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CASE 7

Transitioning from Prison to Community

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“My name is Joe and I’ve been working as an inmate Irish Red Cross volunteer, helping other prisoners with improving hygiene and delivering healthy messages. In the past, I was always a taker – doing drugs, stealing cars, and not thinking about my family – me winding up in prison. Now, when I tell my family what I’m doing, they’re really proud of me, especially my mother. I’m surprised at myself giving back; it makes me feel good about myself.”

This is a reflection of an Irish Red Cross (IRC) inmate volunteer talking at his graduation where his mother and family proudly shared his day.

Carrie McGowan, the IRC, Community-Based Health & First Aid (CBHFA) Prison Programme Manager, applauded as she and everyone else in the room congratulated the latest group of IRC inmate volunteers to graduate from the CBHFA Prison Programme at Wheatfield Prison. “Working with you lads these past six months has been fantastic, and your work as volunteers has had a tremendous impact on the prison community. Fair play to you!” exclaimed Carrie.

The CBHFA Prison Programme trains prisoners as special status IRC volunteers in an effort to promote the health and safety of the prison community through peer-to-peer health education and the implementation of health promotion projects on the prison wings. The Programme operates through a partnership between the IRC, Irish Prison Service (IPS), and Education and Training Boards Ireland (ETBI). As of 2014, approximately 700 prisoners had been trained as volunteers since the Programme’s inception in 2009. Through the Programme, many of the volunteers have demonstrated immense personal development, internalized a more constructive identity, and gained knowledge and skills in the areas of health awareness and personal and community well-being. Due to IRC policies, many inmates only keep their IRC volunteer status whilst in prison and therefore, their skills and knowledge are not harnessed upon their release. They are unable to continue exercising their pro-social identity by way of their roles as IRC volunteers.

Ryan, another inmate IRC volunteer, commented on his experience with the Programme and how it has impacted him:

“They got me started with First Aid training and I loved it. I couldn’t believe that I could deal with these things. I never believed in myself. That is how it all started and I haven’t looked back. It’s especially satisfying to help other inmates overcome the kind of addictions I was once facing. I feel that I am giving the lads some hope. When I came in, I was dependent on drugs and alcohol so I know how it feels. This was the help I needed...I would like to continue with the IRC on the outside if

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possible. This was the help I really needed. I don't want to go back to the old Ryan, the old lifestyle. That will never happen."

Since receiving feedback like Ryan's, the CBHFA Prison Programme team has started working on phase II of the Programme. With phase I of the Programme being the CBHFA Prison Programme that was and is currently in place within the prisons, phase II was being designed to take the Programme in a new direction, from prison to community. The Programme team recognized that the process of reintegrating prisoners into society was filled with many challenges. The thinking that drove phase II development emerged from wondering whether a continuation of the Programme could aid in this transition by providing opportunities for ex-offenders to achieve "active citizenship" by enabling them to take responsibility and initiative in their local community. They could then continue to exercise the positive identity they developed through the Programme while in prison. The team knew that such a Programme came with certain risks and challenges but believed that the potential benefits for both the community and the ex-offenders outweighed said risks.

BACKGROUND

The Irish Prison Service (IPS)

The IPS is one of the CBHFA Prison Programme's primary partners, and it operates as an executive agency within Ireland's Department of Justice and Equality (Irish Prison Service, 2012). Each of the 14 prisons that comprise the IPS possess a similar staff structure with each having a Governor, Assistant Governors, Chief Officers, and Assistant Chief Officers to oversee operations as well as other prison staff. Despite these structural similarities, Ireland's prisons are unique with respect to their level of security, demographic makeup, and particular needs and challenges.

The mission and vision of the IPS is to provide safe and secure custody, dignity of care, and rehabilitation to prisoners in an effort to create safer communities. The IPS strives to achieve excellence in prisoner care and rehabilitation by working closely with several agencies in order to provide opportunities for offenders to access services to improve their lives. Services provided by the IPS include education, a library, work training, mental health services, probation, and health care services (Irish Prison Service, 2012).

The Irish Red Cross (IRC)

The IRC is a member of the International Federation of Red Cross & Red Crescent Societies (IFRC), which is the world's largest global network of voluntary humanitarian action. It is made up of approximately 190 Red Cross and Red Crescent societies in nearly every country in the world. The IRC was formally established in 1939 and has since been providing humanitarian support and community services to the most vulnerable, both locally and abroad (Irish Red Cross, 2016a).

The IRC's work in Ireland is both extensive and diverse. Their programs and services range from ambulance and rescue services, to programs to assist in reconnecting families who have lost contact with each other, and to promoting the awareness of International Humanitarian Law (Irish Red Cross, 2016a). Included amongst this list of programs is the award-winning CBHFA Prison Programme, which is one of the IRC's most innovative community health programs.

The CBHFA Prison Programme was modeled after the CBHFA in action approach, which is an IFRC approach to health education and First Aid. It was designed for use in communities around the world through each country's respective national Red Cross/Red Crescent Society (Irish Red Cross, 2016b).

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The CBHFA approach involves training and mobilizing volunteers from the community to carry out relevant health and safety activities. It is based upon the belief that volunteers from the community understand the community and its needs best and thus know the best ways to address them.

Ireland is the first country in the world to introduce the CBHFA Prison Programme in a prison context, using groups of special status IRC inmate volunteers. The innovative nature of the Programme applied to prison health has captured the attention of many international organizations in the field of prison health and criminal justice.

Carrie McGowan, IRC CBHFA Prison Programme Manager

Carrie studied Psychology at the National University of Ireland from 2006-2009, which she subsequently followed with a two-year Master's degree in Counseling & Psychotherapy at the Irish College of Humanities & Applied Sciences.

Prior to becoming the manager of the CBHFA Prison Programme in March of 2015, Carrie had worked as a psychotherapist in Wheatfield Prison for four years. While working there, Carrie had been very aware of the CBHFA Prison Programme, as several of her clients had become IRC volunteers, and she had noticed first-hand the positive impact the Programme was having on them.

Carrie became involved with the Programme by first providing support to some of the project work the volunteers were doing surrounding overdose prevention and the development of an overdose prevention module.

As Carrie witnessed the power of peer-to-peer education within the prison, her interest and involvement with the Programme grew. She eagerly pursued becoming a part of the CBHFA Prison Programme management team, especially because the Programme was moving to focusing on the transition from prison to community. From her work as a psychotherapist, she had heard first-hand the battles prisoners faced upon leaving prison and returning to the community. She believed that this Programme, which was changing the lives of people in prison, could continue to do so outside of the prison walls.

Graham Betts-Symonds, Programme Director, IPS CBHFA Prison Programme

Graham Betts-Symonds was trained as a registered nurse, teacher, researcher, and manager with experience in community and preventive health, disaster management, emergency care, trauma, and orthopedics. His doctoral research was in the field of change management, experimenting with chaos and complexity theory applied to management learning, which underpinned much of his work in both disaster management and community health.

Graham was previously Director of Combat Medicine for the Middle Eastern Armed Forces after the Gulf War before being appointed as the Emergency Medical Technology Director at Northeastern University – Middle East campus. He later worked with the IFRC as a Regional Disaster Management Delegate for the Middle East based in Jordan with the British Red Cross. Subsequently, Graham became Senior Officer in Disaster Preparedness and Risk Reduction for the Middle East, North Africa, and Asia-Pacific based at the IFRC in Geneva.

Graham has experience in developing and implementing community based programs in Asia, including China and the Pacific Islands.

During the Gulf War, he oversaw the medical management of prisoners of war in specific wards of military hospitals. Graham was responsible for training all medical staff on war-casualty

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management, including Chemical and Biological Warfare casualties. The high risk of chemical attacks overlaid on traditional war casualties created a complex preparedness and response training need as well as significant ethical perspectives never envisaged before (Betts-Symonds, 1994).

As a consultant to the IFRC, Graham designed the methodological approach of CBHFA in Action for the Health Department in Geneva published in 2009 for global use. This built on his previous systems and cybernetic approach to community vulnerability and capacity assessment developed for global use in risk reduction and disaster preparedness.

In 2008, Graham moved to the Irish Prison Service in Dublin, and became responsible for prison health in two major prisons with a remit to implement change management within the health system to create a culture of proactive, preventive health. A collaborative approach was used developing partnerships with the IRC and the ETB and as an example of the Whole Prison Approach to health (World Health Organization, 2007).

The development and implementation of CBHFA in prisons was the change management strategy employed based upon the *learning and action* experience in earlier combat medicine and International Red Cross settings in community health, disaster preparedness, and risk reduction.

THE COMMUNITY-BASED HEALTH AND FIRST AID (CBHFA) PRISON PROGRAMME (Phase I)

The CBHFA Prison Programme was born out of a noticed gap in prison health care delivery with respect to the nine IPS Health Care Standards following an audit in 2008 (Exhibit 1). The fifth standard encompasses all elements of prisoner/patient health awareness and education relating to disease prevention and the maintenance of healthy lifestyles and well-being. The audit of this standard scored poorly — from a prison community-based perspective — because the dissemination of health information was not being undertaken within the community as a result of resource constraints, making nurses only available to provide health advice/information on a one-to-one basis (Betts-Symonds, 2016). As a result, the CBHFA Prison Programme, a peer-led, community, public health program, was developed through the adaptation of the IFRC's CBHFA in action approach and was piloted at Wheatfield Prison in 2009.

As previously highlighted, the CBHFA Prison Programme operates through a partnership between the IRC, IPS, and ETBI. It involves inmates becoming special status IRC volunteers in order to serve as peer health educators and build community capacity relating to public health and First Aid (Betts-Symonds, 2016). The Programme modules (Exhibit 2) are delivered weekly over a six-month period by ETBI teachers in the school unit of the prisons and by allocated nurses/health care professionals who are employed within the prison health care system. This makes the Programme extremely cost effective.

The Programme design is based upon the principle of “learning by doing,” whereby the volunteers apply what is learned in the classroom on the prison wings as they progress through the Programme modules. Throughout the Programme, inmate volunteers assess the needs of their community, learn specific skills based on relevant health topics, and subsequently plan and implement various health promotion projects on the prison wings.

A CBHFA Prison Programme management structure is implemented in each prison. The effective functioning of this structure is crucial to the success of the Programme, as buy-in from governors and prison staff is necessary in order to grant volunteers access to the prison wings

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(Betts-Symonds, 2016). This structure is put in place and attached to each CBHFA Prison Programme in every prison:

- Governor
- Chief Officer
- Assistant Chief Officer
- Prison Officers
- Teacher
- Nurse
- Representatives of the Volunteer Group

This structure also represents the membership of the Community Health Action Committee (CHAC) in each prison, which meets monthly to monitor and drive health projects being planned or implemented by the CBHFA inmate volunteers.

The CBHFA Prison Programme has ensured sustainability by training qualified IRC volunteer inmates as facilitators for CBHFA. These facilitators take on the role of teaching selected CBHFA modules to new volunteers as well as supervising and assisting new volunteers with their project work. Inmate facilitators have had tremendous success in their delivery of both the Overdose Prevention and Culture of Non-Violence and Peace Modules. The Culture of Non-Violence and Peace Module has also been developed into its own workshop, which is delivered by IRC inmate facilitators to the general inmate population on a monthly basis in an effort to help prevent, reduce, and mitigate incidences of violence in the prison community.

THE IMPACT OF THE CBHFA PRISON PROGRAMME

The CBHFA Prison Programme was first piloted at Wheatfield Prison in June 2009 and, following several successful evaluations, was extended to all of Ireland's 14 prisons in 2014. Results from the 2009-2014 evaluation period have shown the profound positive impact the CBHFA Prison Programme has had on prison health and the prison community. The success of many of the projects and campaigns implemented by the IRC volunteers is thought to be a result of the power of peer-to-peer education, which has been shown to be effective at accessing hard-to-reach populations (Clements & Buczkiewicz, 1993).

The positive impact of the CBHFA Prison Programme can be seen through the various health promotion projects undertaken by the IRC volunteers, with a list of the various different projects shown in Exhibit 3. An example of positive impact can be seen in the HIV Mass Rapid Testing & Reduction of Stigma campaign linked to St. James's Hospital's HIV Clinic. This campaign was implemented in three prisons in the Dublin area after discovering that less than 10% of the prison populations knew their HIV status (Betts-Symonds, 2012; 2016).

Inmate volunteers advocated for testing and encouraged discussions about HIV and AIDS amongst inmates, resulting in 55-75% of all inmates from the three prisons presenting for voluntary testing. Many prisoners indicated their participation in the voluntary testing was a result of the advocacy efforts of their peers, rather than doctors and nurses, providing support for the power of peer-to-peer education (Betts-Symonds, 2016).

Ryan first became aware of the IRC volunteers' work during the HIV Testing campaign and commented on how it influenced him to promote his own health:

"My father died when I was ten, and my mother died when I was only fifteen. After my mother died, I turned to alcohol and drugs. When I came into prison, my life was upside down. I thought I might have had AIDS."

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An inmate IRC volunteer befriended me, and they encouraged me to get tested for HIV in the mass voluntary HIV testing campaign organized by Healthcare staff and Red Cross volunteers.

It came back negative. It was a huge weight off my shoulders. It was a second chance.”

The Weapons Amnesty Project is another example of a successful project that was undertaken by the inmate IRC volunteers. This project was linked to the Programme’s Violence Prevention and Reduction module and was planned after inmate IRC volunteers identified violence using cutting weapons as a serious problem in the prison community. The volunteers and prison management decided to work together to address this problem by planning a week-long weapons amnesty (Betts-Symonds, 2016). The IRC inmate volunteers advocated for prisoners to make the prison community a safer place by giving up cutting weapons; prisoners were assured this would not lead to any sanctions against them. The initiative was a huge success, with the percentage of all attacks on prisoners with a cutting weapon dropping from 97% to less than 6% in the months after the amnesty (Betts-Symonds, 2016).

In addition to the impact the CBHFA Prison Programme has had on prison health and safety, the Programme has also fostered significant personal development and empowerment among the inmate IRC volunteers. The benefits of the Programme to the volunteers include improved self-esteem, self-respect, and confidence, and this can be seen in the examples of the guided-reflective exercise undertaken with IRC inmate volunteers during an evaluation of the Programme (Exhibit 4) (Betts-Symonds, 2016).

The significant personal development the Programme has fostered amongst the volunteers was a strong contributor to fueling the team’s belief in the value of a continuation of the Programme that focuses on prison to community. Phase II would allow ex-prisoner volunteers to continue exercising their pro-social identity and living by the humanitarian principles of the IRC.

THE PROBATION SERVICE

In late 2014, the CBHFA in Prisons team brainstormed potential strategies and additional partners for the development of phase II of the Programme. They thought of The Probation Service as an ideal partner, who would be useful to turn to for supporting the intended direction of phase II.

The Probation Service is another agency in the Department of Justice and Equality, which works closely with the IPS as well as with a number of other agencies and community organizations. By definition, to be “on probation” means to be given an opportunity to prove oneself after committing an offence, and the concept emerged over a hundred years ago as a humane approach to helping offenders to change (The Probation Service, 2015).

The Probation Service aims to reduce levels of crime and increase public safety by working with offenders to help change their behaviour through a variety of professional services and supports. Among such services include probation supervision, community service, anti-offending behaviour programs, and specialist support services (The Probation Service, 2015).

According to both The Probation Service and the IPS, the national prison population in Ireland reduced to approximately 3,500 in 2014 from 4,500 in 2009. This reduction in the prison population was thought to be due to a change in the correctional approach, which included a greater use of Community Service Orders and the introduction of a Community Return Scheme (Betts-Symonds, 2016).

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Community Service Orders are an alternative to a prison sentence, which gives convicted offenders the opportunity to instead perform unpaid work for the community. The objective of Community Service is for offenders to pay back the community for the damage caused by their offense (The Probation Service, 2015).

The Community Return Programme, on the other hand, is an incentivized scheme, which provides for earned temporary release in return for supervised Community Service (The Probation Service, 2015). Prisoners are eligible for this scheme if they are serving sentences of one to eight years, with over half of their sentence served, and are assessed by officers of The Probation Service as suitable.

In the early planning stages of phase II, the CBHFA team negotiated with The Probation Service for the possibility of a partnership between The Probation Service and the CBHFA Prison Programme. This was aimed at a possible continuation of the Prison Programme and its volunteerism working in association with one or both of the Community Service Order and Community Return Schemes.

RECIDIVISM IN IRELAND

In 2013, the IPS, in collaboration with the Central Statistics Office, conducted a study of recidivism among all prisoners released by the IPS on completion of a sentence in 2007; the study was based on reoffending data up to the end of 2010. The study demonstrated a national recidivism rate of 62.3% within three years and over 80% of those who reoffended did so within 12 months of release. The high rate of recidivism found in this study demonstrated the need for a greater emphasis on a structured multi-agency approach to preparing prisoners for their release and reintegration into the community (Irish Prison Service, 2013).

This study was the first of its kind in Ireland and was thought to provide the support needed for the development of phase II of the CBHFA Programme, aimed at improving prisoner reentry, reducing recidivism rates, and improving community health. Whilst it is too soon to draw firm conclusions, it is encouraging to see that, between 2009 and 2014, 700 inmates were trained as CBHFA volunteers and of the 350 that were released, 75% remained out of prison in 2015.

PRISONER REENTRY

The successful reintegration of prisoners back into society is a critical process due to the personal and emotional costs to former offenders as well as the maintenance of public safety, community vitality, and controlling the costly expansion of criminal justice systems (O'Donnell, Baumer, & Hughes, 2008). However, this process carries significant challenges and there are several factors that likely have a role in shaping the high rates of recidivism that accompany unsuccessful reintegration.

Risk factors predictive of offender recidivism have often been categorized as either static or dynamic (Andrews & Bonta, 1994). Static risk factors are aspects of the offender's past that are predictive of recidivism but cannot be changed, such as young age and previous convictions (Gendreau, Little, & Goggin, 1996). Dynamic risk factors, also known as criminogenic needs, are changeable and thus, are often targeted in rehabilitation programs. Examples of dynamic risk factors include antisocial cognitions, antisocial companions, antisocial values, and antisocial behaviours (Andrews & Bonta, 1994).

Some argue that the reentry process is often difficult as a result of the damaging effects of incarceration on prisoners' social functioning, ultimately contributing to his or her return to offending following release (Irish Penal Reform Trust, 2016). To exacerbate the challenges associated with the damage that may be done to social functioning, many prisoners also leave

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prison with little money, resources, or social capital; and as a result of their criminal record, are unable to find employment or housing (Makarios, Steiner, & Travis, 2010). Petersilia (2003) argues that due to these deficits, the successful reentry of many prisoners is both difficult and unlikely.

Additional theoretical explanations for why prisoners recidivate also include (a) insufficient positive attachment to social groups, institutions, and supports and, (b) the way certain communities burden residents with stigma, social constraints, territorial confinement, and institutional boundaries that foster recidivism through denied opportunities and hyperscrutiny (Bowman & Travis, 2012).

Numerous societal features also likely play a prominent role in fostering desistance, such as the availability of programming aimed at enhancing the likelihood of successful reintegration — both in prison as well as upon release (O'Donnell et al., 2008). Braithwaite's (1989) theory proposes that certain societal features, most notably strong social interdependencies and high levels of collective participation and social capital, should yield both lower overall crime rates and lower recidivism rates. One of the ideas behind this theory is that such societal conditions make it less likely for offenders to be categorically stigmatized as "offenders" and more likely to be socially supported as contributing members of society upon release (O'Donnell et al., 2008).

The challenges that accompany the reentry process extend beyond recidivism, with prisoner reentry also being associated with adverse health and well-being outcomes, substance abuse challenges, and an increased chance of death (Bowman & Travis, 2012). According to data in Ireland, a significant number of accidental drug overdoses occur in ex-prisoners who do not take into account their loss of drug tolerance upon leaving prison, posing a serious public health challenge in this vulnerable population (Betts-Symonds, 2016).

IRISH CONTEXT: ISSUES & CHALLENGES

When considering the development and implementation of phase II, it was important for the team to understand the characteristics of the Irish prison population and the difficulties faced on an individual level by those who come into contact with Ireland's criminal justice system.

Firstly, the rates of mental illness among the Irish prison population are significantly higher than the general Irish population. Often prisoners with mental illnesses also have problems with drugs and alcohol, with illicit drug use and smuggling having long been a recognized problem within the Irish prison system (Martynowicz & Quigley, 2010). Furthermore, homelessness has also been recognized as a barrier to integration among the Irish prison population. The issue of homelessness and its connection to crime is important because prisoners released without a place to live are more likely to reoffend (Social Exclusion Unit, 2002). According to a study by Seymour and Costello (2005), one in four prisoners in Dublin had been homeless upon committal, and over half of prisoners had experienced homelessness at some stage in their lives.

Ex-prisoners also encounter many barriers in accessing and maintaining employment. Obstacles that impede on ex-prisoners' access to employment include low self-esteem, lack of educational qualifications and training, insecure housing, lack of recent job experience, difficulty in setting up a bank account, and discrimination in trying to get a job (IPRT, 2016). In addition to such barriers, having a criminal record has been recognized as an obstacle to securing employment. Employment is important, as unemployed ex-prisoners are twice as likely to reoffend in comparison to those in full- or part-time jobs (Irish Law Reform Commission, 2007).

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Recently, Spent Convictions legislation, a criminal policy in Ireland that was signed into law in February 2016, was developed to help address the difficulties ex-offenders face with disclosing criminal convictions for employment purposes. Under the *Criminal Justice (Spent Convictions and Certain Disclosures) Act 2016*, a range of minor offences will become “spent” after seven years, meaning adults convicted of an offence covered by the Act would not have to disclose the conviction after seven years except in certain circumstances. Despite good intentions, the positive impact of this legislation may be limited due to restrictions on the types of convictions covered, as well as the requirement that the length of the term of imprisonment be 12 months or less.

In addition to individual-level challenges faced by prisoners, several systemic issues exist in the Irish criminal justice system, which pose a threat to successful prisoner reintegration. Among this list of challenges there exists a large rural versus urban divide with regards to the provision of services in the community, with the majority being concentrated in cities and larger towns. In addition, there seems to be a prioritization of resources by level of risk of committing serious crimes and therefore, risk to the community. This results in limited resources being made available to offenders who pose little or no risk of committing serious crimes, but who could still benefit from increased support. Lastly, even when services are available both in prison and in the community, such information is not always provided on committal to prison, during the sentence, or in preparation for release (Martynowicz & Quigley, 2010).

THE WOUNDED HEALER IN PRISONER REENTRY PROGRAMS

The CBHFA Prison Programme team began to consider ways in which inmate IRC volunteers may be purposefully used in the community after their release. As they brainstormed, they turned to the criminal justice literature to review theories and principles used in various prisoner reentry programs that could help in the development of a suitable program for phase II.

They found that recently, researchers have begun to recognize a coping strategy among formerly incarcerated individuals involved in becoming a “professional ex-” (Brown, 1991, p.219) or a “wounded healer.” Such concepts involve former prisoners taking on helper roles in programming surrounding the rehabilitation and reintegration of other offenders (LeBel, Ritchie, & Maruna, 2015). These strengths-based practices, which make use of individuals’ skills and personal strengths, treat offenders as community assets to be used rather than as liabilities to be supervised (Travis, 2000). Maruna and LeBel (2009) argue that becoming a wounded healer functions as a form of stigma management or reverse labeling, allowing such stigmatized individuals to overcome their labels and reconcile with society for their criminal past.

This concept is further supported by research on narratives of desistance that have found that a characteristic that distinguishes between successful and unsuccessful reformed ex-prisoners is engagement in “generative” activities, which are activities designed to give something back to individuals in his or her community (Halsey, 2008; Marsh, 2011; Maruna, 2001; Vaughan, 2007).

In addition to the benefits incurred by the wounded healers themselves, it has been found that many prisoners and former prisoners wish to receive mentoring from formerly incarcerated persons who have successfully reintegrated into society (LeBel et al., 2015).

The characteristics and roles of the wounded healer in the desistance process is also consistent with several of the major risk/need factors (Exhibit 5) in the Risk-Need-Responsivity (RNR) model including reduced antisocial cognitions, fewer antisocial associates, and a supportive work situation (LeBel et al., 2015). The RNR model is one of the most influential models for the assessment and treatment of offenders and identifies several criminogenic risks and need factors that have the greatest impact on recidivism. It can also be used to direct the focus of

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treatment programs. Evidence has shown that rehabilitation programs can produce significant reductions in recidivism when such programs are in adherence with the RNR model (Andrews & Bonta, 2010).

Research examining the potential benefits of this sort of employment in the desistance process of formerly incarcerated individuals in prisoner reintegration programs has shown promising results. Studies found ex-offender staff members engaged in this sort of employment perceive laws to be less unjust than clients and have lower scores on both the criminal attitude scale and the forecast of arrest for themselves (LeBel et al., 2015).

Such findings support the use of strengths-based activities, such as becoming a professional ex- or wounded healer, and suggests that former prisoners can form positive, prosocial relationships with their peers and can be positive role models to others. Involvement in such work may improve a former prisoner's life satisfaction and self-esteem by giving his or her life purpose, meaning, and significance (LeBel et al., 2015).

REFLECTIONS

As the CBHFA team members sat at their desks reflecting on the Wheatfield graduation ceremony, they thought about the conversation earlier that day with the latest Wheatfield IRC inmate graduates, where they had expressed their desire to continue volunteering with the IRC upon their release:

"We need to expand beyond the prison to back in the community. We've gained a lot of skills and become more confident and we would like to use that in some way to help with IRC after release."

They knew that once released from prison, if inmate volunteers wished to continue volunteering with the IRC, they had to apply as a member of the general public. This process involves police vetting, and the resulting decision depends on the nature of their criminal offence, which results in many of the inmates not being accepted as IRC volunteers outside of the prison. This policy was in place in order to protect the safety of the public, but the team wondered whether there was an opportunity for exceptions to be made in order to develop phase II of the CBHFA Prison Programme.

The Programme team met and discussed the notion of applying the wounded healer approach in the development of phase II. The team also saw that the CBHFA Prison Programme contained several modules that addressed health issues that were prominent in the prison as well as among the population of recently released offenders, such as violence and substance abuse.

The team had many decisions to make and questions to consider. Could the delivery of selected Programme modules address certain public health challenges faced by such vulnerable populations? Should phase II of the Programme extend beyond CBHFA modules and also encompass other forms of support that may assist in desistance and reintegration? Who would the Programme be targeting and could there be an opportunity to partner with The Probation Service's Community Service Order and/or Community Return Scheme? Were there other organizations and agencies that the team should look to for support in developing the Programme further and that could serve as Programme partners?

Carrie and the team knew that the time to act was now. A political window was in place as a result of this newly enacted piece of legislation, highlighting the importance of employment in reintegration as well as the relatively recent recidivism study showing high rates of recidivism in

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Ireland. Furthermore, there was commitment from the IPS & The Probation Service to address reoffending and reintegration challenges along with an ample amount of evidence showing the high costs and usage of national resources associated with incarceration.

CONCLUSION

Carrie and the team were left to determine what theories and research findings to use in order to design phase II. Subsequently, they would need to decide what public health issues to target in this phase of the Programme, as well as how exactly it would be implemented and delivered. The team also needed to discuss what risks, if any, a program involving the use of ex-offenders to promote community health would pose, to both the community and partner organizations. Should the Programme be limited to offenders convicted of certain types of crimes? What impact would placing such restrictions have?

The Programme team was left to use all their individual, unique skills and experience to determine how to implement a program that would make use of the IRC inmate volunteers' skills upon their release. With the number of CBHFA Prison Programme graduates increasing, a window of opportunity and a need for phase II of the Programme, the team knew they had to act quickly in developing recommendations for the Programme's implementation.

EXHIBIT 1

Irish Prison Service Health Care Standards

Standard 1: Health Assessment on Initial Reception into Prison from the Community

1. All prisoners on reception will undergo a clinical assessment.
2. Initial Committal assessment will be carried out on the day of reception in the reception area or other appropriate clinical area. It is desirable that this initial committal assessment be undertaken by a qualified nurse in view of the various health care issues which may arise. In those prisons where nursing staff are not consistently available this function can be undertaken by medical orderlies.
3. Within 24 hours of reception a doctor will undertake a clinical assessment of the prisoner's physical and mental health.
4. Suitable interview and examination rooms which are properly equipped and maintained will be provided within the reception area and/or other suitable area within the prison.

Standard 2: Primary Care

1. Primary Care Services will be provided to a standard equivalent to that available in the general community (GMS standard).
2. Suitable, properly equipped accommodation and facilities for the delivery of primary care will be provided.
3. Access to specialist services appropriate to the health care needs of prisoners will be provided within the prison.
4. Efficient arrangements for referral to external outpatient facilities will be in place.

Standard 3: Mental Health Services

1. To provide an integrated service that meets the needs of prisoners suffering from mental disorder. Services should include appropriate implementation of, a) policy on preventing self-injury among prisoners and, b) relevant mental health legislation.

Standard 4: Transfer, Release and Throughcare

1. To ensure that the health care needs of prisoners are considered and taken into account before transfer to another prison and that these needs are provided for during transfer and on reception at the receiving prison.
2. To ensure that all prisoners with ongoing health care needs are assessed by a Doctor or Health care professional prior to planned release (and appropriate arrangements made for follow up).

Standard 5: Clinical and Related Services for Promoting Health

1. To provide services to prisoners which may prevent illness and promote health.
2. To provide prisoners with the information and opportunity to enable them to make reasoned choices regarding the adoption of a healthy lifestyle.

Standard 6: Communicable Diseases

1. To provide prisoners with appropriate screening facilities based on current public health advice.
2. To provide appropriate diagnostic and treatment facilities to prisoners considered at risk.
3. To provide throughcare and arrange appropriate aftercare where required.

Standard 7: The Use of Medicines

1. To provide pharmaceutical services to prisoners that are efficient, cost effective, meet legal and professional requirements, and reflect good professional practice.
2. To provide a safe and effective system for enabling prisoners to hold prescribed medicines in their possession for self-administration.
3. To provide a system of management for controlled drugs which complies with the relevant legislation and regulations.

Standard 8: Dental Services

1. To provide dental treatment to prisoners of an equivalent standard to that normally available to citizens in the general community covered by the GMS Dental Treatment Services Scheme – DTSS.

Standard 9: Drug Treatment Services

1. To provide clinical services for the assessment, treatment, and care of substance misusers comparable to those available in the community, and which are appropriate to the prison setting.

Source: Irish Prison Service, 2009.

EXHIBIT 2

Community Based Health & First Aid Programme: Summary of Modules & Topics

Seven modules, some compulsory, others optional depending on the health needs identified.

- **Module 1, 4 topics.**
 - The International Red Cross Red Crescent's history and organizational structure, Emblems, Seven Fundamental Principles, National Red Cross Society, Community Based Health & First Aid (CBHFA) in action volunteer.
- **Module 2, 4 topics.**
 - Communication and building relationships, volunteers identify groups and meet with potential partners for the CBHFA programme, implement an awareness-raising meeting to inform the community, promote CBHFA in action activities.
- **Module 3, 8 topics.**
 - Assessment of the community by volunteers through direct observation and community mapping, identify and prioritize health, first aid, and safety issues, develop a CBHFA action plan, learn specific skills and knowledge based on needs identified during the assessment, report on activities in the community.
- **Module 4, 20 topics.**
 - Accredited First Aid Course. Volunteers learn how to assess, plan, implement, and evaluate first aid for various injuries and illnesses and practice communicating injury prevention messages with members of their community.
- **Module 5, 2 topics.**
 - Major emergencies and how that may affect the community, preventing and responding to epidemics.
- **Module 6, 16 topics.**
 - Disease prevention and health promotion including Nutrition, Immunization, and Vaccination Campaigns, Safe water, Hygiene and Sanitation, Diarrhoea and Dehydration, Acute Respiratory Infections, HIV and Sexually Transmitted Infections, Reducing Stigma and Discrimination, Tuberculosis, Influenza. Volunteers support the community to adopt healthy behaviours.
- **Module 7, 8 topics.**
 - Focuses on providing community education and assistance; for example, volunteers learn about Overdose Prevention highlighting the dangers of taking drugs.
- **Additional Module**
 - Non-communicable diseases such as cardiovascular & chronic lung disease, cancer and diabetes.

Additional topics relevant to the prison context such as Mental Health Awareness and a Culture of Non-Violence & Peace are also included.

The projects that are undertaken by the Irish Red Cross Volunteer Inmates either emerge from the Community Assessment in Module 3 or as a result of a Health Emergency that arises, or linked in with national health educational campaigns.

Source: Irish Red Cross, 2016c.

EXHIBIT 3

Example of Projects Promoted by IRC Volunteer Inmates in Different Prisons

- Personal, in-cell, and prison hygiene awareness. IRC volunteer inmates provide instructions on good hand washing techniques and in many prisons a colour coded bucket & mop system has been introduced, thus contributing to cleanliness and the prevention and control of disease.
- Contribute to TB awareness in all prisons and in Mountjoy encouraged mass chest X-ray screening with just over 400 prisoners screened.
- Increase local awareness about seasonal flu, the winter vomiting bug, and hepatitis vaccinations.
- Volunteer led projects on nutrition, fitness, cholesterol, blood pressure checking, and dental hygiene.
- HIV & AIDS awareness and anti-stigma campaigns with voluntary HIV Mass Rapid Testing in Wheatfield, Cloverhill, and Mountjoy Prisons.
- In some prisons volunteers actively conduct practical demonstrations in CPR and basic first aid around the prisons.
- Violence reduction through a Weapons Amnesty Project at Wheatfield – assisting management with an advocacy role through the volunteers linked to the 7 Fundamental Principles to remove cutting weapons from the prison. The results have shown a 95% reduction in cuttings with a weapon and 50% reduction in assaults.
- Volunteers designed a peer led violence prevention course linked to CBHFA that takes place on a monthly basis in a number of prisons.
- 'Safe Zone' in Castlerea where the school is a safe area and inmates have signed a form agreeing not to bully, intimidate, or assault any person while attending the school.
- Overdose Prevention Programme by trained volunteer facilitators in partnership with Merchant's Quay Ireland prison based counselling team.
- 'Packing Project' in two prisons around the practice of packing the rectum with large quantities of drugs. There is not only the danger of over dosage but the long term damage that can occur.
- Volunteers facilitate Smoking Cessation Courses with good success rates.
- Carried out the Irish Heart Foundation's F.A.S.T. Stroke Awareness Campaign & raised awareness about heart disease.
- Mental health & well-being awareness in prisons about key issues including the risks of self-harm, and suicide prevention.
- Advocacy work in setting up unit based nursing, primary care systems improvements such as the allocated days for GP appointments and the medications "in-possession" system.
- Paracetamol reduction project and awareness around the safe use of antibiotics.
- Volunteers at Wheatfield have instigated a prisoner support network particularly aimed at 'lifers'.
- Information leaflets & support to new prisoners, Red Cross Buddy project in Portlaoise.
- Parties for senior citizens to mark International Day for the Elderly in Mountjoy and Christmas party for the elderly at Shelton Abbey.
- Intercultural Day promoted by volunteers with the help of staff in Castlerea.
- Benzodiazepine Awareness Campaign.
- 'How to Say No to Bullying' project in Cork prison.
- Sun Safe Campaign in association with the Irish Cancer Society.
- Caring for elderly prisoners in Arbour Hill, i.e. providing Meals on Wheels, cell cleaning, and social activities.

Source: Irish Red Cross, 2016c.

Transitioning from Prison to Community

EXHIBIT 4

Examples of the Guided Reflective Exercise Undertaken with IRC Volunteer Inmates

| | | |
|---|--|--|
| Think of a time in prison before you became a Red Cross Volunteer What can I see, hear and feel about myself? | Level | Think of a time since you have been working as a Red Cross volunteer in the prison What can I see, hear and feel about myself? |
| I see a lot of inmates doing Red Cross and they introduce me as well | Goals What are my goals? | I'm proud of myself of being a volunteer of Irish Red Cross and want to continue after prison. |
| I'm always down, thinking of can I make it in prison? | Identity Who am I? | I have really changed from who I am when I first came to prison. |
| All my belief is in doing my time and learn something while I'm in prisons | Beliefs and Values What do I believe in and what is important to me? | To make myself available whenever I'm needed for volunteering. |
| I'm not very bold to express myself to any inmate before | Capabilities What am I able to do? | I'm bold to do some volunteer work, like going to landing telling inmates about the Red Cross. |
| My behavior was very bad before | Behaviours What am I doing? | My behavior is totally changed at the moment. |
| I feel not safe when I came into prison | Environment What is this place like? | I feel really safe now with the work of Irish Red Cross |

| | | |
|---|--|--|
| Before | | After |
| No goals | Goals What are my goals? | Since starting Red Cross my goal was to complete the course and pass on my experience to other prisoners. |
| Before starting – didn't know who I was. I was very shy especially talking in front of a group. | Identity Who am I? | Since starting I'm able to speak in front of a large group and not shy anymore. |
| I didn't believe in getting educated in prison | Beliefs and Values What do I believe in and what is important to me? | Now I believe it's important to learn and get educated whilst in prison because of the Red Cross |
| I wasn't capable of doing anything | Capabilities What am I able to do? | I'm capable of doing things for myself such as going to school, working and communicating with other people. |
| Unsure of the unknown | Behaviours What am I doing? | I find myself taking time out to talk and listen to other people |
| I was on a basic landing. | Environment What is this place like? | I'm on enhanced and the environment is much better |

Source: Irish Red Cross, 2016c.

Transitioning from Prison to Community

EXHIBIT 5

The Risk-Need-Responsivity Model – Seven Major Risk/Need Factors Along with Some Minor Risk/Need Factors

| Major risk/need factor | Indicators | Intervention goals |
|--------------------------------------|---|--|
| Antisocial personality pattern | Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable | Build self-management skills, teach anger management |
| Procriminal attitudes | Rationalizations for crime, negative attitudes towards the law | Counter rationalizations with prosocial attitudes; build up a prosocial identity |
| Social supports for crime | Criminal friends, isolation from prosocial others | Replace procriminal friends and associates with prosocial friends and associates |
| Substance abuse | Abuse of alcohol and/or drugs | Reduce substance abuse, enhance alternatives to substance use |
| Family/marital relationships | Inappropriate parental monitoring and disciplining, poor family relationships | Teaching parenting skills, enhance warmth and caring |
| School/work | Poor performance, low levels of satisfactions | Enhance work/study skills, nurture interpersonal relationships within the context of work and school |
| Prosocial recreational activities | Lack of involvement in prosocial recreational/leisure activities | Encourage participation in prosocial recreational activities, teach prosocial hobbies and sports |
| Non-criminogenic, minor needs | Indicators | |
| Self-esteem | Poor feelings of self-esteem, self-worth | |
| Vague feelings or personal distress | Anxious, feeling blue | |
| Major mental disorder | Schizophrenia, manic-depression | |
| Physical health | Physical deformity, nutrient deficiency | |

Source: Bonta & Andrews (2007). Reproduced with permission of the Minister of Public Safety and Emergency Preparedness Canada, 2017.

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INSTRUCTOR GUIDANCE

Transitioning From Prison to Community

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BACKGROUND

The Irish Red Cross (IRC) Community Based Health and First Aid (CBHFA) Prison Program was piloted at Wheatfield Prison in 2009 and, following several successful evaluations, was implemented across all of Ireland's 14 prisons in 2014. The CBHFA Prison Program trains inmates as special status IRC volunteers through weekly CBHFA training sessions, which take place over six months. After completing the community assessment module within the CBHFA program, volunteers, with the support of prison staff, implement projects and engage in peer-to-peer health education in an effort to promote the health of the prison community. In addition to having a positive impact on prison health, many volunteers have internalized a more constructive and positive identity and have developed greater self-esteem, self-respect, and confidence. Unfortunately, as a result of policies surrounding the IRC volunteering process, many inmates only keep their volunteer status whilst in prison and therefore their skills and knowledge are not harnessed upon their release.

With high rates of recidivism and a reentry process filled with challenges, the CBHFA management team wanted to develop the program to allow for its continuation in the community. A continuation of the program could help released offenders maintain their association with the IRC and thus their associated positive identity, as well as help address various health challenges associated with transitioning from prison to community. The CBHFA team debated whether to use the "wounded healer" approach for the program design, which involves ex-offenders taking on helper roles in programming surrounding the rehabilitation and reintegration of other offenders. After determining the general design of the program, the CBHFA team would need to develop recommendations regarding the program's content and its method of implementation and delivery.

OBJECTIVES

1. Identify the social determinants of health, relevant to offenders and ex-offenders, and determine what societal conditions are thought to be conducive of successful reintegration using a social determinants of health lens.
2. Identify the interactions that exist between various social determinants of health and the potential impact such interactions have on individuals and communities.
3. Use a social determinants of health model to assess the protective and risk factors that exist for given public health interventions and propose ways to mitigate risks and harness strengths.
4. Formulate relationships between public health interventions and the social determinants of health in terms of the three levels of interaction: micro, meso, and macro.
5. Assess programs using a health-equity lens and generate implementation recommendations as well as predict potential challenges.

Transitioning from Prison to Community

DISCUSSION QUESTIONS

1. How do social and cultural factors shape patterns of recidivism and the reentry process?
2. What societal conditions are thought to be conducive of successful reintegration?
3. How should the program move forward in its implementation in order to address the outlined issues – consider partners, program design, etc.? What are the benefits and risks?
4. Which CBHFA modules (as well as non-CBHFA, module-based content) would be relevant for use in the prison-to-community program in terms of addressing identified challenges?

KEYWORDS

Social determinants of health; strength-based programming; peer-to-peer education; health promotion.