comprehensive programmes targeting individual risks such as substance use harm minimisation, cardiovascular health or nutrition. Therefore, it should be available for all staff working in prisons. NHS England has created e-learning modules to support systems to implement Core20PLUS5 and comprehensive MECC interactive learning resources[104]. Dedicated training in trauma informed practices is also key so staff understand the impact of trauma and can encourage people to engage in non-medical models of wellbeing such as the 5 ways to wellbeing which are also fundamental to all models of health prevention and promotion.

Summary

There are a significant amount of health promotion interventions and activities across the prison estate, however they remain poorly prioritised, poorly understood and evaluation is largely absent. There is a need to reduce silo-based working to bring together existing strategies and activities (for example drug recovery with health and wellbeing) to maximise joint outcome opportunities. A holistic, whole prison approach will be integral to the success of interventions and for effective outcomes.

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