



**families
outside**

**voicing the needs
of families affected
by imprisonment**

**A tool to tackle health inequalities in the families of people in prison?
Evaluating the Families Outside Family Support Worker role from a
health perspective**

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Executive summary

The aim of this document is to report an evaluation of the Families Outside Family Support Worker (FSW) role from a health perspective.

Background to the evaluation

Family Support Workers (FSWs) are community-based support workers for the families of prisoners although they may also work directly with prisoners. Many of the issues that families have concerns over are health and wellbeing-related. The clients of the FSWs represent some of the most vulnerable and deprived of the population, at risk of significant physical, mental and social health problems and yet, generally they are not formally on the agenda of statutory agencies such as health, criminal justice or social services.

Recent Scottish Government policy has emphasised the importance of tackling health inequalities, particularly through focusing on families and children's early years and improving mental health and wellbeing. Criminal Justice policy also recognises the role that families play in reducing future re-offending. It is therefore for a variety of reasons that it is important that the health and wellbeing of the families of prisoners is improved and the Third Sector has a role to play in that.

Evaluation methodology

The evaluation collected information and data from interviews with the four FSWs who are managed by Families Outside, seven service users and analysis of the FSW database over a six month period.

Results of interviews with FSWs

The most commonly cited reason for seeking help from a FSW was poor emotional and mental wellbeing. Other issues included advice about caring for the children of prisoners while requests for general prison information were less common. Some families had experience of community psychiatric services and social services.

FSWs generally had contact with other agencies, including the NHS, on a case-by-case basis rather than at a strategic level. FSWs working out of Prison Visitors Centres had slightly more contact with the NHS, mainly through occasional health events at the Centres. FSWs generally had experience and/or qualifications in a psycho-social discipline and were able to provide peer-support to each other on an informal basis.

FSWs called for greater recognition of the needs of families of prisoners, particularly in view of the high burden of poor mental health and wellbeing. There was some interest in family support groups but there was concern about issues such as confidentiality in some circumstances. FSWs also called for more formal assessment of the impact they make with families.

Results of interviews with the families of prisoners

Seven family members were interviewed. They were all women and, on average, aged 49 and living in areas of moderate deprivation. All of the interviewees reported poor mental health and wellbeing relating to the imprisonment, most commonly, of a son. Other problems reported including issues with kinship caring and mobility restricting access to prison visits. All still suffered with their overall health but generally, did not know how else the NHS might be able to help, except by making psychological services more accessible.

The family members found the input of the FSWs very helpful. There were mixed opinions of whether they would welcome family support groups due to concerns about confidentiality. In terms of improving their own health, the only real concern for most was about the need for weight loss.

Results of analysis of FSW database

The database had records for 123 clients of whom the vast majority (70%) were adult women. Most clients were parents or partners of prisoners, with 80% of the prisoners being convicted, consistent with the overall proportion of convicted prisoners in Scotland. Routes out of Prison (ROOP) life coaches were a significant source of FSW referrals, with others coming from Visitors Centres and the Families Outside helpline.

70% of clients only had up to 3 contacts with a FSW with almost half reporting issues relating to either their physical or mental health and wellbeing, including emotional difficulties, bereavement, self-harm and substance misuse. Other concerns were about family or children-related issues, finance, housing, education or prison life. Perhaps unsurprisingly, contact with a FSWs was higher in areas where a FSW was physically available.

Conclusions and discussion

The results of the FSW interviews, the service user interviews and the database analysis all highlight that poor mental health and wellbeing is a considerable problem for the families of people in prison. However, FSWs appear to have a beneficial impact on mental wellbeing, also offering a 'one stop support shop' to help families navigate their way to and through complex large support organisations including public sector services and some voluntary organisations. Visitors Centres act as a useful mutual point of access for services and families.

There is potential for FSWs to tackle health inequalities in line with the drive from Scottish Government, primarily by improving the mental health and wellbeing of these families and possibly, by acting as a conduit to families for statutory health improvement services. There is also potential to help harness the power of the clients themselves by using a more community development approach to empower this stigmatised and vulnerable community. Along with this, it will be important to measure the impact that FSWs have with this community in order to justify ongoing resourcing.

Recommendations

Policy level ie Scottish Government

1. Lobby the Health Department to contribute to funding of FSWs as part of the Government's commitment to tackling health inequalities, primarily through the FSWs' contribution to improving the mental health and wellbeing of the families of prisoners.
2. Lobby the Criminal Justice Department to consider the routine provision of Visitors Centres to at least all new build prisons, as a useful point of access to the families of prisoners, in line with policy in England and Wales.
3. Lobby the Chief Medical Officer (CMO) to include a section on the health of prisoners' families when drafting his Annual Report.

Strategic local level ie Health Boards

4. Lobby Health Boards directly to:
 - i. Formally recognise that the families of prisoners are a vulnerable group, already suffering health inequalities, primarily through high levels of poor mental health and wellbeing but also through poor physical health. As such, Health Boards should ensure this vulnerable group is clearly identified as a priority within their actions to reduce health inequalities and in strategies to improve mental health and wellbeing.

- ii. Contribute towards the funding of FSWs.
5. Encourage Health Board Health Inequality programme teams to use the FSWs, Families Outside and Prison Visitors Centres as points of access to this vulnerable and largely, invisible group. For example, they may wish to bring in teams who specialise in promoting better mental health and wellbeing.

Operational local level ie FSWs

6. Where funding is available, increase the number of FSWs and reduce the geographical areas covered by them, ideally in line with Community Justice Authority boundaries or otherwise reflecting inter-agency arrangements for throughcare.
7. Improve access for family members to a FSW, independent of whether the prisoner themselves has requested it.
8. Make routine the use of an appropriate assessment tool in order to measure the impact of the FSW work with clients. This should routinely include assessment of health and wellbeing impact, especially of mental health and wellbeing.
9. Consider introducing a greater community development approach to supporting and empowering families, for example through the introduction of Family Support Groups.
10. Continue ongoing supervision and training of FSWs to support them in their role.
 - i. This should include adequate psychological support and training in view of the high client needs in mental health issues.
 - ii. Consider routine training of all FSWs in basic counselling and motivational interviewing skills and/or Mental Health First Aid.
 - iii. Consider community development training for all FSWs if this approach is to be adopted by Families Outside and FSWs.

Section 1 – Setting the scene

1.1 Introduction

“Imprisonment is a family affair.....Families suffer the pain of separation, but they also suffer in other ways such as loss of income, loss of home, anti-social behaviour by distressed children, and shame.”^{1,2} Family Support Workers are one tool in the provision of support to this vulnerable group.

This report presents findings of the evaluation of the Families Outside Family Support Worker (FSW) role from a health perspective. The evaluation, conducted in 2011, collected information and data from interviews with the FSWs who are managed by Families Outside, service users and analysis of the FSW database over a six month period.

The evaluation was conducted between May and July 2011 by Dr Liz Brutus, Specialty Registrar in Public Health during a secondment to Families Outside from the Scottish Public Health Network.

Section 1 of this report provides background information about the FSW role and about the issues facing the families of people in prison in Scotland. It outlines some of the health issues including health inequalities in Scotland.

Section 2 describes the methodology for the evaluation.

Section 3 reports on the findings for the evaluation, specifically in relation to the views of FSWs, service users and the findings from the analysis of the FSW database.

Section 4 concludes the report with a discussion of the findings, particularly in the context of a behaviour change model and community development. Finally, the report makes recommendations.

1.2 The role of Families Outside Family Support Workers

Family Support Workers (FSWs) are a relatively new role within the Criminal Justice setting. They are community-based support workers for the families of prisoners, who may also work directly with prisoners, offering broad-based advice and support and in some cases, a means of advocacy with the administration system within the prison. They were first established in England, where the model tends to involve both the prisoner and their family. There, early evaluations have been positive, indicating a high need for the FSW role.³

Families Outside is a charity providing care and support for the families of prisoners in Scotland. They currently manage four FSWs in Scotland who, although not all funded alike, support the families of prisoners across the 15 prisons in Scotland.

Many of the problems that are brought to FSWs are health-related, often related to mental health and wellbeing and substance misuse issues.

There are four Family Support Workers (FSWs) who are managed by Families Outside. They hold a mixture of full- and part-time posts. Two FSWs work out of the two main Prison Visitors Centres in Scotland (at HMP Edinburgh and HMP Perth) and two work out of the

¹ Loucks N. Prison Without Bars: Needs, support and good practice for work with Prisoners' Families. Dundee and Edinburgh: Tayside Criminal Justice Partnership and Families Outside. 2004a.

² Loucks N. The Tayside Family Project. Dundee and Edinburgh: Tayside Criminal Justice Partnership and Families Outside. 2004b.

³ Boswell G, Poland F, Price A. Prison Based family support: An evaluation of the effectiveness of the Family Support Worker role piloted in four English prisons in 2009-10. Ministry of Justice. 2010.

Routes Out Of Prison partnership⁴ (ROOP) offices in central Glasgow. The four posts are variably funded from one year to the next. Funders include Crossreach, ROOP, Families Outside and (initially) the Lothian and Borders Community Justice Authority (CJA). Depending on the specifics of their job description and any pre-conditions of their funding source, the FSWs receive referrals from a variety of sources including self-referrals, telephone calls to the Families Outside Helpline, the two Visitors Centres, prisoner induction and via ROOP contacts with prisoners.

Job description and objectives

The job description of the FSW role highlight that it is to provide one-to-one support to families affected by imprisonment and includes managing a client caseload, addressing individual needs and referring to appropriate services including health. This may also involve supporting families to be involved in case conferences and discharge planning where possible. The role also includes ensuring access to a range of information for families to support their needs, attending family induction sessions in prisons and being flexible enough to provide support, advice and guidance to service users in addition to various general duties. A sample job description is attached at Annex A.

Specific outcomes for FSWs are aligned to the Families Outside strategic aims. Regarding the support of families, the outcomes most relevant to them are that:

- Families have increased awareness about the criminal justice process – and what to expect
- Families have improved access to practical support
- Families have increased ability to cope

There are currently no FSW objectives or desired outcomes specifically referring to health (including mental health) per se although these general outcomes arguably encompass health benefits as a more general aim.

In addition, there is no specified method of working for FSWs, for example, through a counselling or community development approach. Families Outside describes its Family Support Work as taking a holistic, solution-focused approach to the needs of families affected by imprisonment, meaning the workers respond to the needs of families on an individual basis rather than through a set package of services or over a fixed period of time. The 'person specification' in the job description at Annex A shows a preference for staff with backgrounds in social care or other relevant field, with skills in counselling or mental health beneficial but not essential.

1.3 Health inequalities and the wider Scottish Government policy context

Looking specifically at the needs of the children of prisoners, Scotland's Commissioner for Children and Young People commented that they "are the invisible victims of crime and our penal system. Their voices are silenced by the shame and stigma associated with imprisonment. They are not seen, not heard and not guilty."⁵ However, the same could be said about a prisoner's wider family.

The clients of the FSWs represent some of the most vulnerable and deprived of the population, at risk of significant physical, mental and social health problems and yet, generally they are not a designated group on the agendas of statutory agencies such as

⁴ Routes Out of Prison is a partnership of the Wise Group, Scottish Prison Service, Families Outside and Apex. Working with prisoners before they are released from HMPs Addiewell, Barlinnie, Cornton Vale, Dumfries, Polmont Young Offenders Institution, Kilmarnock and Greenock, and for a number of weeks after, the Routes out of Prison project helps prisoners acquire the life, social and employment skills they need to rejoin society.

⁵ Scotland's Commissioner for Children and Young People. Not Seen. Not heard. Not guilty. The rights and status of the children of prisoners in Scotland. 2008.

health, criminal justice or social services.⁶ They are also generally 'hard to reach' by conventional health services. Community Justice Authorities have made some headway on this, with two of the eight CJAs running specific working groups on families of offenders. Families affected by imprisonment nevertheless remain in the background, with no one agency taking ownership of this agenda and no funding stream directly applicable to their support.

There are a number of Scottish Government policies which are relevant to the challenging situation that many families of prisoners may find themselves in and which may adversely affect their health. The most immediately relevant policies include:

- Equally Well
- The Early Years Framework
- Mental Health Strategy for Scotland: 2012-2015
- National Strategy for the Management of Offenders

*Equally Well*⁷ reported on the findings of the Ministerial Task Force on health inequalities. This was set up to tackle the inequalities in health that will otherwise prevent Scotland from achieving the Government's overall purpose of sustainable economic growth, supported by increased healthy life expectancy. Difference in income is not the only factor to blame for inequalities. Health may also vary according to people's age, disability, gender, race, religion or belief, sexual orientation and other individual factors. These interact with socioeconomic status and low income. While the Task Force has been primarily interested in health inequalities that result from socioeconomic circumstances, they have also considered how health and other public services respond to this range of complex factors which affect people's health. Scientific evidence now helps explain how deprivation and other forms of chronic stress lead to poor health.

In order to reduce inequalities in healthy life expectancy and wellbeing generally, the Task Force has identified priorities where action is most needed:

- Children's very early years, where inequalities may first arise and influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.
- The "big killer" diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

*The Early Years Framework*⁸ describes an approach which recognises the right of all young children [defined as pre-birth to 8years old] to high quality relationships, environments and services which offer a holistic approach to meeting their needs. It calls for these needs to be interpreted broadly and encompass play, learning, social relationships and emotional and physical wellbeing. This approach is important for all children but is of particular benefit in offering effective support to those children and families requiring higher levels of support.

⁶ Dalziel Y. Prison leavers and families affected by imprisonment: A report of the Edinburgh CHP Prison Leavers Project. Partnerships for Access to Health (PATH) project. NHS Lothian. 2009. Available at: <http://www.pathproject.scot.nhs.uk/Prison%20leavers%20report%20FINAL.pdf>

⁷ Scottish Government. Equally Well: Report of the Ministerial Taskforce on Health Inequalities. 2008. Available at: <http://scotland.gov.uk/Resource/Doc/229649/0062206.pdf>

⁸ Scottish Government / COSLA. The Early Years Framework. 2008. Available at: <http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf>

The *Mental Health Strategy for Scotland: 2012-2015*⁹ recognises that mental health is important to all of us, as it affects every aspect of our lives; there is no health without mental health. The Scottish Government reports that it is committed to working to improve the mental health of Scotland's people through ensuring that appropriate services are in place, but also by working through social policy and health improvement activity to reduce the burden of mental health problems and mental illness and to promote good mental wellbeing.

*The National Strategy for the Management of Offenders*¹⁰ aims to reduce reoffending. The Strategy acknowledges the impact of crime, not just on victims and their communities but also on their families. It sets out a list of factors known to reduce the chances of reoffending including, 'Maintained or improved relationships with families....' and 'understanding of the impact of their offending on victims and on their own families.'

This strategy recognises the important role that families can play in making offenders less likely to re-offend. However, it is important to highlight that families must not be treated merely as a means to reduce the offending of the prisoner but as people in their own right who have their own needs and rights.

1.4 The role of the Third Sector in implementing policy

Within various policy documents, Scottish Government highlights that Third Sector organisations have a role to play.

In *Equally Well*, they note that where Third Sector services demonstrate that they contribute to meeting local outcomes and priorities, they should be given the resources by their funders and commissioners to allow services to be maintained, developed and make more financially sustainable.

Similarly, within previous and current Scottish Government mental health strategies, the Third Sector's role can be to:

- deliver services which directly or indirectly promote mental health improvement;
- innovate in the development of new service approaches and interventions;
- act as a catalyst in promoting active citizenship and social capital to develop community capacity;
- advocate change and improvement for service users and the general population; and
- provide a key location for undertaking peer to peer support.

FSWs' contribution to implementing Scottish Government policy on health and health inequalities

Part of the rationale for assessing the FSWs' contribution to the health of family members will be to understand the contribution that FSWs make towards the Scottish Government policy just detailed.

In 2011-12, Families Outside received £132, 712 from the Scottish Government (£70,000 from Community Justice and £62,712 from Children & Families, with an additional £29,892 in restricted funds from the Scottish Prison Service to support the work of the Helpline and contributions to the work of the National Suicide Risk Management Group). This made up 40% of the organisation's entire budget. The remainder is raised primarily through ongoing applications to charitable trusts. If FSWs can be seen to be making a significant contribution to improving health and tackling health inequalities, should their role not be better recognised in the health sector and attract funding and collaboration to support this work?

⁹ Scottish Government. *Mental Health Strategy for Scotland: 2012-2015*. Available at: <http://www.scotland.gov.uk/Resource/0039/00398762.pdf>

¹⁰ Scottish Executive. *Reducing Reoffending: National Strategy for the Management of Offenders*. 2006. Available at: <http://www.scotland.gov.uk/Resource/Doc/121591/0029340.pdf>

Section 2 – The Evaluation

2.1 Aims of the evaluation

The Government and the NHS are key stakeholders in making a large, permanent and systematic difference to the health and wellbeing of vulnerable groups such as the families of prisoners however, a charity such as Families Outside is independent, responsive and innovative. In order to be in a good position to influence these key stakeholders, Families Outside face the challenge of capturing their results and operating within a politically-sensitive field. It is recommended that charities such as Families Outside do more to measure their work and share their experience.¹¹

For these reasons, an evaluation of the Family Support Worker (FSW) role from a health perspective should give further insight into their impact on the health issues experienced by prisoners' families and give a better indication of the health needs of this group for Health Boards. In addition, using a behavioural change model to interpret findings from the evaluation will assist in making recommendations for the future.

2.2 Methodology

Evaluation has been defined as 'the use of social research methods to systematically investigate the effectiveness of social intervention programs'.¹² A frequent distinction is made in the research literature between 'formative' evaluation and 'summative' evaluation. Formative evaluation 'is intended to help the development of the programme', while summative evaluation 'concentrates on assessing the effects and effectiveness of the programme'. Another important distinction made is between 'outcome' and 'process' evaluations, where the former measures how far the programme has met its stated goals and the latter 'is concerned with asking a 'how?' or 'what is going on?' question'.¹³ This evaluation tends to be a more summative and outcome-focused in order to assess the impact of the relatively new role of family support worker for Families Outside.

The methodology relied on various methods of data collection:

- Interviews with FSWs
- Interviews with families
- Analysis of the FSW database

2.2.1 Interviews with FSWs

Semi-structured face-to-face interviews were conducted with the four FSWs managed by Families Outside. All four FSWs were interviewed at their normal place of work by the researcher during May - June 2011.

The interviews covered the following main themes:

- Reasons for clients seeking help and their 'journey' to the FSW
- What specific support services, including health, are available for clients
- Relationships with other agencies
- Background information about the FSW including qualifications and previous experience
- Ideas for improving the service

Notes were taken by the researcher on a specific proforma for the purpose. The notes were then analysed on the basis of already-identified and emerging themes.

¹¹ De Las Casas L, Fradd A, Heady L, Paterson E. Measuring together. Improving prisoners' family ties: piloting a shared measurement approach. New Philanthropy Capital. Apr 2011.

¹² Rossi P, Lipsey M, Freeman H. Evaluation. A Systematic Approach. 2004. Thousand Oaks, CA: Sage.

¹³ Robson C. Real World Research. 2002. 2nd Ed. Oxford, Blackwell.

2.2.2 Interviews with families

Semi-structured telephone interviews were conducted with families selected and enrolled by the FSWs. Effectively, this was convenience sampling¹⁴ which was less than ideal as it risks poor quality data. It was likely to have resulted in selection bias, with FSWs only choosing clients who were, for example, happy with the support of the FSW, better able to articulate themselves or leading less chaotic lives which made contact by the researcher, easier. However, it was a reasonably pragmatic choice in view of the sensitivity of the subject matter. As highlighted by Loucks^{15,16}, it can be difficult to engage prisoners' families in research or even persuade them to use support services. Many families remain hidden within larger populations of marginalised groups, such as single mothers. These families fall outside formal NHS ethical frameworks for research, though the research was nevertheless conducted within an appropriate ethical framework (e.g. informed consent).

Nine family members gave permission for the researcher to contact them about their experience of a Family Support Worker (FSW). The researcher was able to conduct seven telephone interviews. The telephone interviews were conducted during June 2011.

The interviews covered the following main themes:

- Reasons for clients seeking help and their 'journey' to the FSW
- Experience of health and healthcare services
- Involvement of other agencies
- Views on what could be done to improve the support provided
- Views on whether and what they could do to improve their health
- Characteristics of the service users such as age, relationship to the prisoner, receipt of benefits, postcode

Notes were taken by the researcher on a specific proforma for the purpose. The notes were then analysed on the basis of already-identified and emerging themes.

2.2.3 Analysis of the FSW databases

There were 3 databases to analyse as two of the FSWs shared a database. Data for the last 6 months preceding the start of the evaluation was selected ie from November 2010 to the end of April 2011.

The 3 databases were amalgamated and a case load analysis completed for the following variables:

- Age of clients
- Gender of clients
- Relationship to prisoner
- Whether the prisoner was convicted or remand
- Source of referral to FSW
- Frequency of contact with the FSW
- Distribution across the Criminal Justice Authorities
- The reason for the client seeking help
- The nature of the help provided by the FSW

¹⁴ Marshall M. Sampling for qualitative research. *Family Practice* 1996; 13: 522-525.

¹⁵ Loucks N. *Prison Without Bars: Needs, support and good practice for work with Prisoners' Families*. Dundee and Edinburgh: Tayside Criminal Justice Partnership and Families Outside. 2004a.

¹⁶ Loucks N. *The Tayside Family Project*. Dundee and Edinburgh: Tayside Criminal Justice Partnership and Families Outside. 2004b.

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The analysis aimed to identify patterns in the sources of and reasons for referral, the types of family members supported, and the extent to which the support from the FSWs met the needs of the families. The analysis had a particular focus on health issues, especially where these may be hidden under broader categories such as 'emotional support'. Successful outcomes would be that FSWs successfully identified and supported the needs of the family members, including through referral to longer-term support in the community where appropriate.

Section 3 – Findings from the Evaluation

3.1 Results of interviews with Family Support Workers

3.1.1 Key interview themes

The following key themes were evident from the analysis and consequently developed:

- Reasons for clients seeking help and their 'journey' to the FSW
- What specific support services, including health, are available for clients
- Relationships with other agencies
- Background information about the FSW including qualifications and previous experience
- Ideas for the future

3.1.2 Results of interviews

Reasons for clients seeking help and their 'journey' to the FSW

The most commonly cited reason for a family member seeking help from a FSW was poor emotional and mental wellbeing – 'feeling unable to cope anymore' and a general sense of stress and anxiety related to the imprisonment. Issues relating to the care of the prisoner's children also featured heavily and included coordinating contact between the prisoner and their children, caring responsibilities of the family 'outside' (often newly acquired by a grandmother) and financial support and access to the appropriate child-related benefits.

Requests for general information about prison life appeared less common and this may have been related to how the individual FSWs developed their client base. Two of the FSW were funded by Routes Out of Prison (ROOP) and their clients originated from direct referrals for family members made following requests for help from the prisoner themselves. Families where prisoners were already involved in ROOP appeared better able to take advantage of the support of the FSW just for themselves rather than asking for help on behalf of the prisoner. FSWs reported that many family members were concerned about the availability of drug support services for the prisoner on their release.

They also highlighted that their family member clients were usually also materially deprived with poor levels of literacy, education and employment.

In terms of specific health-related issues brought by the family member to the FSW, the dominant concern was consistently poor mental health. The next most common health-related concern related to disability and poor mobility (which impaired the family member's ability to visit the prison), often related to a combination of complex physical health problems such as respiratory, heart and musculo-skeletal problems.

Interestingly, despite family members' own very real problems, FSWs reported that they were also often pre-occupied with concern for the loved one in prison rather than for their own physical and mental wellbeing. This parallels findings from the Tayside Family Project¹⁷, where concern for the prisoner was ranked as the top concern for families (88%).

What specific support services, including health, are available for clients

In general, family members were already in contact with their GP and FSWs consistently sign-posted family members with health concerns back to their GP, as the 'gatekeeper' to all other health services. FSWs reported that while some family members were already 'in the

¹⁷ Loucks N. The Tayside Family Project. Dundee and Edinburgh: Tayside Criminal Justice Partnership and Families Outside. 2004b.

system' for Community Mental Health Services (and may have had contact with a community psychiatric nurse (CPN)), for others, there appeared to be some reluctance on the part of family members to seek help for mental health problems from their GPs. Despite the reported heavy burden of mild to moderate mental health problems, FSWs reported that none of their clients had experienced specialist psychological services.

Other services that clients were accessing or referred to on a fairly frequent basis included Scottish Families Affected by Drugs and Social Work Departments (although consistently FSWs reported a general reluctance on the part of family members for involvement with Social Work¹⁸). Family members were also referred to local resources such as Carers' Centres or other local organisations relevant to their specific needs. Most FSWs reported that family members felt less comfortable in accessing groups, preferring one-to-one support.

In addition, depending on the individual FSW's areas of past experience, family members may informally receive varying amounts of counselling / motivational support to deal with their own problems.

FSW relationships with other agencies

The general impression is that the FSW role is much more operational than strategic and relationships with other agencies are on an 'ad hoc' basis with individual fellow 'front line' workers as required. Generally, each FSW had developed a folder of local contacts from relevant organisations and relied on the internet, previous experience and work contacts and for example, networking opportunities at meetings and conferences, to develop their local support network. There appeared to be no systematic approach to developing this network and it very much depended on individual FSWs to negotiate.

FSWs were all happy to support a family member in their contact with the relevant organisation, including health services, but all consistently reported that they encouraged all of their clients to take responsibility for this themselves. Support of the family member ranged from a telephone call, letter or accompanying the person to a meeting with the relevant agency.

In general, relationships with the NHS were limited to contact with individual healthcare professionals, for example, a request for liaison with a family member's CPN. The two FSWs working out of a Prison Visitors Centre had slightly more contact with the NHS, through occasional health events held at the Centre.

Background information about the FSW including qualifications and previous experience

Perhaps unsurprisingly, there was generally a strong base of experience and qualifications in psycho-social care. Individual FSWs had different areas of expertise derived from previous training or work experience in criminal justice, substance misuse, carers' support and citizen's advice. As such, between them, they have a great deal of relevant experience for the one-to-one support of family members and the concerns they bring.

All the FSWs reported being able to share concerns with fellow FSW colleagues or their Supervisor, about individual clients / issues and ask for advice at their monthly FSW meeting or as required during the month, by telephone. In addition, the FSWs felt able to request additional training if required although were aware of the financial constraints of working for a charity.

¹⁸ Reluctance for families to engage with Social Work commonly reflects families' concerns about differential power relationships: non-statutory services do not have the power that social workers do to take children into care, for example, whereas the perception – rightly or wrongly – is that social workers 'take your kids off you'.

FSWs' ideas for the future

a) General changes

Universally, the FSWs called for greater formal societal recognition of the adverse impact that imprisonment has on the families of people in prison and particularly, for the need for more consistency of the services available across Scotland. The provision of Visitors Centres (and the associated support services that are available with them) across the prison estate was singled out as a particular problem area when looking at inconsistency and inequality of the support available to the families of people in prison.

In addition, with only four FSWs at Families Outside, the provision of FSWs to families across Scotland is low. Other organisations, in particular The Lighthouse Foundation and Circle as well as HOPE and some Citizens Advice Bureaux provide support for families of prisoners in certain geographical areas, but overall the availability of dedicated support work is limited. Therefore, the FSWs called for smaller geographical patches with more FSWs to cover these smaller areas.

b) Possible changes to FSW work

In terms of specific areas of concern, the FSWs highlighted the large burden of poor mental health and wellbeing of their clients. As such there was interest in being able to call on more psychological support for their family members. Ideas included being able to provide relaxation classes (as currently provided by The Lighthouse Foundation) at the Visitors Centres.

There was also some interest in looking at the potential for developing support groups for the families of prisoners however, there was a strong caveat to this in terms of preserving confidentiality. There was a concern that what might be discussed in a support group on the 'outside' might have a negative knock-on effect on the 'inside', in prison where information about the prisoner or their family could be exploited.

In terms of how the FSW role might evolve to help support family members better, the ROOP-based FSWs were particularly keen to see improved access for family members to a FSW, independent of whether the prisoner themselves had requested it.

The FSWs could see the benefit that their clients derived from their support – both in an improvement in their mental health and wellbeing and often, through improvement in their material circumstances, for example, through the award of a charitable grant. However, they were aware that measuring the impact of their input was poor. The FSWs had only just introduced the use of a simple 'before and after' assessment tool called the Support Needs Tool¹⁹ but were keen that this should become routine where practical. However, such a tool will not be practical for one-off or very short-term support.

Summary of FSW interviews

The FSWs reported that the dominant reasons for seeking help from a FSW were related to mental health and wellbeing and concerns regarding the impact of imprisonment on children with relatively less concerns raised about prison-related issues. Generally, where health was concerned, FSWs referred clients to their GP as the overall 'gatekeeper' to health services. Contact with other agencies was on a case-by-case basis as needed by individual clients.

FSWs came with a background of psycho-social care but with varying expertise in different specific support services. They felt able to ask for more training in specific areas if required. In order to improve the support provided by them, the FSWs made various suggestions

¹⁹ The client reports twice using a simple scale – at initial contact with the FSW and on closure of the contact – in order to measure 'distance travelled'. They are asked to assess how they feel about their finances, accommodation, physical health, mental health, substance misuse, emotional support, employment, training and education and about any children.

including greater recognition of families of prisoners as a distinct group in need of support; universal provision of Visitors Centres across Scotland; help to better support families with problems in mental health and wellbeing and the possible provision of family support groups.

3.2 Results of interviews with family member clients

3.2.1 Key interview themes

The following key themes emerged and were developed:

- Basic demographic information such as age, relationship to the prisoner, receipt of benefits, postcode
- Reasons for client seeking help and their 'journey' to the FSW
- Experience of health and healthcare services
- Involvement of other agencies
- Views on what could be done to improve the support provided
- Views on whether and what they could do to improve their health

3.2.2 Results of interviews

Only 7 family members were interviewed and it is unlikely that they will be representative of everyone who seeks help from a FSW. It is likely that these clients reflect those suffering most severely from the impact of imprisonment. It is also possible that with such a small sample, a full range of themes may not emerge. However, it should be noted that the analysis of the database (which included over 120 clients) reflected many of the findings expressed by the 7 who were interviewed.

Table 1: Basic characteristics of family member client such as age, relationship to the prisoner, receipt of benefits, postcode

Family member client	Gender	Age	Relationship to prisoner	Number of people supported	Registered with GP	Support with benefits	Measure of deprivation	
							Carstairs score*	Decile [#]
1	F	42	Mother	2	Y	Y	-1.69	4
2	F	57	Grandmother	1	Y	Y	1.91	8
3	F	58	Mother	1	Y	Y	9.25	10
4	F	21	Partner	1	Y	Y	-0.6	5
5	F	57	Mother	2	Y	Y	0.45	7
6	F	49	Mother	2	Y	N	4.42	10
7	F	62	Mother	1	Y	Y	5.66	10
Average		49.4		1 - 2	7 of 7	6 of 7	2.77	7.7

* The Carstairs deprivation score is based on Census information.²⁰ It assigns a score dependent on the levels of home overcrowding, male unemployment, social class and car ownership within a particular postcode sector. The score ranges from -8 (most affluent) through to +16 (most deprived) where around 0 is the Scottish average level.

[#] Deciles divide the Scottish population into tenths according to their Carstairs score, with Decile 1 (most affluent) ranging to Decile 10 (most deprived).

²⁰ McLoone P. Carstairs scores for Scottish postcode sectors from 2001 Census. MRC Social & Public Health Sciences Unit. 2004.

Reasons for clients seeking help and their 'journey' to the FSW

Most of the interviewees reported that they had sought help from the FSW due to their extreme distress at the imprisonment of their loved one, in most cases, of their son. The distress was felt in terms of 'strain', feeling 'uptight and agitated', 'depression' and at its worst in a couple of cases, 'feeling down and suicidal'.

In one case of kinship caring, there was also financial difficulty and family conflict as the child benefit was not being paid to the child's new carer and this had to be negotiated. In another case, limited mobility and accessing the prison for visits was the main driver for seeking help from the FSW.

Two interviewees admitted to concern about domestic abuse, one from the imprisoned person and the other from another family member.

Experience of health and healthcare services

On a 5 point scale, self-rating their health at the time of initial referral to the FSW and at the time of the interview, there had been an improvement in the health (predominantly of their mental health) for all 7 interviewees.

In 5 of the cases, self-assessments of mental health moved from Point 5 (very bad) to Point 2 (good), a 6th case from very bad to ok. No one currently rated their mental health as very good (Point 1) although one person rated their physical health as very good. The one interviewee who still rated their current mental health as 'very bad' explained that this had been an improvement on the previous year when they had felt suicidal, describing their FSW as, "Like a fairy godmother. She doesn't tell me what to do but advises on what's available".

When asked what their main health problems were, all of the interviewees felt that the 'strain of caring' about the imprisoned person was affecting their mental wellbeing. Four of the interviewees also suffered from combinations of conditions resulting in significant physical ill health including rheumatoid arthritis, trauma-related brain injury, heart disease, respiratory disease, poor sight, diabetes and thyroid disease.

All the interviewees were registered with GPs and two were in contact with Community Mental Health Services. Three had not told their GPs about their relatives' imprisonment for different reasons – shame, too busy to seek help for themselves and "because no one asked why I was stressed". The other 4 interviewees felt supported and able to ask for help from a healthcare professional.

Involvement of other agencies

Four of the interviewees had had some contact with social services (two because of kinship caring of children) but all four reported feeling uncomfortable to deal with them.

Contact with Prisons' Family Contact Officers was generally positive as was contact with the Routes Out of Prison partnership.

Two of the interviewees had benefited from small grants from other charities towards household purchases related to their new childcare responsibilities and another from some help towards arranging transport to help with visits.

Views on what could be done to improve the support provided

All seven interviewees reported being very satisfied with their support from their FSW. They found the FSW's approach to be supportive and encouraging. The FSWs were described as follows:

“Absolute Godsend.”

“Gives 120% - nothing more to be done.”

“A fantastic lassie – I don’t know what I’d have done without her help.”

“A great listener. At the end of the phone. Helps put things into perspective.”

“Like a ray of sunshine on an otherwise dull day.”

“Very down to earth and easy to tell her what’s happening to me.”

Two of the interviewees expressed an interest, in addition to individual FSW input, in attending a support group for the relatives of other people who had been imprisoned. They felt that not only would they have benefited from hearing other people’s experiences but that they were now in a position where they would like to be able to help others who were new to the situation of having a family member imprisoned.

In addition, their demands of the NHS were low, with only 3 people feeling that the NHS could do more to help them. In 2 cases, there was a request for greater availability (shorter waiting times) of psychological services for them and in the 3rd case, for psychological services for their imprisoned son on release.

Views on whether and what they could do to improve their health

When asked about any changes they would like to make to their health, three of the interviewees did not feel that any changes were necessary. The other four all felt that they would like to lose weight in order to try and improve their physical health. Two felt that Weightwatchers would be helpful and one was planning to enrol with a fixed date in mind but the 4th felt that here disability prevented her from exercising. All four thought that it would feel difficult at first but that visible signs of weight loss would be encouraging. Improved health was the motivation for three of them while the third felt that weight loss would allow her to look after her young grandson better.

Summary of findings

All the family members were women, mostly the mothers of men who had been imprisoned. Everyone’s mental health or wellbeing had been adversely affected by imprisonment, with half the group also experiencing ongoing complex physical health problems. Most of the women live in areas of relatively greater deprivation, with 5 of the 7 women in the 7th decile of relative deprivation or greater. We know that poor health and deprivation are strongly associated.

On the whole, the family members sought help from the FSW for emotional and problem solving support but with a couple also receiving practical support. They all saw an improvement in their sense of mental wellbeing, most feeling considerable improvement, rating the support of their FSW very highly.

In terms of what extra help they would want, their demands were low; most could not see what else their FSW or the NHS could do to help them. There was a call from some, for better access to psychological services.

In terms of helping their own health, 4 of the 7 women saw that weight loss could help while the other 3 did not feel the need for any other health changes.

3.3 Database findings

The database period selected was found to include a total of 123 clients, and the data set was complete for 94 of these clients (76%).

Basic characteristics of the service users and relationship to prisoner.

Figure 1 shows that almost all the users of the FSWs were adults, with almost half the adults over 40 years old. This is suggestive of either parents or partners of prisoners seeking help, as opposed to the children seeking help.

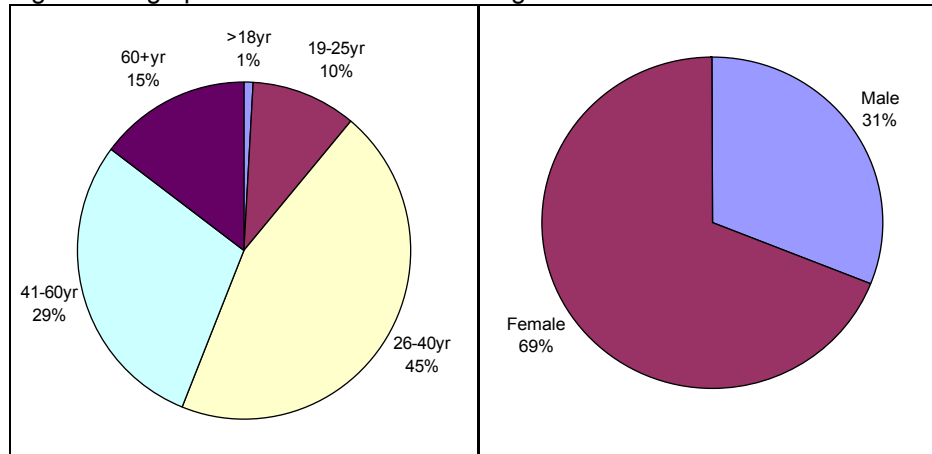
However, Table 2 shows that a single person contact with an FSW may result in the support of more than one person including the wider family. This may consist of several adults and/or children.

Table 2: Number of people affected by contact with an FSW

Adults	Children	Total	Number of people affected			
			1-2	3-4	5-6	7+
182	104	285	55	41	9	3

Figure 2 shows that almost 70% of primary contacts with FSWs were initiated by women, which is consistent with the findings of other support services including health services, where women often present for help on behalf of the wider family.

Figure 1: Age profile of service users Figure 2: Gender of service users

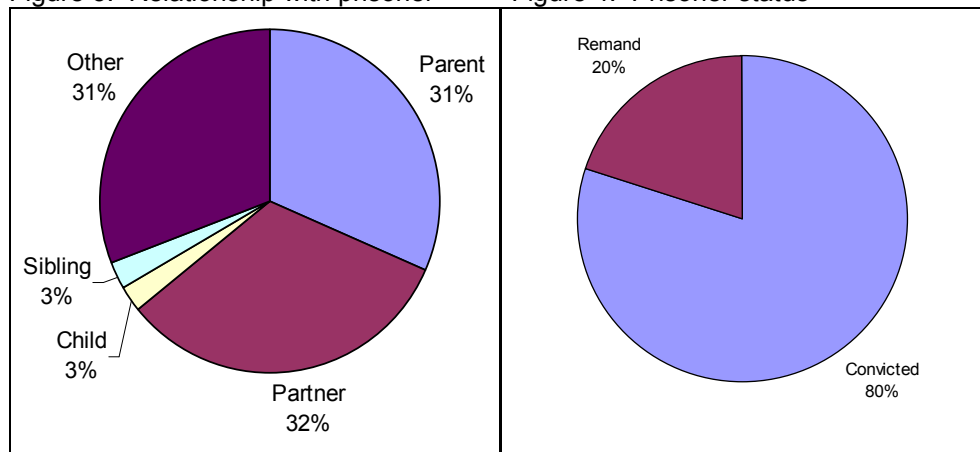


Total: 116

Total: 119

Figure 3 shows that almost a third of contacts with FSWs were made by either the parents or partners of the person imprisoned. Siblings and the children of prisoners were much less likely to make contact with a FSW.

Figure 3: Relationship with prisoner Figure 4: Prisoner status



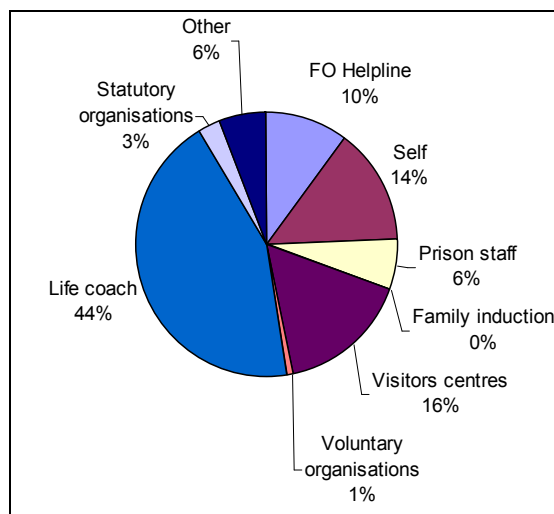
Total: 117

Total: 115

Figure 4 shows that 80% of contacts with FSWs are from the families of prisoners who have been convicted. While this is consistent with the overall proportion of convicted prisoners in Scotland²¹, in reality this is likely to suggest an under-representation of remand prisoners and their families for support and advice.

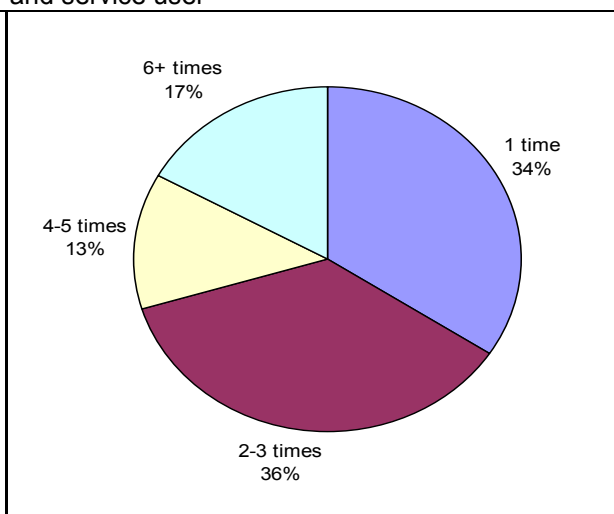
The time on remand can be a particularly challenging and turbulent times of change when families may be trying to make sense of both the imprisonment and how to navigate their way through different prison-related services, including the Families Outside offering. This is one of the key times when Families Outside would wish to be involved. This proportion of requests for help from families with a prisoner on remand may also reflect the more limited access of remand prisoners themselves to signposting/referral to the help of FSWs.

Figure 5: Source of referral to FSW



Total: 118 service users

Figure 6: Frequency of contact between FSW and service user



Total: 94

Figure 5 shows that the largest single source of referral is from life coaches. This refers to the life coaches of the ROOP Project where prisoners are coached in preparation for their release and for time afterwards. Visitors centres, self-referral (which are most likely to arise from advertisement of FSWs at a Visitors Centre) and the Families Outside helpline generate the next most common referrals. Stutory organisations, prison staff and other voluntary organisations make few referrals. It would be important to understand why so few referrals are made by them as one would expect that they have frequent interactions with family clients who could benefit from the support of an FSW.

Figure 6 shows the frequency of contact between a FSW and client. Approximately a third of clients will have only one contact with an FSW, for example, with a specific query or concern. Approximately a third of clients will have contact on 2-3 occasions, either through face to face contact or telephone. Less than a third of people will have more than 4 contacts with an FSW, which may contribute to making assessment of the impact of FSWs more difficult.

²¹ National Statistics for Scotland. Statistical Release Crime and Justice Series: Scottish prison population projections: 2010-11 to 2019-20. 2011.

Figure 7 shows what clients report as issues. Almost half (46%) report issues related either to their physical or mental health and wellbeing. These include emotional difficulties, bereavement, self-harm, substance misuse, disability or other physical health problems. Approximately, one fifth of clients have family or children-related issues. The remainder report a mixture of concerns related to finance, housing, education or the prisons. Perhaps surprisingly, only 11% report specific problems related to the prisons per se, including prison complaints, their relative leaving prison or visits. (However, this latter group of prison-related concerns should be treated with caution as it may not be indicative of actual satisfaction with the prison but may reflect a reluctance to raise concerns.)

Figure 7: Reported client issues

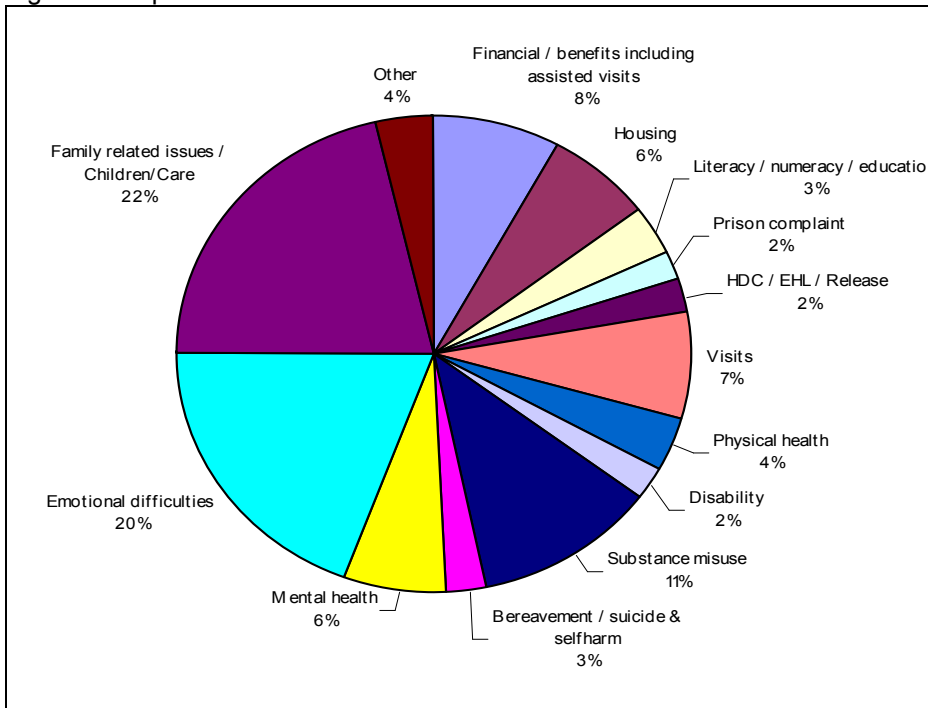
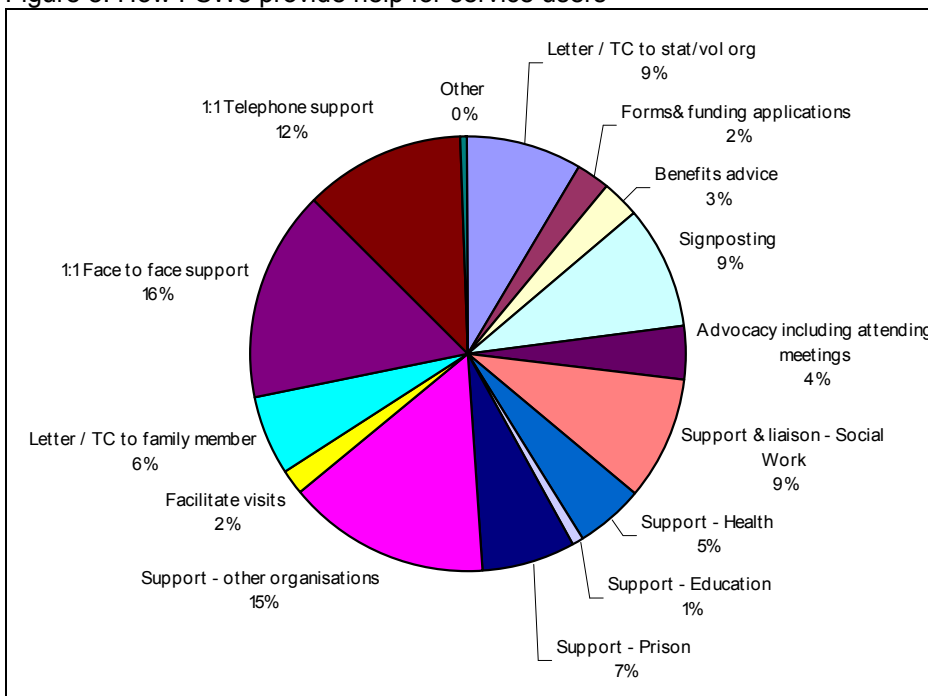


Figure 8: How FSWs provide help for service users



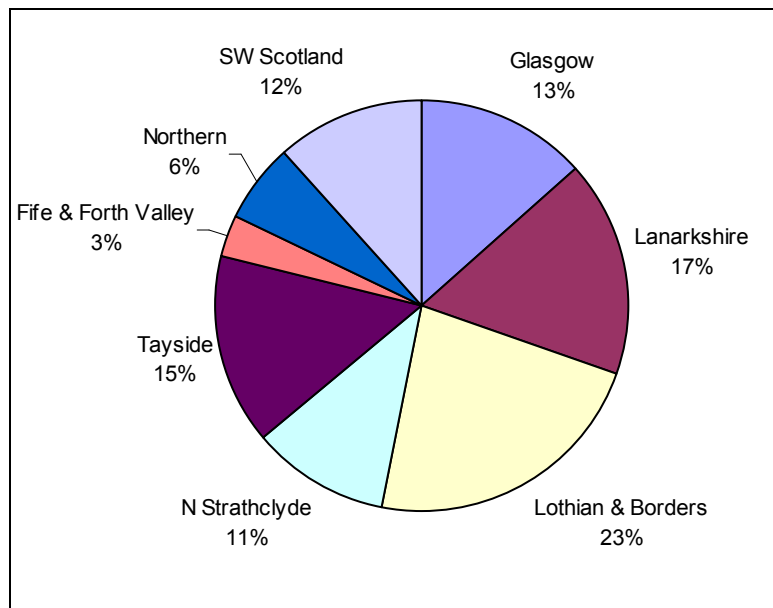
Total: 414 'provisions of help'

Figure 8 shows how FSW respond to service users' concerns. Approximately one quarter of help is provided in the form of the FSW's telephone or face-to-face contact with the client. 8% of help is for the client to make or maintain contact with their relative in prison.

Significantly, the remainder of help (approximately two thirds) is provided by the FSW in supporting the client through their contact with various agencies – both voluntary and statutory - including education, health, social work and benefits. This may be in the form of attending meetings or making telephone calls on behalf of the client. This also includes help with form filling and signposting to relevant agencies. This highlights the challenge that many people find in navigating their way through organisations and their bureaucracy, particularly if there are issues about literacy, self-esteem and self-confidence.

Figure 9 shows the distribution of clients across the eight Community Justice Authorities (CJAs). All of the CJAs are represented and while it largely reflects the general proportions of prisoners within each CJAs, there are some anomalies, for example, Fife & Forth Valley, which probably reflect the lack of the physical presence of a FSW.

Figure 9: Distribution of clients across Community Justice Authorities



Total: 119 clients

Section 4 – Conclusions, discussion and recommendations

4.1 Conclusions and discussion

As noted at the outset, this analysis aimed to identify patterns in the sources of and reasons for referral to Family Support Workers, the types of family members supported, and the extent to which the support from the FSWs met the needs of the families. The analysis had a particular focus on health issues, especially where these may be hidden under broader categories such as 'emotional support'. Successful outcomes were that FSWs successfully identified and supported the needs of the family members, including through referral to longer-term support in the community where appropriate.

The results of the FSW interviews, the service user interviews and the database analysis all highlight that poor mental health and wellbeing is a considerable problem for the families of people in prison and that FSWs work to address these issues as part of their remits. This included provision of emotional support themselves as well as supported referrals to more specialist providers.

While the clients interviewed are likely to represent those with a longer-term relationship with the FSW and therefore at a more severe end of the spectrum, their poor mental health and wellbeing is consistent with the general findings of the database which included a larger number of clients. Interviewed clients reported accessing health services through their GPs but that not all felt comfortable enough to report the level of distress caused by the imprisonment of a family member. Community mental health services were involved in approximately one third of client cases but waiting times for this and subsequent services (for example, specialist psychological interventions) were long.

The clients all reported the positive impact that their involvement with the FSW had had on their mental health and wellbeing, with the FSW often using psychological techniques such as solution-focused work to help clients solve their problems.

FSWs also support clients in their use of other services, provided by both statutory and voluntary organisations, often helping clients navigate their way through the organisational complexity and bureaucracy. FSWs appear to offer a 'one stop support shop' or being a 'Fixer', providing a holistic service which addresses the psycho-social, and sometimes, physical needs of their clients.

It is clear that FSWs provide committed one-to-one support, advice and signposting for their clients and that this appears effective in dealing with a broad range of issues which may impact adversely on their clients' mental wellbeing. It highlights that conventional 'health services' may fail to address the wider health of people because of their focus on a bio-medical model of illness, without adequate recognition of the social determinants of ill health, such as debt, poverty, poor housing, poor education and social stigma.

In terms of other aspects of health, consistent with the findings of other studies of people who suffer poverty or social stigma, such as many ethnic minorities, there was evidence of poor physical health as well as poor mental health. However, with the exception of a desire for weight loss for better health, conventional 'health improvement' issues, such as healthy eating, physical activity, smoking and alcohol use were not perceived as specific issues for clients' health. This may have been related to the more pressing demands made by poor mental health and social problems. It would be useful to understand why families do not / have not engaged in their health and what are the issues surrounding this. One method for exploring this might be through community development (see later) which develops a way of identifying problems and then for the community concerned to start to tackle the problem. In the short term, this finding suggests that it would be important for NHS health promotion

services to consider how they present health promotion messages in a way that 'chimes' with this target population.

This evaluation shows that there are potential opportunities to help tackle health inequalities, primarily through addressing the mental health and wellbeing of the families of people in prison. By focusing on mental health, the aim is that there is a greater chance of raised self-esteem and improved ability to engage more fully with society, services and ideally, with employment. This might have the knock on effect of raising people out of poverty and consequently, even reduce the future risk of crime of their partner or children.

Harnessing the power of clients with a community development approach

The approaches used by FSWs currently focus on the individual and their family, often focusing on the immediate presenting problem rather than looking at common themes shared by their 'community' of clients. The nature of their one-to-one work is resource intensive, which raises the question of sustainability of this work should awareness of (and consequently demand for) the service increase. At the time of this review, only four Families Outside Family Support Workers – three full-time equivalents – were available to support families across Scotland. This meant that collaboration with other organisations to provide support was essential, but similar support is not readily available throughout the country.

Further, the current model of Family Support Work does not naturally lend itself to the wider empowerment of the individual to influence change. One of the social determinants of health, as described by the World Health Organisation²², is the ability of people to be able to participate in and influence society.

There is real potential for FSWs and Families Outside to consider adopting a community development approach. A community development approach consists of a set of methods which can broaden vision and capacity for social change.²³ It is an approach that is informed by principles such as equity, partnership, participation and empowerment and is defined as 'a way of tackling a community's problems by using the energy and leadership of the people who live there.'²⁴

The 'community' of families affected by imprisonment have the potential, with encouragement and support from organisations such as Families Outside, to challenge their place in society and to call on organisations such as the Scottish Government, Health Boards and Community Justice Authorities to help tackle issues such as the health inequalities that they experience.

See Annex B for further details on how a community development approach might need to be addressed for the community of families of people in prison.

While the clients' power is currently low (related to poor mental health and wellbeing, fears of stigma and of 'rocking the boat' for themselves or for their imprisoned family member), there is potential for FSWs to help harness their clients' assets and power. A community development approach may help identify and tackle issues where a change in health behaviour could help. The approach could also be used more widely in tackling other concerns that families may have about their family member's imprisonment. The families could be helped to participate and influence society's policy on supporting the families of prisoners and in the process, also improve their health and wellbeing. In addition, the peer

²² World Health Organisation (2005), *Commission on Social Determinants of Health*. Available at: www.who.int/social_determinants

²³ Dalziel Y. Prison leavers and families affected by imprisonment: A report of the Edinburgh CHP Prison Leavers Project. Partnerships for Access to Health (PATH) project. NHS Lothian. 2009. Available at: <http://www.pathproject.scot.nhs.uk/Prison%20leavers%20report%20FINAL.pdf>

²⁴ Thomas, DN (1995) in *Community Development & Involvement in Primary Care*, Freeman, R. et al, London: King's Fund (1997).

support of families able to participate at the group level, could help release the FSWs to work with those unable to work in the group setting.

Measuring the change related to FSWs

Measuring the impact that FSWs and Families Outside have on the health and wellbeing of the families of prisoners will be vital in ensuring the continued support of funding bodies such as Scottish Government and Health Boards.

New Philanthropy Capital have developed a model, based on the theory of change, that can help organisations involved in working with the families of prisoners to measure their impact.²⁵ The theory of change is a logical model that describes the causal links between an activity and its aims or impact. The work of the FSWs can be mapped onto this theory of change.

For example, viewing Figure 10, it can be seen that the FSWs primarily operate through providing the following activities:

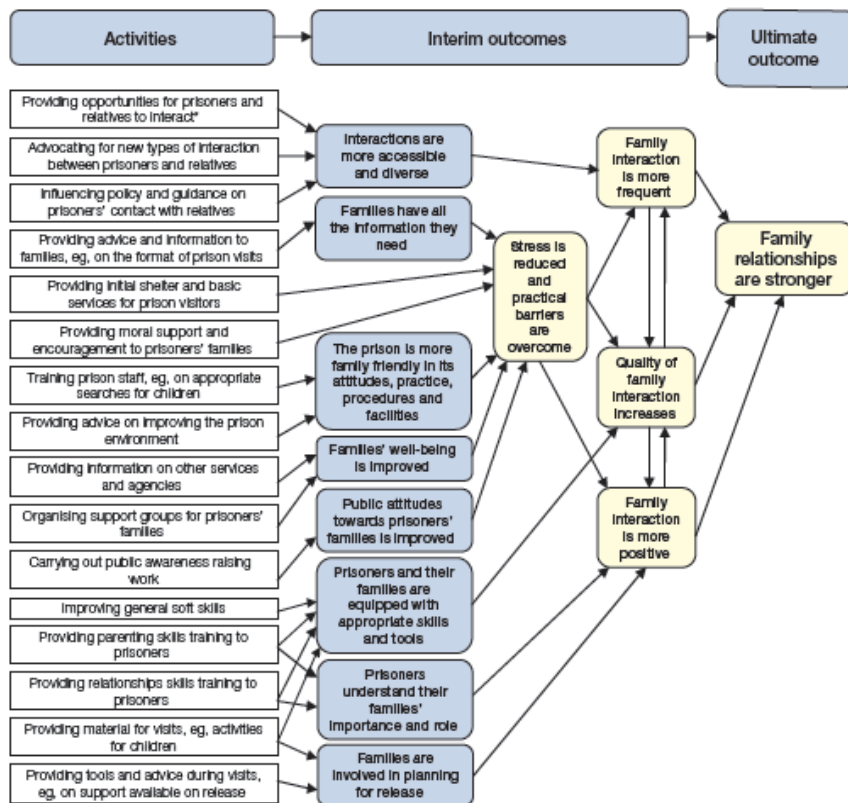
- Providing advice and information to families eg on the format of prison visits
- Providing moral support and encouragement to prisoners' families
- Providing information on other services and agencies
- Improving general soft skills

These in turn would be anticipated to lead to the associated interim outcomes, leading on to the ultimate outcome, 'that family relationships are stronger'.

It will be vital for Families Outside to ensure that individual activities are assessed and evaluated from time to time in order to be able to provide a wider picture of their impact on the families of prisoners. The FSW Assessment Tool is such a tool that is already in use by Families Outside FSWs to measure their impact with families.

²⁵ De Las Casas L, Fradd A, Heady L, Paterson E. Measuring together. Improving prisoners' family ties: piloting a shared measurement approach. New Philanthropy Capital. Apr 2011.

Figure 10: Theory of change for working with prisoners' families



Source: Measuring together: Improving prisoners' family ties²⁶

4.2 Recommendations to Families Outside

Policy level ie Scottish Government

11. Lobby the Health Department to contribute to funding of FSWs as part of the Government's commitment to tackling health inequalities, primarily through the FSWs' contribution to improving the mental health and wellbeing of the families of prisoners.
12. Lobby the Community Justice Directorate to consider the routine provision of Visitors Centres to at least all new build prisons, as a useful point of access to the families of prisoners, in line with policy in England and Wales.
13. Lobby the Chief Medical Officer (CMO) to include a section on the health of prisoners' families when drafting his Annual Report.

Strategic local level ie Health Boards, Local Authorities, Community Planning Partnerships, Community Justice Authorities, Community Safety Partnerships, Alcohol & Drug Partnerships

14. Lobby Health Boards et al. directly to:
 - i. Formally recognise that the families of prisoners are a vulnerable group, already suffering health inequalities, primarily through high levels of poor mental health and wellbeing but also through poor

²⁶ De Las Casas L, Fradd A, Heady L, Paterson E. Measuring together. Improving prisoners' family ties: piloting a shared measurement approach. New Philanthropy Capital. Apr 2011.

physical health. As such, Health Boards should ensure resources are made available to support them.

ii. Contribute towards the funding of FSWs.

15. Encourage Health Board Health Inequality programme teams to use the FSWs, Families Outside and Prison Visitors Centres as points of access to this vulnerable and largely, invisible group. For example, they may wish to bring in teams who specialise in promoting better mental health and wellbeing.

Operational local level ie FSWs

16. Where funding is available, increase the number of FSWs and reduce the geographical areas covered by them, ideally in line with Community Justice Authority Boundaries.

17. Improve access for family members to a FSW, independent of whether the prisoner themselves has requested it.

18. Make routine the use of an appropriate assessment tool in order to measure the impact of the FSW work with clients, for example, the Support Needs Tool.²⁷ This should routinely include assessment of health and wellbeing impact, especially of mental health and wellbeing.

19. Consider introducing a greater community development approach to supporting and empowering families, for example through the introduction of Family Support Groups.

20. Continue ongoing supervision and training of FSWs to support them in their role.

i. This should include adequate psychological support and training in view of the high client needs in mental health issues.

ii. Consider routine training of all FSWs in basic counselling and motivational interviewing skills and/or Mental First Aid.

iii. Consider community development training for all FSWs if this approach is to be adopted by Families Outside and FSWs.

Dr Liz Brutus

Specialty Registrar in Public Health
July 2012

Acknowledgements

Many thanks go to the people who made this evaluation and report possible. These include the families of people in prison who were prepared to be interviewed, the four Family Support Workers managed by Families Outside and Families Outside themselves. In addition, I am very grateful for the information and suggestions provided by the Visitors' Centre managers at HMP Edinburgh and HMP Perth.

²⁷ The client reports twice using a simple scale – at initial contact with the FSW and on closure of the contact – in order to measure 'distance travelled'. They are asked to assess how they feel about their finances, accommodation, physical health, mental health, substance misuse, emotional support, employment, training and education and about any children.

Annex A

**Family Support Worker
(region)**



KEY TASKS, DUTIES & RESPONSIBILITIES

1. Provide one-to-one support to families affected by imprisonment.
2. Consult with families on an ongoing basis to ensure continued relevance to needs (ie housing, addictions, benefits, childcare).
3. Manage a client caseload and address individual needs, referring to appropriate services (ie housing, health, welfare) as required.
4. Support families to be involved in case conferences within the prison and discharge planning where possible.
5. Ensure access to a range of information for families to support their needs, especially in the early stages of imprisonment.
6. Highlight emerging needs of families to Visitor Centre Manager.
7. In conjunction with the Visitors' Centre Manager and Families Outside colleagues:
 - Develop and support local Family Support Networks, building on existing support mechanisms where they exist.
 - Develop and manage the peer support element of the network.
 - Create a directory of support services for families in Lothian & Borders and Fife & Forth Valley.
 - Establish a range of support services within the Centre for families based on their needs.
8. Establish close links with Family Contact Officers in prisons returning prisoners to ___ CJA areas.
9. Offer support to children and young people within the Visitor Centre and contact agencies as needed to develop community support.
10. Attend, where possible, family induction sessions in the relevant prisons.
11. Adopt flexible working while maintaining appropriate boundaries in provision of support, advice and guidance to service users.
12. Seek support and help from the line manager when appropriate and necessary. Monthly supervision from Families Outside will be given, and the opportunity to debrief at other times will be paramount.
13. Collaborate and maintain contact with a wide range of external organisations which will prove beneficial to life coaches and families.
14. Adhere to Families Outside policies and procedures, work within and promote policies in relation to Equal Opportunities and anti-discriminatory practices, including confidentiality, equal opportunities, child protection, health and safety and security.

15. Assist in statistical monitoring as required.
16. Work as part of the staff team to ensure the overall aims of Families Outside are achieved.
17. Participate in Families Outside meetings, training and supervision as appropriate.
18. Undertake any other reasonable duties as required. (Additional duties will be to cover unforeseen circumstances or changes in work and will usually be compatible with the regular type of work. If an additional task or responsibility becomes a regular or frequent part of the job, it will be included in the job description in consultation with the post holder.)

NOTES

As part of this project, all staff involved will be subject to an Enhanced Disclosure check. It is expected that some applicants may have a previous criminal record, in which case further criteria will be used for selecting successful applicants. These criteria will include the necessity for individuals to be currently stable in relation to housing arrangements, addictions and offending activity.

PERSON SPECIFICATION

Post Title: Family Support Worker

Applicants should be able to demonstrate the following:

	SELECTION CRITERIA:	Essential	Desirable
EDUCATION	Appropriate Qualification	*	
	Good level of literacy and numeracy skills	*	
PREVIOUS EXPERIENCE	Experience of community work	*	
	Working with families	*	
	Personal experience or knowledge of working with disadvantaged or vulnerable groups	*	
SKILLS AND ABILITY	Good negotiation, communication and interpersonal skills (both written and verbal), and the ability to relate sensitively to the needs of prisoners' families	*	
	Ability to work with a wide variety of people at all levels	*	
	Case management experience and ability to access support with external agencies	*	
	Ability to work on own initiative and as part of a team	*	
	Ability to prioritise and manage work load in a pressurised environment	*	
	Ability to use IT including: Microsoft packages	*	
	Reliable	*	
	Current driving licence		*
PERSONAL QUALITIES	Adaptable	*	
	Calm attitude	*	
	Non-judgemental	*	

Annex B

Theories and models of behaviour change underpinning a shift to a community development approach

Considerable attention has been given in the literature to models of individual behaviour change²⁸ per se – but much less attention has been given to models or theories that attempt to understand behaviour change within groups, organisations and whole communities.

A major strength of the Stages of Change model is that it has also been used in conjunction with a variety of other theories and models that are relevant to different levels of influence at an intrapersonal, interpersonal, institutional, community or public policy level.^{29, 30} The design of programs to reach populations requires an understanding of how those communities work, their barriers and enablers to change, and what influences their behaviours in general.

Owen and Lee (1984) highlighted a number of commonalities that various models of behaviour change shared. These authors proposed an integrated stage-based model in which behaviour change is viewed as a cyclical process that involves five stages:

1. Awareness of the problem and a need to change
2. Motivation to make a change
3. Skill development to prepare for the change
4. Initial adoption of the new activity or behaviour, and
5. Maintenance of the new activity and integration into the lifestyle.

Any community development approach for the families of prisoners would need to recognise that for an individual family member to take part in a community action, for example, to become more assertive in demanding what they need from a Health or Criminal Justice statutory organisation, they would need to undergo these various stages of change. It would be unlikely that a family member would suddenly become very assertive within a Family Support setting without support and time to change.

A major insight offered by stage theories of behaviour change, then, is the emphasis they place on matching interventions to the stage of readiness of the individual. This kind of approach provides an excellent framework for understanding and examining individual differences in motivation for, and involvement in, the shift from operating as an individual family client to operating as a Family Support Group member. Over time, this would include patterns of initiation, maintenance, relapse, and resumption as listed in the stages of change above.

Family Support Workers would need support and training to be able facilitate this change in their clients' behaviour; from being relatively less assertive to becoming much more assertive in demanding what they need from statutory bodies.

²⁸ These include conceptual models of behaviour change, such as Bandura's Social Cognitive Learning Theory (1986), Becker's Health Belief Model (1974), Azjen and Fishbein's Theory of Reasoned Action (1975).

²⁹ Glanz K, Rimer B. (1995). *Theory at a glance: A guide for health promotion practice*. Bethesda, MD: National Institute for Health, National Cancer Institute.

³⁰ Oldenburg B, Glanz, K French M. (1999). The application of staging models to the understanding of health behaviour change and the promotion of health. *Psychology and Health*. 1999, Vol. 14, pp. 503-516