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Title: Developing a typology for peer education and peer support delivered by prisoners

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All authors have completed the Unified Competing Interest form at <http://www.icmje.org/conflicts-of-interest/> (available on request from the corresponding author) and declare that (1) all authors have support from NIHR HSDR stream for the submitted work (2); No authors have relationships with companies that might have an interest in the submitted work in the previous 3 years (3); their spouses, partners, or children have no financial relationships that may be relevant to the submitted work; and (4) No authors have non-financial interests that may be relevant to the submitted work.

Developing a typology for peer education and peer support delivered by prisoners

Abstract

Peer interventions delivered for prisoners by prisoners offer a means to improve health and reduce risk factors for this population. The variety of peer programs poses challenges for synthesizing evidence. This paper presents a typology developed as part of a systematic review of peer interventions in prison settings. Peer interventions are grouped into four modes: peer education, peer support, peer mentoring and bridging roles, with the addition of a number of specific interventions identified through the review process. The paper discusses the different modes of peer delivery with reference to a wider health promotion literature on the value of social influence and support. In conclusion, the typology offers a framework for developing the evidence base across a diverse field of practice in correctional health care.

Key words: peer education, peer support, prison, typology, systematic review

Introduction

Peer-based interventions are a feature of prison health services and there is an established literature around peer education, and to a lesser extent peer support, in the contexts of incarceration. Given the high prevalence of poor physical and mental health in the prison population (Enggist, Møller, Galea, & Udesen, 2014; WHO, 2008), combined with exposure to risk factors detrimental to health both prior to and within the prison setting (de Viggiani, 2006; Plugge, Douglas, & Fitzpatrick, 2011), interventions delivered by inmates for inmates offer a means to reduce risk factors and improve health for this population. Devilly et al (2005) summarized the value of peer programs in terms of benefits to inmates from accessing credible sources of knowledge and positive role modelling, benefits to peer educators gained through their role, and organizational benefits including increased service capacity as well as the contribution to maintenance of good order in the prison.

There are a wide range of peer programs in this heterogeneous field of practice. A survey conducted in England and Wales by the Prison Reform Trust in 2002 found that around 7% of inmates were engaged in some form of peer support. Since then there has been an increase in the applications for peer programs (Edgar, Jacobson, & Biggar, 2011; Snow & Biggar, 2006). The evidence base has grown with a small number of reviews on the effectiveness of peer education (Devilly et al., 2005; N. Wright et al., 2011) and also international comparisons of service provision (Daigle et al., 2007). More recently a large mixed method systematic review, conducted by the authors, assessed the effectiveness and cost-effectiveness of peer interventions in prison settings (J. South et al., 2014). This systematic review uncovered a diverse range of peer interventions, including both peer education and peer support as well as other types of peer program. There was considerable variation in terms of intervention mode, health topic, type of setting, target population, and in some cases, theoretical models. Treating the included studies as a homogenous whole would have

undermined the validity of the conclusions. Therefore a typology of prison-based peer interventions, accompanied by working definitions, was developed in order to group interventions so that data synthesis could take place (Bravata, McDonald, Shojania, Sundaram, & Owens, 2005). The typology may have wider application in building the knowledge base for correctional health care because it provides a framework for understanding peer programs, their similarities and distinguishing features. The aim of this paper is to present the typology, describe how it was developed and discuss its application and value in differentiating types of peer intervention. The paper starts first with a brief introduction on the concepts of peer education and peer support.

What is a peer intervention?

Peer interventions are based on the principle of homophily and therefore seek to utilize social and communicative processes occurring between those who have similar demographic characteristics or sets of experiences for the purpose of achieving health or social goals (Chiu & West, 2007; Harris et al., 2015). The social influence of peers (Parkin & McKeganey, 2000) forms the basis for development of therapeutic or affirmative relationships that enable health promotion, prevention or care activities to proceed more effectively with a given target population (Dennis, 2003). Reach is a key concept, as network membership offers opportunities to connect with under-served and marginalized communities (Chiu & West, 2007).

Peer education and peer support are normally distinguished from each other on the basis of different aims, emphasis and also different traditions. Peer education has been defined as a process of education and information sharing occurring between individuals from the same age group or from similar social backgrounds (Milburn, 1995; Sriranganathan et al, 2010).

Various theoretical perspectives have been offered to justify peer education; Turner and Shepherd (1999) listed Social Learning Theory, Social Innoculation Theory, Role Theory, Differential Association Theory, Subculture theories, and Communication of Innovations Theory. In health promotion, there has been a strong critique of peer education in terms of poor application of theory to intervention design and evaluation (Milburn, 1995; Turner & Shepherd, 1999) and lack of definitional clarity over the term 'peer' (Parkin & McKeganey, 2000; Shiner, 1999). There have been questions about whose agendas are being served when peer education is used in an instrumental rather than empowering fashion (Frankham, 1998; Milburn, 1995), a point also made in the context of peer education in prisons (M.W. Ross, 2011).

Peer support concerns different forms of support provided and received by those who share similar attributes or types of experience. Dennis (2003), in a key conceptual paper on peer support in health care contexts, built on this definition to argue that peer support involves emotional support, informational support in terms of advice and feedback, and appraisal support facilitating self-evaluation and problem-solving. These facets of support are then applied to help the recipient cope with actual or anticipated stressors. Dennis went on to argue that peer support can lead to better health due to the direct effects of improved social relationships on wellbeing, through buffering mechanisms that enhance coping skills, or through the mediating effects of building self-efficacy and positive reinforcement of positive behaviors. In a realist review of community-based peer support, Harris et al. (2015) concluded that homophily, matching individuals on the basis of shared characteristics, is insufficient, as peer support interventions work best when they promote social interaction that builds trust and bonds in groups and when they give autonomy to peer supporters in how tailored advice and support is delivered.

Many of the generalized theories of peer education and support have been applied in the prison literature (see for example Boothby, 2011; Devilly et al., 2005; Snow, 2002); however three points can be made regarding this unique setting. First, peer identities based on shared experience or mutual history of incarceration have been given as a result of coercion not choice. Unlike in civil society where group identities may be hidden or negotiated, incarceration brings a sharp distinction between inmates and prison staff. Second, although peer interventions can reduce barriers to advice and support for inmates (Zack et al., 2004), Ross (2011), drawing on Goffman's notion of the 'total institution' (Goffman, 1961), argued that inmates' lack of agency and resistance to authority can make the delivery of health promotion more difficult as health becomes a 'battleground' where tensions over power and control surface (Ross, 2011p.15-16). Third, peer support can occur through informal networks of prisoners and be a valuable source of assistance without use of formal interventions. Collica (2010) argued that 'prosocial networks' can not only help with adaption to prison life, but also provide a sense of community that may extend on release. Conversely informal peer networks may support risky behaviors through distribution of contraband such as drugs or result in some inmates being socially isolated or bullied (Wheatley, 2007).

Developing a typology for peer interventions

As discussed above, the typology was developed as a framework for categorizing formal interventions as part of a systematic review of the effectiveness and cost-effectiveness of peer interventions in prison settings (J. South et al., 2014). The study used standard systematic review methodology to undertake systematic searching, then to select, appraise and review a total of 57 quantitative, qualitative and mixed method studies reporting health outcomes from

peer interventions and one cost-effectiveness study. Results from the review are reported elsewhere, where a full list of included studies can be found (Bagnall et al., 2015).

One of the challenges in the review process was dealing with a heterogeneous group of studies that covered diverse intervention types, prison contexts and health topics. It was clear that aggregating all the intervention modes as 'peer-based' would fail to distinguish critical differences in methods; but at the same time an overly cautious approach to grouping interventions would limit the extent to which evidence could be synthesized. Therefore it was decided to draw up an initial categorization framework for intervention modes. These modes would represent the general approach and orientation of interventions and additionally describe the primary role of the peer worker. It was recognized that peer interventions might use multiple methods, such as health promotion campaigns, counselling or advice, within an overall model. Discussion with the advisory and steering groups highlighted the utility of being able to group similar models during the process of synthesis. This was in preference to an alternative grouping of health topics as many interventions aimed at improving general health and reported a range of health and social outcomes.

An initial scan of background literature did not identify any existing typologies of peer-based interventions in prisons, although some literature included relevant definitions and also descriptions of types of program found in practice (see for example Daigle et al., 2007; Devilly et al., 2005; Edgar et al., 2011; Levenson & Farrant, 2002). A framework developed from an earlier systematic scoping study on community-based lay health worker roles (J South, Meah, Bagnall, & Jones, 2013) did not provide a sufficiently comprehensive framework to categorize peer interventions within the prison setting. A new typology of peer-based interventions was therefore developed, using existing theoretical and empirical literature, until there was a complete set of definitions for intervention modes covering the included studies in the review.

The analytical approach drew on qualitative thematic analysis techniques (Miles & Huberman, 1994), in that initial categories were developed from the literature and refined until the final typology provided the best fit to explain the interventions as reported in the included studies. A staged approach to analysis was adopted:

- i. Identification of relevant background literature. This included: key papers providing discussion of theoretical or conceptual issues around the nature of peer interventions; theoretical papers offering classifications of peer education and peer support; and publications with description of peer programs in practice. Most of these papers were identified through the review process during initial scoping searches and through contact with experts.
- ii. All included studies in the review had information extracted on intervention mode, setting and population as part of the review process. Data extraction records indicated where publications contained ‘thick’ descriptions or definitions of the intervention and also where studies identified the application of a theoretical model.
- iii. Preliminary definitions of types of intervention were then developed using both background literature and descriptions found in included studies. Some additional literature was identified from reference lists where required; for example, a definition of peer mentoring was sourced through the reference list of an evaluation of a peer mentoring scheme.
- iv. An iterative process of comparing definitions with reported intervention modes in the included studies was undertaken until the best fit was obtained. Some codes were merged at this stage or defined as sub-categories, for example, specific models of peer support. Where individual studies could not be easily categorized, a brief description of the intervention was given.

- v. Information on the application of the intervention mode in prison settings was added to the typology to ensure that relevant aspects of program delivery and social context were not lost.
- vi. The final stage was applying the typology of definitions in coding and grouping studies for the process of review and synthesis. Both the final typology and the categorization of included studies were agreed by all members of the review team.

A typology of peer interventions in prison settings

The typology of peer interventions in prison settings represents intervention types identified in published literature since 1995. The typology (presented in Table 1) groups interventions by mode: peer education, peer support, peer mentoring and bridging role. Additionally, a number of specific interventions identified through the review are included and mapped to the modes where appropriate. The typology is a descriptive framework, and therefore, no hierarchy is suggested nor does inclusion denote relative significance in correctional health care practice. The main characteristics of intervention types are summarized below, with descriptions of peer roles, intervention components and theoretical frameworks where reported in the literature.

Peer education

Prison-based peer education involves communication, education and skills development occurring between prisoners with the aim of increasing knowledge and awareness or effecting behavior change. This extends the definition of peer education used by Milburn (1995) in the context of correctional settings. The review found that peer education has been applied in

prisons in a number of countries predominately in relation to HIV prevention and risk reduction, where changes in knowledge, attitudes and behavior around sexual health and intravenous drug use were typically sought (see for example Bryan, Robbins, Ruiz, & O'Neill, 2006; Collica, 2007; Dolan, Bijl, & White, 2004; O. Grinstead, Faigeles, & Zack, 1997; Martin, O'Connell, Inciardi, Surratt, & Maiden, 2008; M. W Ross, Harzke, Scott, McCann, & Kelley, 2006; Schlapman & Cass, 2000; Sifunda et al., 2008; Vaz, Gloyd, & Trindade, 1996). There were also peer education interventions addressing personal development, for example, improving prisoner literacy (O'Hagan, 2011) and parenting (Penn State Erie, 2001).

Peer education interventions usually involved a formal training component to increase the knowledge and skills of prisoners recruited as peer educators, which may in turn have direct health benefits for those individuals (Scott, Harzke, Mizwa, Pugh, & Ross, 2004). The peer educator role was reported to include delivery of formal educational components to fellow prisoners, for example, running group sessions on undertaking HIV risk reduction planning (O. A. Grinstead, Zack, Faigeles, Grossman, & Blea, 1999) and informal education through social interactions within the prison (Bryan et al., 2006).

A number of publications discussed theoretical justifications for peer education in prisons in relation to social influence and reinforcement of positive social norms through peer-based social networks (Bryan et al., 2006; Zack et al., 2004). Risk reduction was a theme around HIV prevention, with recognition of the value of prisoners' experiential knowledge of risk behaviors both inside and outside prison (Collica, 2010; Zack et al., 2004). In the context where functional access to health care in prison might be good, outreach activities were reinterpreted as accessing lay (prison) networks to overcome low literacy and social exclusion (O. A. Grinstead et al., 1999) and improving the credibility of information in the face of resistance to professional advice (M. W Ross et al., 2006). The reach of the peer

intervention could extend beyond the immediate target group, as transmission of health messages might occur between prisons as prisoners moved, and potentially further afield to families (Scott et al., 2004).

Peer support

Prison-based peer support involves peer support workers providing either social or emotional support or practical assistance to other prisoners, in line with other forms of peer support in healthcare contexts (Dennis, 2003). Most of the prison peer interventions identified in the review involved peer support delivered on a one-to-one basis in response to prisoner needs or through informal social networks. In contrast, a minority of peer support interventions involved group work, such as self-help groups on substance misuse (Levenson & Farrant, 2002). While the basis for most prison peer support is forming supportive relationships in the context of stressors created by the experience of incarceration, roles can encompass counselling, listening, befriending, carrying out domestic duties for other prisoners (for example fetching meals), liaison with prison staff, translation, providing basic information and signposting to other services (Edgar et al., 2011; Stewart, 2011).

A range of peer support interventions involving the provision of emotional support to alleviate stress were identified. The review found two programs used a similar model specifically targeted at suicide and self-harm prevention; the Listener scheme (Davies, 1994; Dhaliwal & Harrower, 2009; Foster, 2011; Richman, 2004; Snow, 2002) and SAMS (Samaritans of Southern Alberta) (Hall & Gabor, 2004). The Listener scheme is a prison suicide prevention scheme that has been widely adopted in adult prisons in England and Wales (Davies, 1994); and in 2006, there were an estimated 1400 Listeners (Snow & Biggar, 2006). The Samaritans, a national mental health charity, select, train and supervise volunteers

who then provide confidential emotional support to fellow prisoners who are experiencing distress (Edgar et al., 2011). The review found two other interventions that were focused on the alleviation and prevention of mental distress. The Peer Support Training (PST) program, Canada, was implemented across a number of women's prisons and was described as being based on a holistic, women-centered approach to health care that aimed to be culturally sensitive and to develop the women's autonomy and self esteem (Blanchette & Eljdupovic-Guzina, 1998; Correctional Service of Canada, 2009; Delveaux & Blanchette, 2000; Eamon, McLaren, Munchua, & Tsutsumi; Syed & Blanchette, 2000a, 2000b). The Insiders Scheme was a UK based intervention that aimed to alleviate the stress of arrival in prison (Boothby, 2011) with the focus on peer support workers providing reassurance, information and practical assistance, rather than emotional support, to new prisoners (Jacobson, Edgar, & Loucks, 2008).

A small group of studies (n=3) on prisoner volunteers in US prison hospices was identified in the review (Cichowlas & Chen, 2010; Maull, 1991; K. N. Wright & Bronstein, 2007a, 2007b). Prison hospices were described as being based on a concept of providing a 'decent prison' which entailed maintaining terminally ill prisoners' humanity and dignity (K. N. Wright & Bronstein, 2007a). Prison hospice volunteers worked within a wider multi-disciplinary team to provide companionship, practical assistance and social and emotional support to terminally ill patients (K. N. Wright & Bronstein, 2007b).

The review found that theoretical justifications for peer support related to the buffering effect against stressors (Dennis, 2003) and the mitigation of mental health risks associated with incarceration and the removal of the prisoner from their normal social networks (Boothby, 2011; Snow & Biggar, 2006). Many of the interventions also combined emotional support with instrumental support, that is practical assistance and care (Ferlander, 2007), for example Insiders (Boothby, 2011) and prison hospice care (K. N. Wright & Bronstein, 2007b).

Peer mentoring

The process of mentoring describes a relationship between two individuals, one of whom acts as a role model and supports the personal or professional development of a mentee (Finnegan, Whitehurst, & Deaton, 2010; Jolliffe & Farrington, 2007). Peer mentoring in a prison setting involves the establishment of affirmative relationships between individual prisoners and ex-prisoners, usually with the primary purpose of guiding personal development and supporting successful transition through release. There is an established literature on peer mentoring in the criminal justice system, where interventions are primarily focused on social goals such as resettlement, social inclusion and prevention of reoffending (Jolliffe & Farrington, 2007; Tolan et al., 2013). The review identified a small number of prison-based peer mentoring interventions that had a health component or reported health outcomes around improved mental health and confidence (Goldstein, Warner-Robbins, McClean, Macatula, & Conklin, 2009; Mentor2work, 2005; Schinkel & Whyte, 2012; The Learning Ladder Ltd). Peer identity was defined by a common history of incarceration, with the peer mentor usually having successfully navigated a pathway from offender to rehabilitated citizen.

Applying the conceptual framework for peer support in health care proposed by Dennis (2003), mentors offered appraisal support by encouraging reflection on choices and reinforcing of positive attitudes and behaviors; but also in some interventions, instrumental support was offered in terms of navigating the practicalities of release (Goldstein et al., 2009; Schinkel & Whyte, 2012). Unlike other peer interventions delivered solely within the prison setting, the peer mentoring interventions identified in the review crossed the boundaries between prison and civil society. For example, the 'Routes out of Prison' initiative based in

Scotland involved ex-prisoners or those with history of addictions as life coaches who met prisoners in the prison setting and also outside the gate to allow some continuity of support (Schinkel & Whyte, 2012).

Bridging roles

Bridging roles occur where lay health workers act as cultural connectors in improving access to information, support and health services for underserved communities (Rhodes, Foley, Zometa, & Bloom, 2007). In the review, two distinct interventions were identified where peer workers acted as cultural connectors and where signposting to other services was a major component. Both interventions also had a strong element of informational peer support and were explicitly focused on reducing inequalities.

Prison health trainers worked with other prisoners to motivate and support them to adopt positive health behaviors, for example healthy eating or better stress management, and provided information on other health services (Brooker & Sirdifield, 2007; Sirdifield et al., 2007). The role was adapted from a public health initiative, introduced over a decade ago in England, to reduce inequalities by recruiting lay health workers from disadvantaged areas to support individuals around health behavior change (White & South, 2012). Prison health trainers received formal training on health promotion, communication skills and mental health, adapted from a standardized competency framework (Sirdifield et al., 2007). Like the wider health trainer service, a major objective was increasing the skills, qualifications and employability of those who took on a peer worker role.

The *peer advisors* program, also a UK initiative, was focused on housing advice within prison and also during and after release (Boyce, Hunter, & Hough, 2009; Hunter & Boyce, 2009). Peer workers assessed housing needs of new prisoners or those due for release, helped with accommodation and welfare payments, and signposted to other sources of help. Like health trainers, there was a formal qualification and a focus on the personal development and post-release employment of the peer workers.

Other peer models

The review confirmed that this field of practice is diverse with peer interventions being adapted to a range of contexts and populations. It was not possible to categorize four interventions because they had very distinctive components or deviated from existing models in significant ways that were assumed to affect the way the intervention worked. For example, the ‘Alternatives to Violence Project’ used a specific cascade training model that involved peer education combined with prisoner involvement in project management structures (Walrath, 2001). Another study reported on the peer counsellor role as one component of a formal substance abuse treatment program linked to spiritual care (Chen, 2006). Two interventions, one focused on harm reduction and the other on suicide prevention, had some similarities to peer education and peer support interventions respectively; but the roles described were not sufficiently aligned to justify grouping them with existing models. Peer observers in the suicide prevention initiative watched prisoners who were at risk of suicide, but did not take on the more active peer support aspects of Listeners (Junker, Beeler, & Bates, 2005). A Moldovan harm reduction program had a single focus on improving access to health resources using prisoners to distribute condoms, needle exchange supplies and information booklets (Hoover & Jurgens, 2009). It was possible informal peer education

occurred alongside the distribution activities; but this was not the focus of the intervention. Therefore it could not be categorized as peer education.

Discussion

Peer-based interventions are complex interventions with a number of inter-related components relating to the selection, preparation and supervision of peer workers, their subsequent roles in care or prevention and the nature of interactions with the target population. The typology presented here provides a framework for categorizing interventions reported in an international literature and describing, where possible, their main features and theoretical underpinnings. It cannot be viewed as a comprehensive classification or taxonomy, nonetheless the typology does provide a means of distinguishing different intervention modes within a transparent framework related to the prison setting. This builds on earlier work, published more than a decade ago, that described existing models in practice (Devilly et al., 2005; Levenson & Farrant, 2002). While a previous systematic review highlighted the role of peer education (N. Wright et al., 2011) particularly in relation to HIV/AIDS prevention, this paper describes a number of peer support interventions, many of which are focused on promoting mental health or alleviating emotional distress. The typology therefore reflects the breadth of peer-based health interventions and provides a more complete picture than a single focus on behavior change.

The typology describes four major intervention modes that utilize the social influence brought by peers. Prison is evidently a unique setting but peer education and peer support draw on a set of justifications and principles of design that have a long history in health promotion and healthcare contexts (Dennis, 2003; Milburn, 1995). Similarly, prison peer mentoring fits within a wider field of mentoring (Jolliffe & Farrington, 2007; Tolan et al.,

2013). What appears critical in the context of correctional health care is the significance of peer identity for a population that is marginalized and experiencing barriers to good health. Justifications for peer education relate less to traditional notions of ‘reach’, but to credibility and tacit knowledge (Zack et al., 2004) and, for peer support, the ability to empathize with those experiencing stressors generated by incarceration (Boothby, 2011; Snow & Biggar, 2006). This mirrors the conclusions of Harris et al (2015) that effective community-based peer support requires peers to share experiential knowledge as equals and to form social groups and bonds.

A further issue is limits to confidentiality which vary depending on legal jurisdiction and may affect the application of peer mentoring. In the USA, there are clear guidelines on privacy through the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, which means it may be unsuitable for non-medical professionals (peers) to be involved in the support or management of prisoners with specific health conditions for fear of breaching individuals’ health status (Barraza et al., 2015). In other countries, peer workers may be able to speak confidentially with other prisoners, but may face pressure from staff to disclose the nature of their contact (Jaffe, 2012).

Limitations

The typology was developed from a systematic review of quantitative, qualitative and mixed methods studies (J. South et al., 2014) as a heuristic tool to help categorize studies so appropriate synthesis could occur. The systematic review process included systematic searching and selection; and non-evaluative studies were excluded due to the focus on effectiveness. This meant that additional literature had to be sourced to build the typology and this literature was not selected in a systematic fashion, more in the manner of purposive

sampling to gain further illumination where gaps in descriptions existed. A non-linear, iterative approach to literature searching is advocated by Finfgeld-Connett & Johnson (2013) for qualitative reviews that build knowledge or generate theory as opposed to assessing effectiveness. The final typology was refined through to an inductive process of defining, checking and sorting until saturation was reached and categorizations stood.

The typology was developed from the 57 included studies in the main effectiveness review. It is likely that a scoping review (Arksey & O'Malley, 2005) that took a more inclusive approach to searching and study selection would have uncovered further types of peer intervention in prison settings. The majority of interventions described in the typology worked with male, adult prisoners (one exception being the Canadian PST program) and more research is needed to examine the application of peer programs for young offenders and female inmates. The research team were keen to gather grey literature through contacts with experts and practitioner networks in the UK (Woodall, South, Dixey, de Viggiani, & Penson, 2015) as there was an assumption that some interventions would not be reported in the formal academic literature. Grey literature can broaden evidence sources (Bravata et al., 2005); however it can also be context specific and it was not possible to extend that search into other countries. Contact with international networks would have generated additional interventions as this is a heterogeneous field of practice. There is undoubtedly scope for more international comparisons about interventions and practice.

The sampling bias towards UK and also North American peer interventions is a major limitation of the typology. There are a number of potential explanations for the geographical spread and dominance of certain types of interventions which could affect transferability and generalizability. Whether and how peer interventions are implemented will reflect differences in legal systems between countries, differences in penal policy, types of institutions and the demographics of prison populations, and differences in the practice of correctional health

care and the organization of health systems more broadly. Despite similarities between several UK and non-UK peer support interventions, it cannot be assumed that specific programs presented in this paper are widely implemented. An international task force on suicide prevention in prisons compared eight countries and found marked differences in policy and practice as to whether peer programs were used (Daigle et al., 2007). The typology may also reflect publication bias, including country or language bias (Song et al, 2010), as well as variations in research capacity and funding between countries that influence whether intervention studies are undertaken. Overall more research would be needed to test the transferability of the typology, particularly within countries and settings not well represented in the prison literature.

Potential applications

By defining the main features and identifying underpinning theories of different peer intervention modes, the typology offers a platform for further research and theory development. This is a diverse field of practice and interventions need disaggregating if conclusions are to be drawn about their effectiveness and appropriateness. Bravata et al. (2005) identify the development of standardized definitions of concepts as a core strategy to deal with a broad-based literature. Where detailed accounts of intervention components were reported, as was the case with some of the peer education programs aimed at HIV/AIDS prevention, this allowed for meaningful evidence synthesis between interventions (Bagnall et al., 2015). Conversely, many studies did not report in detail how interventions worked; and fewer still used any explicit theoretical models. The typology provides the basis for developing more sophisticated logic models (Baxter, Killoran, Kelly, & Goyder, 2010) for

prison-based peer interventions that unpack the causal chains that lead from recruitment of peer workers to health and social outcomes in the prisoner population.

Building understandings of how prisoners can be involved in correctional health care can aid development of practice through shared learning. As demonstrated in this paper, prison-based peer interventions represent a heterogeneous group of approaches in terms of the mode of delivery, theoretical underpinnings and health focus. The typology offers practitioners and health service planners a summary of some of the options for involving prisoners in health promotion and care. A practice briefing has been produced for prison governors, officers and health care staff in prisons in England and Wales to aid knowledge translation (J. Woodall et al., 2015). There is considerable potential to explore the transferability of specific peer interventions for different prison populations, and also for inmates post-release. Edgar et al. (2011) argue that there need to be many more opportunities for prisoners to undertake active citizenship roles, such as peer support, that might be of benefit to them and others.

Conclusion

The typology presented in this paper provides a framework to map and understand the range of peer interventions in prison settings and the major modes: peer education, peer support, bridging roles and peer mentoring. This typology was developed as a part of a systematic review; and although it is not a definitive list of peer intervention types, a number of specific models from North America and from the UK are identified. It is important to recognize the heterogeneity of peer-based approaches. Not only is there a spread of health topics from mental health issues through to communicable diseases, there are also differences in

intervention design, modes of delivery and theoretical underpinnings. One conclusion of this paper is that aggregating peer approaches as a single method is not justified and over simplifies what is evidently a rich and diverse set of practices in health care and prevention.

The typology of peer-based interventions provides a set of working definitions accompanied by descriptions of program components that will be of use to those developing and evaluating peer based interventions. The paper has highlighted the scope for involving prisoners as change agents, although transferability to other contexts would need to be tested. There are opportunities for shared learning in this field and for more comparative research on what interventions work, for whom and in what contexts. There is also scope for theory development around how peer approaches mitigate risk factors and promote positive prison health. Overall, the typology provides a platform for further development of an evidence base for peer interventions, acknowledging that categorizations will evolve and expand as the body of knowledge increases.

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Table 1: Typology of intervention modes

Intervention mode	Definition	Number of studies (n=57) & country of origin
Peer education	Communication, education and skills development occurring between individuals who share similar attributes or types of experience with the aim of increasing knowledge and awareness of health issues or effecting health behaviour change. Prison peer educators can deliver formal educational interventions to fellow prisoners and/or engage in awareness raising through social interactions within the prison.	21 studies (37%) – USA (14), UK (2), Ireland (1), Russia (1), Australia (1), Mozambique (1), South Africa (1).
Peer support	Support provided and received by those who share similar attributes or types of experience. Peer support in a prison setting involves peer support workers providing either social or emotional support or practical assistance to other prisoners on a one-to-one basis or through informal social networks.	<i>Peer support – general</i> 6 studies (11%) – UK (3), Canada (2), Australia (1)
Specific peer support interventions	Listener scheme (peer support) A suicide prevention scheme, where prisoners provide confidential emotional support to fellow prisoners who are experiencing distress. Listeners are selected, trained and supported by the Samaritans and the scheme operates across most adult prisons in England and Wales, UK. Peer Support Team (PST) program (peer support) A Canadian model where women prisoners provide emotional support on a one-to-one basis to other women prisoners. The model uses a holistic, culturally sensitive approach that aims to develop women's autonomy and self esteem.	6 studies (11 %) - UK (5), Canada (1) 6 studies (11%) – Canada

	Insiders (peer support) Volunteer peer support workers who provide reassurance, information and practical assistance to new prisoners on arrival in prison.	2 studies (2%) - UK
	Prison hospice volunteers (peer support) Prison hospice volunteers provide companionship, practical assistance and social support to terminally ill prisoners. They work as part of a multidisciplinary hospice team.	3 studies (5%) - USA
Peer mentoring	Peer mentors develop supportive relationships and act as role models with mentees who share similar attributes or types of experience. Prison peer mentoring involves prisoners or ex-prisoners working one-to-one with offenders both in the prison setting and ‘through the gate’. Prison peer mentoring schemes focus on education and training and/or resettlement and prevention of reoffending.	4 studies (7%) - UK (3), USA (1)
Bridging roles	Bridging roles involve lay health workers acting as cultural and social connectors for underserved communities. In the prison setting prison peer workers provide informational support and connections to health and welfare services.	
Specific bridging interventions	Prison health trainers (bridging) Prison health trainers work with fellow prisoners around healthy lifestyles and mental health issues. Prison health trainer schemes are adapted from the community-based health trainer model where lay public health workers use a client-centred approach to support individuals around health behaviour change and/or to signpost them to other services.	2 studies (4%) - UK

	Peer advisors (bridging) Peer advisors provide housing and/or welfare benefits advice to other prisoners, particularly new prisoners and those planning for resettlement. Some peer advisors support prisoners ‘through the gate’ when prisoners leave prison.	2 studies (4%) - UK
Other intervention modes	Other interventions not categorised in the review: <ul style="list-style-type: none"> • Peer training (violence reduction) • Peer outreach (harm reduction) • Peer observers (suicide prevention) • Peer counsellors (substance misuse) 	1 study (2%) - USA 1 study (2%) - Moldova 1 study (2%) - USA 2 studies (4%) – UK (1), Israel (1)
