



PeP-SCOT a health coaching intervention for people in prisons: the development of the intervention protocol

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Abstract: There is a need for an alternative approach for health promotion prisons since previous work has indicated that health education, while improving health knowledge, does not result in behaviour change. Evidence has suggested that a health coaching assists in this regard. However, the question remained whether this approach would be appropriate and possible in prisons? This paper presents the public health strategies used to work in partnership with prison management to address challenges and accept opportunities as a health coaching intervention protocol was developed for oral health and wellbeing in the prison setting.

Key words: prison, oral health improvement, health coaching

1. PeP-SCOT intervention protocol: the impetus for an action plan

In Scotland, the framework for improving the health of Scottish Prisoners (Scottish Prison Services, 2011), the Dental Action Plan (Scottish Government, 2005) and the 2015 prison oral health improvement policy (Scottish Government, 2015) gave the impetus to develop and redesign oral health interventions for the prison environment. The resulting intervention called Mouth Matters (MM) (Freeman et al., 2013; NHS Health Scotland, 2014), consisted of six units ranging from providing knowledge to supporting change in oral health behaviour.

The need for this alternative approach was necessary since, previous work in the prison setting had suggested that health promotion interventions had increased knowledge but had little effect upon behaviour (Akbar et al., 2012). Thus a new approach was needed. Cinar's work using health coaching to assist people to change their health-related values and beliefs resulted in the modification and maintenance of behaviour change (Cinar et al., 2014). Health education and health coaching differ from one another in a variety of ways. These include different agenda setting strategies, different motivation approaches and different communication pathways to promote and maintain health (Table 1).

It was envisaged that a health coaching intervention could inform and act as the sixth and final unit of MM as it uses a client-centred approach to assist in behaviour modification and maintenance. Named PeP-SCOT, it aimed to empower people in prison through improvement of their psycho-social and cognitive skill sets to act as health coaches for others (i.e. peer coaching).

2. Aim and objectives:

The aim was to develop an intervention protocol to promote cognitive skills (health-learning capacity) together with psycho-social (self-esteem and self-efficacy) skills within a health coaching framework.

The objectives were to:

1. Integrate PeP-SCOT into the prison setting;
2. Promote a continuous learn-act-grow health cycle within participants;
3. Assist participants to adopt healthier lifestyles and maintain them;
4. Develop psycho-social and cognitive skills to work with and assist others;
5. Improve self-esteem and self-efficacy for increased satisfaction with 'self'.

3. Public health competencies

In order to integrate PeP-SCOT within the prison estate, it was necessary to adopt partnership working within a multi-sectorial approach. The first part of this work was to open negotiations with prison authorities and those people involved with education and physical activities. This allowed a discussion platform to be convened. Discussions included the suitability of the intervention for the prison setting, the format of participative workshops and the personnel needed to assure that people taking part would be available for training. The second part was to ensure that the content of the intervention was appropriate. This was provided by Positive Prison? Positive Futures, who gave important insights, comments and feedback on the developing intervention protocol. Part three was liaising with NHS Boards. This allowed additional health promotion and coaching support to be provided. PeP-SCOT was

then focused upon agreed common, value-based goals to promote psycho-social and cognitive skills to empower people living and working in prison.

This collaborative method was aligned to that of the WHO's Health in Prison (Enggist et al., 2014) and the

Scottish Prison Service's (SPS) framework for improving health of prisoners (SPS, 2011) (Figure 1).

The public health competencies of partnership working, capacity building and personal skill development facilitated the development of the PeP-SCOT intervention protocol.

Table 1. Comparison of Health Education and Health Coaching

	<i>Health Education</i>	<i>Health Coaching</i>
Focuses on	Information about specific health condition or health behaviour Disease or problem oriented	Client's whole life and well-being Client's identified health goals and action plans Positive health improvement and maintenance
Agenda provided by	The health professional Health professional/educator is the expert for the client's health	The client Client is the expert for her own health
Themes and tailoring	Standardized information provided Themes decided by the health professional	Themes decided by the client Themes are flexible and may be modified by the coach using specific communications such as open questions, summaries and reflections
Motivation and Goals	Extrinsic motivation Goals/targets are presented by the health professional Standardized pre-described regimes to improve health for all clients	Intrinsic motivation Addresses internal resources Coaches with the clients assist them in identifying their own ideas and resourcefulness, encouraging clients to improve their health by enabling them to see their lives from now to the future as a personal project. Clients' achieve their action plan by exploring and using their own resources Coaches facilitate their clients' engagement towards their own identified health goals
Communication pathways	Reactive: focusing on how to treat disease/problem Clinician centred Options presented Told and informed Adherence vs. non-adherence Doing to	Proactive; focusing on improve positive health from today to the future Client centred Informed choice Asked and guided Active listening Challenging, determined, ambitious Doing together

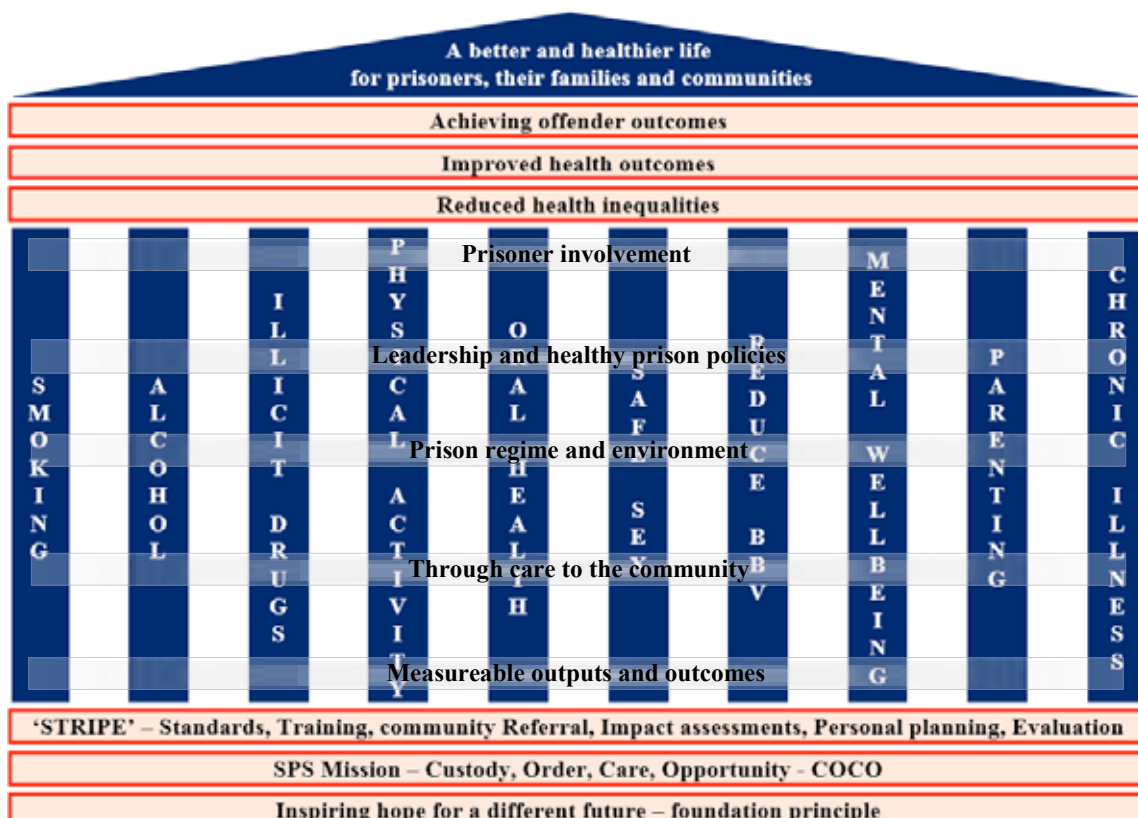


Figure 1. A framework for improving the health of Scotland's prisoners (SPS, 2011)

4. Challenges and opportunities of working in the prison setting

Working in the prison environment presents a series of challenges, but also opportunities. For instance, the prison environment had been shown to both enable and inhibit people's oral health behaviours (Freeman et al., 2013). Prison policy, with its restrictions on toothbrush type, dental floss and the availability of healthy foods emerged as a challenge to the adoption of positive oral health behaviours. At the same time the very structure of prison life provided an opportunity to restructure of personal hygiene activities and ensure that offenders brushed their teeth with fluoride toothpastes (Akbar et al., 2012). People in prison are considered to be at a higher risk of non-communicable diseases because of unhealthy lifestyles such as e.g. smoking (Enggist et al., 2014). They have a greater prevalence of dental caries and periodontal disease (Freeman et al., 2013) and have mental health problems as well as poorer oral hygiene and xerostomia (Heidari et al., 2014; Enggist et al., 2014). The adoption of positive oral health behaviours, in particular toothbrushing, have been proposed as promising entry points for the acceptance of other associated health behaviours (Cinar et al., 2014). Using a common risk factor approach (Sheiham and Watt, 2000), the SPS and WHO have recommended that: 1, oral health promotion should be an integral part of the prison health service; and 2, oral health should be incorporated into prisoner induction programmes and health triage systems.

It was agreed that the inclusion of the common risk factor approach was necessary and should be a central component of the PeP-SCOT intervention protocol.

5. Working in partnership to create the PeP-SCOT intervention protocol

In order to formulate the PeP-SCOT intervention protocol several steps were undertaken:

Step 1: A set of principles were agreed by the research team, Positive Prison? Positive Futures, SPS and NHS, to form the foundation of the PeP-SCOT intervention protocol (Table 2).

Step 2: The need for an evidence-base to underpin the PeP-SCOT intervention protocol resulted in further challenges. The deficiency of evidence regarding best practice for oral health and health promotion interven-

tions within the prison setting presented a challenge to the PeP-SCOT intervention. Work from America, however, suggested that health promotion in the form of health coaching could assist 'the transition from prison to the community' (Spaulding et al., 2009), and when incorporating motivational interviewing elements was 'particularly useful in coaching individuals with ... substance abuse' (Spaulding et al., 2009). It seemed that health coaching could transform behaviour, strengthen social bonds and, with reports of community reintegration, affect recidivism. Health coaching had been shown to contribute to turning points in offenders' life experiences by providing the cognitive skills to improve decision-making and psycho-social skills (Sampson and Laub 2005). Health coaching, thus, provided an alternative to health education approaches. Therefore, it was agreed between partners that a health coaching format should be adopted and used in PeP-SCOT.

Step 3: Other concerns raised included, time-tables for PeP-SCOT implementation; lack of available funding; potential communication difficulties when handling health issues with participants; the sustainability of self-management and positive oral health behaviours; and the routes to achieve the core health coaching elements of trust and empathy within a prison setting. Research from the management of NCDs provided a solution (Heisler, 2007; WHO, 2008). It showed that peer support was a particularly effective strategy, since it allowed the benefits of both receiving and providing social support while promoting empowerment to increase social capital (Heisler 2007, Fisher et al., 2012). The following elements were, thus, incorporated into the PeP-SCOT intervention protocol:

1. Support and mentoring for peers to promote the adoption of health behaviours (including residential officers);
2. Training in psycho-social skills, to include cognitive skills and participative activities to promote self-esteem and self-efficacy (including residential officers);
3. Tailoring of health education and health-related activities for use by trained peers;
4. Training in practical health skills, psycho-social, cognitive and life skills to promote empowerment and social interaction.

Table 2. Agreed working principles for the creation of the PeP-SCOT protocol

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1. People in prison have the same right to health care as everyone else;
 2. Prison health is an issue on the public health agenda;
 3. Everyone in prison has a shared responsibility to promote oral health and wellbeing of all people in prison;
 4. Everyone in prison has a shared responsibility to deal with prisoners primarily as people with additional and specific needs;
 5. Everyone in prison must make every opportunity a health promoting opportunity to aim for a holistic approach to health care;
 6. Health policy in prisons should be integrated into national health policy, and the administration of public health should be closely linked to the health services administered in prisons;
 7. There is a need for common health promotion programmes for everyone in prison to improve psycho-social skills, and health literacy to reduce health inequality and contribute to lowering recidivism.
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6. The PeP-SCOT intervention protocol

i Content of the PeP-SCOT intervention

As a consequence of the preliminary work undertaken to develop the PeP-SCOT intervention protocol the health coaching programme was accepted by all partners. It was grounded in the requirements of the International Coaching Community but modified to suit the requirements of the client group (Cinar and Schou, 2014a,b). Consultations with the prison authorities and those people involved with education and physical activities took place. The consultation period allowed for engagement of all stakeholders. This permitted discussion of the suitability of the intervention for the prison setting along with the format of participative workshops and the personnel needed to assure that people taking part would be available for training. This enabled the prison requirements, the tailoring of the programme to address the needs of those in prison and their expectations to be realised. Armed with this information, the content of the PeP-SCOT training was designed specifically in accordance with the stakeholders' requirements and expectations.

ii Participant Recruitment

In close consultation with the prison, five prisoners and one residential officer were recruited to take part as health coaches. The prisoners were those who were passmen (that is, they are allowed to leave their cells to carry out specific duties), who had completed other in-house training programmes and had agreed to take part. Prisoners due to be released within three months of the start of the programme were excluded. All participants were informed about the study details and given assurance about ethical principles, such as anonymity and confidentiality.

During the 3-month training period, all participants were trained to be health coaches. They were required to complete reflective log-books and diaries and to write notes of their meetings with their own coachees to be presented during supervision meetings. The programme and the one-to-one supervision meetings were conducted by, a qualified health coach and a qualified internal coach (AC). Together they led the training and supervision, one-to-one support and feedback to the health coach candidates, during the three-months' training and the six-months following its completion.

iii Evaluation and peer coaching experiences

The evaluation of the programme was in two parts: an educational evaluation and an evaluation of the effectiveness of the PeP-SCOT intervention.

The educational evaluation included a formative assessment with feedback during one-to-one supervision

sessions. A summative assessment, at the end of the third month included an external independent assessor who observed a coaching session to ensure that a standard had been achieved by all trainee coaches that reflected the programme goals. The second part of the evaluation process will assess the effectiveness of the PeP-SCOT intervention to promote psycho-social and cognitive skills. An independent researcher will use a mixed methods approach, including questionnaires to assess partnership working within the prison. At baseline and at three and six-month follow-ups participants' health-related knowledge (cognitions), self-efficacy, self-esteem and behaviours will be assessed. In addition, in-depth interviews will be conducted with participants to explore their thoughts and opinions and to assess the effect of the coaching upon their coachees' behaviours. Interviews with personal officers will be conducted to discover the effect of PeP-SCOT on participants' behaviours within the halls.

iv Ethical considerations

Ethical approval was obtained from the University of Dundee Ethics Committee (UREC 15118) and by the Scottish Prison Service Ethical Committee. All the coaches and coachees received a participant information sheet (PIS) and provided written and informed consent.

7. Learning points and future implications

The key learning points and implications for practice are as follows:

The importance of partnership working and multidisciplinary collaboration through effective communication with prison administration, NGOs and NHS Boards;

Acknowledgement of the need for the core elements of consultation, negotiation, trust and empathy as effective strategies to ensure multi-sectorial working;

The need for evidence-based theory to be blended with best practice in health promotion to identify strategies to improve cognitive (health-learning capacity) and psycho-social (self-efficacy and self-esteem) skills, and empowerment to ensure capacity building.

Health coaching may seem a very expensive approach at the outset. However, this must be considered in relation to the initial opportunity costs, the financial costs of 'providing a prison place' (£36,259) and the additional costs of 'holding a prisoner' (£33,291) for each year the individual is in prison (Ministry of Justice, 2015). As the evidence suggests that coaching interventions that assist in enhancing self-efficacy and attitudes are associated with a reduction

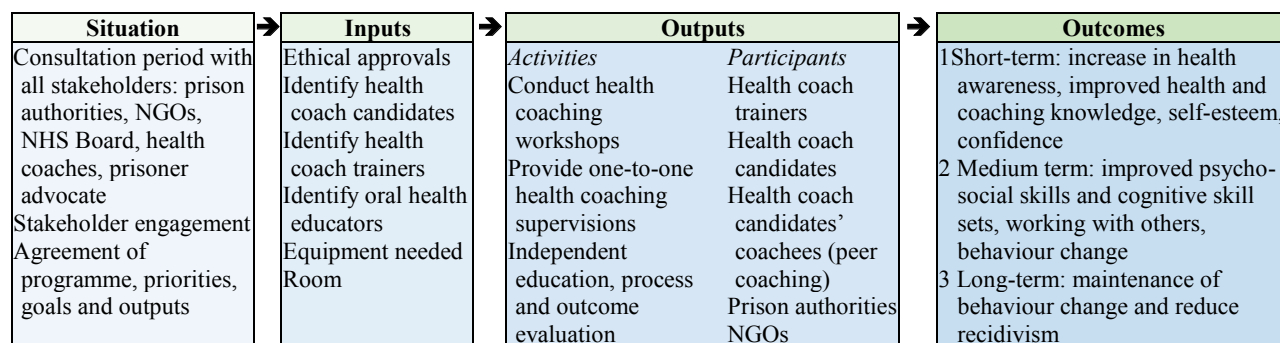


Figure 2. The PEP-Scot logic model

in risk-taking behaviours and improved health outcomes, (NHS Health Education, East of England, 2014), the initial costs of a health coaching intervention must be weighted up in relation to improved self-efficacy together with the behavioural changes linked to less disruption in the prison environment and the eventual reduction in reoffending.

It is suggested here, that by adopting a partnership working within the prison environment that health coaching may act as a turning point for people in prison and enable a change from disadvantage to advantage, create a healthy environment and through learn-act-grow empower participants and increase their self-esteem and self-efficacy.

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