

Review Article
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An Innovative Nursing Management Solution to Improve Community-Based Health in Prisons: Modelling in Ireland for a Global Approach to Community-Based Health in Detention

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ABSTRACT

People deprived of their liberty are often vulnerable due to poor health and living choices. These can include drug addiction and associated blood-borne virus risks, amongst people who Inject Drugs (PID).

Prison populations also include people who have neglected their health, suffering chronic Non-Communicable Diseases (NCD) as well as being vulnerable to violence in prisons.

The nature of prisons requires its organisation into regimes in order to manage the large populations whilst also providing safe and secure custody. As a result, clinical care, drug administration, nursing interventions and mealtimes for both prisoners and staff must be managed according to tight time windows.

The role of nursing in Irish prisons needs to fit into the organisational regimes of the prison. Experience has indicated that the important nursing role in providing community-based health awareness is limited due to the existence of regimes.

Following an audit of prison healthcare in Irish prisons, the need to provide an innovative solution to community health and wellbeing awareness within the community was apparent.

A model originally developed within the Red Cross/Red Crescent Movement, using community members as peer educators was adapted, planned and implemented as action research in one prison and then extended to all prisons in Ireland over a five-year period.

This innovative nursing management solution required the adoption of the WHO (2007) 'whole prison' approach to health and the organisational changes to effect it.

The theoretical underpinning of the project was based on systems theory, the fractal models of chaos theory and complex adaptive systems.

Following fifteen years of successful operation in Irish Prisons, a Global Hub for community-based health in Detention was established in Ireland. Using the Irish model, Community-Based Health in Detention was piloted in Northern Ireland, Wales (UK), Australian and Norwegian Prisons. Evaluations in Ireland and internationally identified the important value of training prison inmates as peer health educator volunteers linked to prison healthcare units.

This paper explores the development of a successful working model of peer health educators as an extension of nursing. It has resulted in reduced violence, increased health screening participation and increased self-esteem and mental health amongst prisoner peer educators. The use of the theoretical principles underpinning the Irish model in other jurisdictions is described.

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Introduction

A creative nursing management approach to improving community health, well-being and safety in Irish Prisons is presented, utilising peer education. It is an example of partnership development between three organisations – Irish Prison Service, the Irish Red Cross and the Prison Education system. In addition, the approach created the opportunity to break down departmental silos, thus encouraging the WHO (2007) Whole Prison Approach to health.

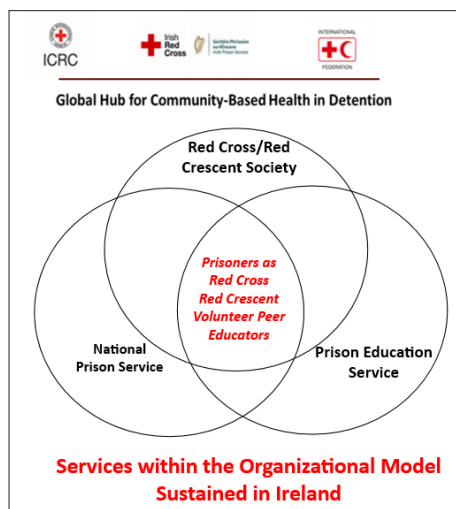


Figure 1: Partnership Development of Three Organisations to Facilitate Community-Based Health in Irish Prisons

The project utilised the expertise and cooperation of all three organisations in order to create one integrated training programme for prisoners as peer health educators, linked to professional nursing input for health education training and oversight in each prison in Ireland (Figure 1).

This paper will present the Irish Community-Based Health in Detention (CBHinD) programme as a model of peer-led health education, developed within an Action Research Framework over the period 2009-2015 in Ireland. The educational strategies were drawn from systems theory its subsets of chaos Theory and Complex Adaptive Systems. This is a novel approach to learning and organisational change [1].

It was designed to facilitate change, not only in volunteer peer educators, but the staff and prisoner community as a whole system change.

The theoretical underpinning of the programme design is presented later in this paper. It follows an earlier proven methodological approach used by the author (2000-2006) in the context of community disaster preparedness and risk reduction training [2-3]. Research between 1987 and 1999 was conducted in the context of disaster response training for nurses and in nursing management courses [4-5]. The studies investigated perspectives transformation for creative problem-solving using curricular models based on chaos theory and deep reflective learning.

The Irish Community-Based Health in Detention programme (CBHinD) has continued in Irish Prisons from its inception in 2009 to the present time. Its sustainability and longevity has led to the formation of a Global Hub for Community-Based Health in Detention in 2022 within a Memorandum of Understanding between the Irish Red Cross/Irish Prison Service, the International Committee of the Red Cross (ICRC) and the International Federation of the Red Cross & Red Crescent in Geneva.

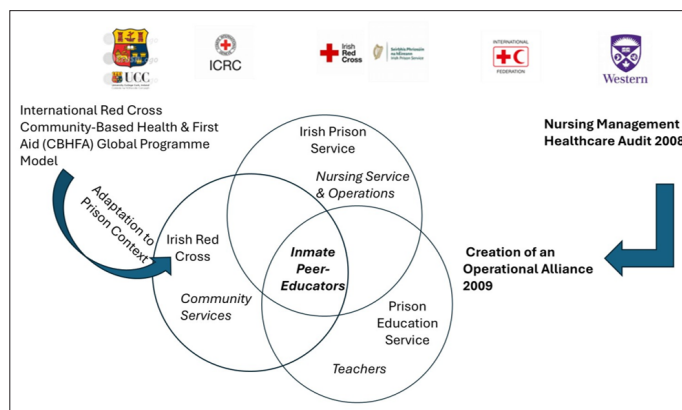


Figure 2: The development of the Nursing Management solution for Community-Based Health Education, creating a WHO (2007) ‘Whole Prison Approach’ to Health in Irish Prisons through a partnership between three organisations in 2009.

The paper will explore the significance of this scaling up of one national model for Community-Based Health in Detention, emerging from a nursing management solution for improved prison community health. This replicable model has been made possible through the creative use of educational theory in which both chaos and order coexist.

A Nursing Management Audit of Prison Healthcare

The initiative emerged from a Nursing Management Healthcare Audit of Prison Health in Ireland as the platform for identifying a community health education gap in services.

The audit examined all elements of health care including infrastructure, equipment and service availability that ensures care equitable with those available in the wider community.

Medical and nurse staffing was reviewed, external specialist in-reach clinics and the systems to ensure timely referral to external hospital facilities where appropriate.

In line with a proactive approach to health, the audit included mechanisms for community-based health education and awareness. This was considered an essential component of fostering preventive health, wellbeing and safety for prisoners and an environment conducive to a healthy and safe working environment for staff.

Prisoners are a vulnerable part of Communities (iCRC) in relation to health, wellbeing and safety.

The audit included work study activity analysis, identifying that the nursing time available of prison nurses precluded significant opportunities for effective community health education by nurses.

The requirements of security and the organisational logistics of prison management, identified the regime-focused operational priorities that were time-bound around which health care activities needed to be provided. Even though, nurse staffing might appear adequate, the organisational structure of prisons may be divided into up to six geographical locations.

This requires that a registered nurse is able to be operational at each location at the same time windows for specific activities.

These include medications administration, addiction services administration of Methadone, clinical activities including phlebotomy, dressing clinics, urine screening clinics for monitoring addiction management, operating GP Doctor’s surgeries, urine and other clinical interventions.

The analysis of the available clinical hours, exclusive of morning, lunch, afternoon and evening breaks for prisoners and then staff, leaves relatively short periods available for community health education.

Whilst some health education may be imparted as part of clinical activities, there is limited opportunities for dedicated Community-based health education in meaningful way.



Figure 3: An example of a prison regime which has an ordered rigid timetable around which health interventions must fit

The nursing management approach emerging was to provide simple and focused learning opportunities for prison inmates to be trained as peer educators. This creative way to provide health education linked to nurses is a systems change which fits into a context in which both order and disorder can co-exist.

The nursing role has always included health promotion activities. The added value of providing this training to groups of inmates in each prison as peer educators, could be transformational.

There is a wide body of knowledge supporting the effectiveness of peer education [6-8].

Nursing management’s prior experience within the Red Cross / Red Crescent Movement, was helpful in the development of a solution. The Community-Based Health Programme (IFRC 2009) as an action-learning methodology, was designed by the author and operational in excess of 100 countries world-wide. In this, local communities in villages and towns were trained as Red Cross/Red Crescent volunteer peer educators and linked to local nurses in Health Clinics.

This model was adapted in 2009 to the prison context, where parts of prisons would be aligned with ‘neighbourhoods’, specific parts of prisons could equate as ‘streets’ and prison cells as Households with one to three occupants as pseudo-family groups.

The Training Modules the Community Based Health in Detention The Content of the Community-Based Health Programme has a structured format and includes:

- Red Cross/Red Crescent Volunteering and knowledge
- Community Information and mobilisation

- Principles of behaviour change
- Community Assessment
- First Responder and Psychological First Aid.

The health topics taught to Red Cross peer educators are related to health problems identified in the community assessment.



Figure 4: The Modular Structure of for Inmate Red Cross Volunteer Peer Educators Delivered by the Nursing Practitioner, Teacher and Psychologist in each of Ireland’s Prisons Nationally.

An Action-Research framework was planned and implemented as cycles of Action Research in one prison, evaluated and the lessons learned applied to the next action research cycle until all Irish Prisons were included.

Evaluations

These were Conducted in 2010, 2013, 2018 and University-led evaluations conducted in 2015 and 2023. Over the fifteen years, approximately 2,500 inmates were trained in Ireland. This ensured that at least 10 new inmate volunteers graduated in each prison every year from 2009 to the present.

The continuous training of new peer educators each year compensates for the inmate volunteers released from prison. This has provided a fairly constant rate of 5 – 8% of the inmate population in each prison are conducting relevant health education activities throughout the year.

Some Examples of Health Projects and Campaigns Undertaken by Inmate Peer Educators Linked to Formal Health Systems

In Irish Prisons, volunteer inmate peer educators may provide over eighty health awareness campaigns in the prison communities across Ireland with supervision from nurses, psychologists and teachers. The topics chosen are based needs identified in a community health assessment conducted at the beginning of training. The assessment involves inmate peer educators talking to key informants such as the prison nurse, doctor, psychologist and addiction counsellors.

Some Examples of Peer-led Health and Wellbeing Projects are Presented Here.

Social Inclusion Activities in the Womens’ Prison

The Female Red Cross volunteers in the Dochas Centre focused significantly on social inclusion within their community with various projects. These were identified, planned and implemented by the IRC inmate volunteer peers and women prisoners. They included Knitting Groups, Sharing and caring and community walks in the Prison Yards.



Sharing and Caring Project in the Dochas Women’s Prison

A popular project that brings the community of women together are knitting projects in the Dochas Centre. These items are donated to good causes.



The Knitting project and exercising together promotes community spirit whilst also contributing to healthy living and mental health wellbeing

Figure 5: Red Cross Peer educators leading Social Inclusion Activities in the Female Prison

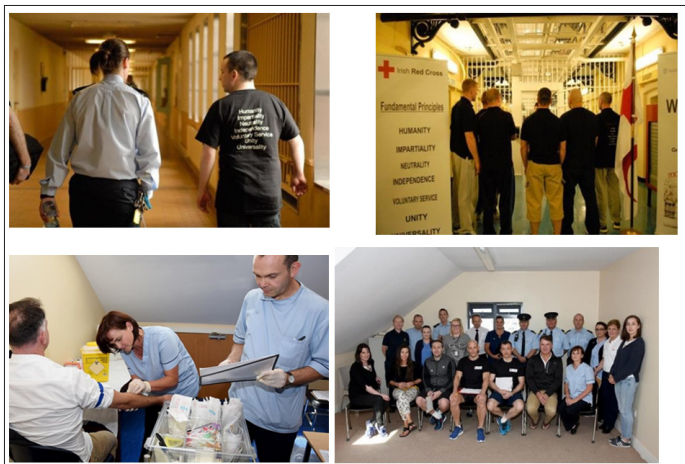


Figure 6: Prison-wide Mass Voluntary Hepatitis C Testing Campaign with the Nurse-led project Conducting

Clinical phlebotomy (bottom left) and Inmate Peer educators being deployed for awareness-raising and advocating for testing (top left and right) The multi-disciplinary team and inmate peer educators (bottom right) reflect the WHO (2007) Whole Prison Approach to Health.

This health campaign was organised by Prison Healthcare professionals, linked to specialist inreach services for Hepatology. The mass Hepatitis C screening project was organised on the WHO (2007) whole prison approach to health mobilising nurses, medical staff, counsellors, prison officers and management to ensure the involvement and cooperation of all staff.

Prior to the campaign, Hepatology nurses provided the inmate volunteer peer educators with information on Hepatitis C and advocacy skills to conduct an awareness campaign in the two weeks prior to the start of testing. This approach was well received by the prisoner community as inmate peer educators were able to provide information in a way that the community could understand it.

Results

80% of the prisoner population attended for testing due to inmate peer educator advocacy. Qualitative interviews conducted after screening indicated the main reason for getting tested was because of the peer Red Cross volunteers’ encouragement. In addition, the peer educators received their screening before the general prisoner community in order that they could reassure others.

19 new cases of Hep C were identified and entered into treatment plans providing curative treatment and removing them as an infection risk in the community.

The Health Economics

Cost of Mass Screening	30,443 Euros
Cost of treatment of 19 cases	171,000
Cost of life-time management of Chronically infected person	216,000
Lifetime cost of 19 people not detected	4,104,000
Societal cost savings 19 people with normal life cycle	3,902,557
19 people not infecting other	

Good Practice Exemplar: HSE Public Health National Protection Office

Irish Red Cross Community Based Health in Prisons Programme to Improve the Knowledge and Awareness of TB Among At-Risk Groups

All prisons in Ireland have Irish Red Cross volunteers in place as community advocates in all aspects of health and well-being. The values by which the Red Cross abide by are humanity, neutrality, impartiality, independence, voluntary service, unity, and universality.

Since 2009, people that are currently either on remand or are serving a sentence in prison are invited to complete an innovative Red Cross peer-peer health education and awareness programme. Many of those who complete the programme progress on to become Red Cross volunteers. Operational, health care and education staff within the prisons collaborate to effectively support the programme.

In one prison, the Red Cross volunteers were instrumental in engaging others in the prison to become involved in a TB research study. The volunteers delivered information sessions about TB and the study to their peers prior to the study commencement.

All of the Red Cross volunteers also participated in the study, enabling them to speak about their experience with others in the prison, helping to build engagement. This exemplar illustrates an innovative agile approach to reducing health inequity among a vulnerable group.

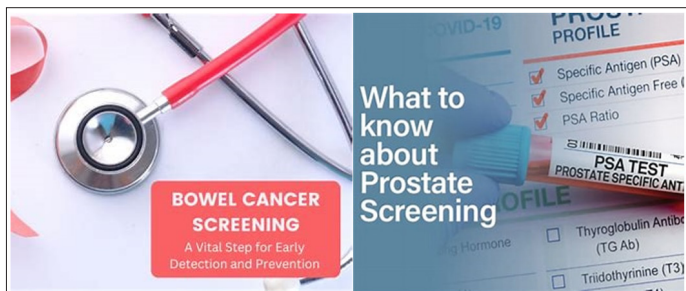
Box 1

Striving to End Tuberculosis – A Strategy for Ireland 2024 - 2030 outlines the priorities, objectives, actions and enablers to end tuberculosis in Ireland, HSE Public Health National Protection Office

Chronic Disease Management Initiative in an Irish Prison

The Irish Red Cross has inmate IRC volunteers in all prisons in Ireland who engage in peer-supported awareness-raising and advocacy for engaging with professional health and psychology services. Such activities include supporting addiction services, mental health well-being, prevention of non-communicable diseases, violence prevention, vaccination and screening support.

In one prison, a very proactive nursing team are responsible for men of varying ages and have taken the initiative to focus on Chronic Disease Management and the proactive screening for cancer affecting the prostate, bowel and skin, which is common in Ireland.



The role of inmate Red Cross volunteer peer educators is to provide awareness and advocacy about these common chronic diseases. They direct prisoners to healthcare services in order that screening can be offered.

Figure 8: Chronic Disease Management Project

The ‘Do No Harm’ Principle of Inmate Community-Based Health Volunteering

The training of health topics are provided in each prison by a Programme-dedicated nurse practitioner who also provides support for project planning, implementation and evaluation, along with the course teachers and psychologists. Their role is clearly understood to have two main purposes:

- 1) The raising of health awareness and advocacy for screening activities through nurse-led or psychologist-led campaigns and
- 2) directing inmates to professional care as needed.

There is a clear separation of roles between inmate volunteers and professional nurses and psychologists. Volunteer functions are limited to providing health and safety messages and sign-posting to professionals. Inmate volunteers do not provide medical or nursing advice.

Locally produced health education posters are created by peer educators in picture format and/or simply-worded messaging. This is important to ensure that information is provided in clear and easily understood messages.

To ensure quality assurance, all materials created by inmate volunteers and their teachers, are approved by the Programme Nurse or Psychologist for accuracy before distribution.



Figure 9: The International Global Hub Training Centre at the Irish Prison Service College, Ireland

International Training Courses Using Systems-Thinking methods including Chaos Theory and Complex Adaptive Systems, facilitated by the author and the Irish CBHInD Programme Team of Irish Red Cross, Prison Nurses, Psychologists, Teachers and Prison Governor/Directors

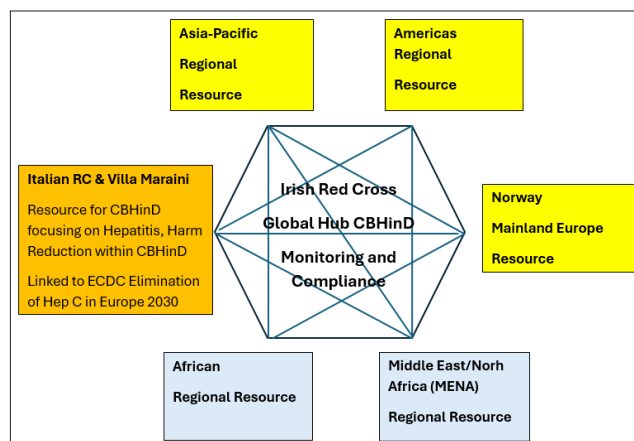


Figure 10: A Fractal model of the Longer-term vision (2022-2050) of the scaling up of the Irish model of Community-Based Health in Detention (CBHInD)

Most prison systems internationally have prison nurses as part of their formal health systems. This common denominator provides the potential opportunity for Nursing-led models of CBHInD in other jurisdictions. Examples of international scaling-up pilot projects through training and implementation support from the Irish Prison Service/Irish Red Cross since 2014 are shown in Figure 10 below.



Figure 11: International Scaling up of Inmate Peer Health Education by the Irish Red Cross and Prisons Service partnership using Prison Nurses as Facilitators in Australia and Norway



Establishing Basic Standards to Enable the Selection of Potential National Societies and their Detention Services to ‘Do No Harm’ in Implementing CBHinD.

The principle of ‘Do No Harm’ is of paramount importance in considering Movement interactions in detention settings. Work on this was engaged upon in 2022 whilst negotiating the MoU between ICRC, IFRC and IRC, it was further ratified and agreed by all three parties to the agreement.

It took the form of a Flow Chart, where a national society and its detention authority was required to ensure that the standards identified could be met. It was agreed that where a particular standard was not met, advice could be given through ICRC on changes to be made, after which, CBHinD might be approved to progress.



Figure 12: The Flow Chart Used as part of the ‘Do No Harm’ Assessment in other countries prior to planning and implementing the Red Cross/Red Crescent Community-Based Health in Detention Peer Educator Programme

Developing a Framework for Global Hub Operation

The Framework for the Global Hub was developed by the Global Hub team in collaboration with ICRC and IFRC Geneva. This was to create a clear understanding of the categories in which the Global Hub would be responsible.

The Framework identified two main spheres of activity. One was Operational where the Global Hub would support the training and implementation of pilot CBHinD projects in other jurisdictions.

The second Objective of the Global Hub would be its Organisational component. This was about developing the Global Hub as an action research centre for gathering lessons learned from Operational activities, information base, quality assurance and knowledge sharing.

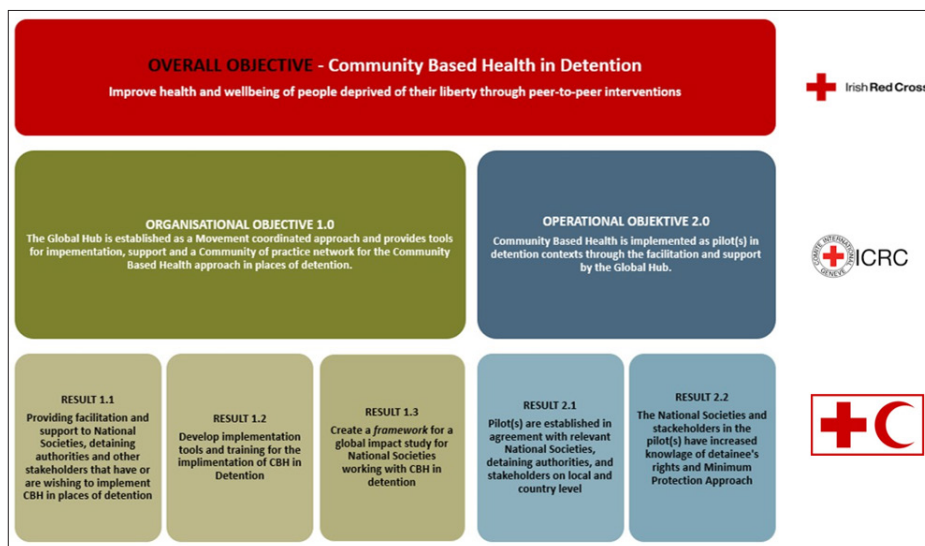


Figure 13: Framework for the Global Hub for CBHinD

Developing the Building Blocks of CBHInD as a Part of Complex Systems

Significant time was devoted to identifying what we have termed the ‘Building Blocks’ that would be used for designing the training structure and methods that might be transferable across culture and organisational behaviour.

These building blocks emerged from our review of Irish, Norwegian and Australian CBHInD models, each of which were different but shared a common core of essential components. These building blocks were defined as:

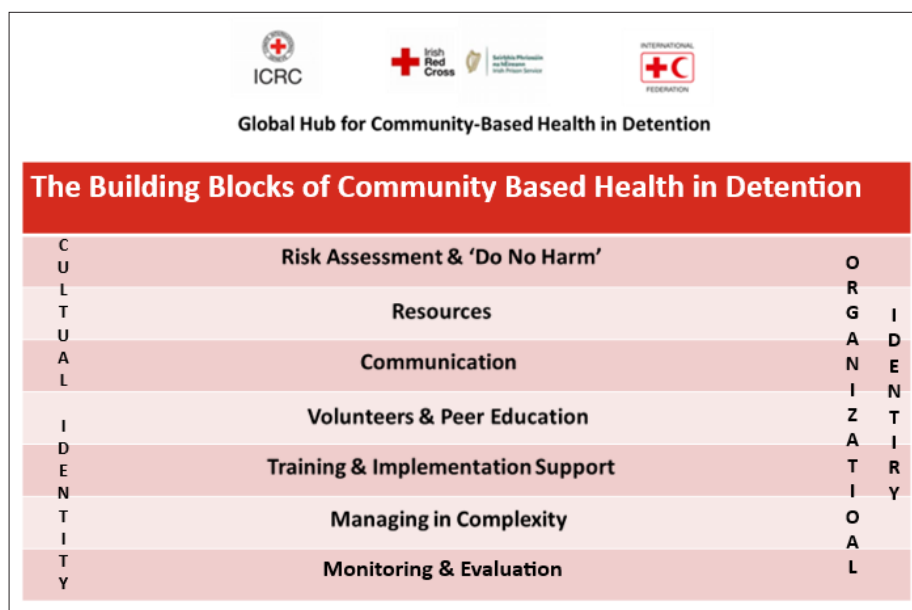


Figure 14: The Common ‘Building Blocks’ that can be used internationally as the order of a fractal model, co-existing with the disorder (chaotic) random elements of individual country organisational and cultural differences

To create a CBHInD project in different prison contexts, Chaos theory is a useful model as it displays both unpredictability and order. Applied to CBHInD in complex systems, the Building Blocks represent order and everything else unpredictability. Highlight several determinants of transfer success which includes the contextual fit between the intervention (CBHInD) and the new environment (target country).

Human behaviour is partially chaotic and therefore affects both prisoners and staff in a prison context. Decisions, emotions, and interactions are influenced by numerous factors that interact nonlinearly with the context of the environment. Relationships, for example, can oscillate unpredictably, yet underlying patterns often guide long-term dynamics. It suggests that unpredictability is not a flaw but an inherent feature of adaptive systems.

Planning for the International Scaling of CBHInD Peer Education into other Jurisdictions

The planning, implementing and evaluating new national pilot projects in other jurisdictions is a complex process that requires activities that train the trainers and supports ‘whole systems change’. This is because providing inmates with peer-education skills in isolation from systems change and staff perspective transformation is likely to result in conflict, inmate volunteer demotivation and systems breakdown.

Internally, within the prison system, imprisonment tends to disempower inmates. Creating Red Cross peer educators actually re-empowers prisoners. Pre-existing beliefs and values of staff may be perceived as a threat. Corresponding training/capacity building of staff members, is essential prior to programme implementation [10].

Essential Preparatory Activities Prior to Acceptance into the Three-Phase CBHInD Training

The process of taking a national society from a state of interest in CBHInD to implementing a pilot project can be prolonged. This is because negotiations must take place between the national RCRC, its Prison Authorities and Ministry of Health as the basis for a collaborative partnership. Experience has shown that this process may take varying periods of time (see figure 14). Such variations in preliminary planning amongst different countries may preclude being able to have several countries attending Phase 2 Training in Ireland at the same time.

It is more likely that countries may require staggered three-phasing support and this is an important factor supporting the need for longer-term approaches and funding streams.

Following cooperation agreements to support a CBHInD pilot project has been agreed between the Red Cross/Red Crescent Societies, their Prison Services and Health Ministries, a process of information gathering and fact finding needs to be undertaken.

The Global Hub, in collaboration with ICRC and IFRC needs to investigate the nature of how the relevant RCRC and its prison service is structured and operates. There needs to be a screening process of the National Society and Prison Service through a risk assessment.

The IRC/ICRC/IFRC Flow Chart and Standards must be discussed with the target RCRC society and prison service as well as discussions with the ICRC and IFRC. The purpose is to ensure that the Do no Harm principle can be upheld with the implementation of the project.

In some cases, a site visit may be undertaken, depending on funding to increase the Global Hub understanding of the target prison, its organisation, staffing and selection of Pilot team leaders and instructors.

These preparatory processes may take at least six months before the three-phase programme can be safely implemented. These factors illustrate the importance a longer-term approach to both programming and funding

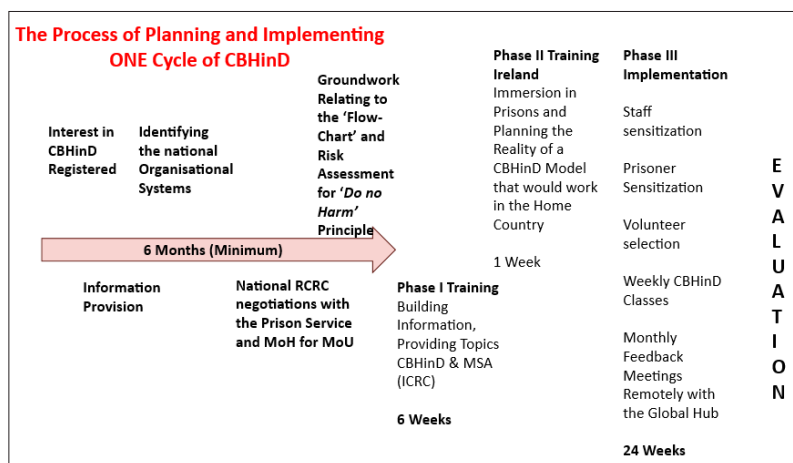


Figure 15: Planning of the Process of CBHinD Training and Implementation Support in Other Countries The Three-Phase Training/Implementation Plan and Volunteer Selection

The purpose of Phase 1 is to build a picture of how the target country prison works that might facilitate a CBHinD pilot project. Essential information about the CBHFA model and the importance of the ICRC Minimum Standards Approach is provided as a backdrop to the project along with Systems Thinking.

Phase 2 is provided in Ireland by the Global Hub and National CBHFA Programme for Immersion in the Irish working model. Essentially Phase II is also about identifying how the target country CBHinD pilot could utilize the common building blocks and reassemble an organisational and culturally sensitive pilot project.

Phase 3 is the pilot Implementation phase of 24 weeks. In this period staff sensitization and prisoner awareness about the CBHinD Programme and the role of inmate RCRC volunteers. It is essential that volunteers are connected to the Healthcare Department for health education oversight and clearly defined role as peer educators (1) providing health and wellbeing information and (2) directing inmates to professional health and psychology services. There must be a separation of volunteers and Health Professionals and management understanding that volunteers cannot replace professional staff.

There needs to be an inmate selection process which may begin through self-referral, recommendations from teachers or other staff.

An essential screening process is required for all applicants by the prison intelligence system to ensure that prospective volunteers are not known to be involved in illicit activities, drug trafficking, history of bullying and Violence. The purpose of this is to protect the Red Cross/Red.

Evidence of the Importance of an IRC/ICRC/IFRC Global Hub Three-Phase Approach to CBHinD Training and Implementation

Preparatory visits were made in prisons in Mexico, Honduras and Columbia. These visits were illuminating in highlighting some key issues relating to the importance of having a Global Hub for CBHinD partnering ICRC and IFRC.

The dangers of attempting to copy the Community-Based Health in Prisons programme in Ireland, replicated in Mexico without contact or training, highlighted some significant shortcomings.

Unknown to the Irish Red Cross, the Mexican Red Cross had been operating CBHFA in Prisons for nine years. Concern exists as the 'do no harm' principle is unable to be guaranteed and may reflect on the Irish Red Cross and the Global Hub.

Another example of the need to use the three-phase training and support model of the global hub is apparent in Honduras. In 2014, a one-off training was requested to support the Honduran Red Cross to implement CBHFA in two prisons. The funding was provided for the one-off training and for a return evaluation visit after 12 months.

The training was successful in that after one year, volunteers were still operating in the two prisons. In one prison, interviews with key informant medical staff and volunteers indicated that basic hygiene and health messages were being conducted. Health staff and volunteers indicated that there was a good two-way communication providing healthcare with relevant timely information of health problems. Health staff were using volunteers to disseminate health messages and there was a reduction in diarrheal diseases.

In the second, more violent environment, there was a significant reduction in the number of murders, prisoner-on-prisoner.

However, the Honduran Prison Service suffered numerous changes in management from civilian to military and back again. As a result, since all management tiers changed frequently, the CBHFA initiative failed.

These examples from Mexico and Honduras underpin the importance of the stability and standards of training, implementation and supervision that can be assured through the Global Hub for CBHinD and its three-phase continuity. It reinforces *from experience* that CBHinD is a 'learning process' which is dangerous and unsustainable as a 'one-off' training.

Box 2

Lessons Learned Contributing to a Three-Phase Training/ Implementation CBHinD Approach Research

Crescent Movement and Emblem to ensure the integrity of the Movement. Those applicants approved by Intelligence proceed to interview and selection.

The basic modules of the CBHFA approach adapted to the prison context is provided to volunteers by agreed instructors. Each weekly session should include basic awareness of health and wellbeing topics relevant to prisoners. A plan of peer education of the classroom learning in simple terms is planned for each week. An essential part of the programme is that there is integration of classroom learning and project action in the community.

Recent Research Studies

A University College Cork study ‘Exploring the Impact of the Community-Based Health & First Aid Programme Amongst People in Custody’ is a mixed-methods study. It uses semi-structured interviews for thematic analysis and numerical values using psychometric measures at time 1 (start of the training) and time 2 (at the conclusion of volunteer training). The study utilizes secondary data from a two-year period in a ten-year longitudinal study.

The study indicates a statistically significant improvement in mental health wellbeing and self-esteem in prisoners participating in the CBHinD programme.

This is an important finding as it brings quantitative evidence that supports the qualitative findings of earlier research and evaluations (Abiodun 2015; Braich et al 2023).

From the Global Hub’s perspective, it provides a potential evaluation tool relating to a potential strategy for improving mental health and self-esteem that can be utilised in other jurisdictions to test its generalization further.

A study by University of Western Ontario, Canada undertook a ‘Review of the Evolution of the IRC Global Hub for Community-Based Health in Detention Programme Across International Contexts: A realist Approach’

The study is a ‘realist’ approach which reviews the CBHinD programmes of six countries and asks the question ‘what is it about this programme that works, in what context, how and why?’ It was commissioned to be used as a grounding document for how the Global Hub should be developed internationally through the lessons learned across six country pilot projects. These included Ireland, France, Honduras Norway, Australia and Columbia.

Using the ‘realist approach’, it looks for the three main tenets of Context, Mechanisms and outcomes. Through this, the lessons learned direct us to those mechanisms that optimize outcomes in different contexts.

It reinforces the importance of context, the value of complexity in understanding organisational and individual behaviour. For CBHinD to function not just as a promising intervention but as a sustainable system reform, it must be integrated into institutional logic, not merely appended.

The literature on complex systems and institutional science affirms that innovations are more likely to be sustained when they are congruent with existing routines and goals, rather than positioned

as externally driven reforms.

These ideas emphasise the importance of a three-stage embedding of CBHinD into the fabric of carceral life, as opposed to an externally driven course.

The Theory, Education and Organizational Principles Underpinning a Global Hub CBHinD

This part of the paper, focuses on explaining the importance of the process methodology of CBHinD. It has been developed through educational action research over many years and in different training contexts and research studies [12-15]. The impact of change occurring in inmates trained as volunteer health educators has also been published [16].

Other earlier contexts have included the development and implementation of IFRC Vulnerability and Capacity Assessment training/implementation between 2000-2005 and the design of CBHFA global action Learning approach to Community-Based Health.

The theoretical background underpinning the methodology is evidenced in the Irish national CBHinD programme that has been sustained and embedded in the Irish Prison Service over sixteen years.

The original vision of the IRC Global Hub in the period leading up to the establishment of the MoU in 2022, was a long-term commitment, evidenced by the five-year timeframe needed for CBHinD to become fully established.

This vision was supported by Irish Red Cross senior management and its Board at the time. It included a potential plan to train and implement regional CBHinD resources over 10-20 years with the Global Hub in Ireland overseeing quality, standards and monitoring.

Such a vision was supported by ICRC who recognized the opportunity to establish improved standardisation of effective community health in prisons ensuring the ‘Do no harm’ principle is central to Global Hub supported programmes.

The regional modelling approach facilitates two important elements of successful change – regional cultural and linguistic training and implementation support. This supports the notion that sameness rather than difference creates greater rapport between trainers and students.

The Evidence-Based History of the Action-Learning Model of CBHinD

The Global CBHFA model of Action-Learning (published by IFRC in 2009), was designed and field tested in Asia Pacific and Africa regions by the current Advisor to the Global Hub and then adapted to prison contexts in Ireland between 2009 and the present.

The methodology, researched and developed over some thirty years integrated strategies in educational psychology designed to develop second order change strategies into training and learning curricula.

Traditional training programmes have typically focused on delivering trainings based on a linear approach as separate entities in themselves. Such methods do not always lead to the transfer of training into transformative learning and action.

Transformative learning leads to second order change. Described the difference between first and second order change, where old rigid first order patterns can be broken. It is about using strategies in learning that create a shift in the rules or assumptions of a system using inductive rather than deductive methods [17].

Inductive systems capable of bottom-up problem-solving are more likely to endure and evolve effectively over time [18]. Such approaches are more likely to generate trust, interpret prison community needs and enhance system-wide responsiveness.

Evidence of transformative learning indicating second order change amongst inmate volunteers of CBHinD has been demonstrated in several studies.

Qualitatively, demonstrates linguistic structures of thought processes representing the neurological levels in figure 5, changing from self-limiting at time 1 (before training) to positive outlooks at time 2 (after training). used psychometric measures at time 1 and time 2, demonstrating statistically significant improvement in mental health and self-esteem.

Similar impacts of CBHinD have been Demonstrated in Norway [19-21]

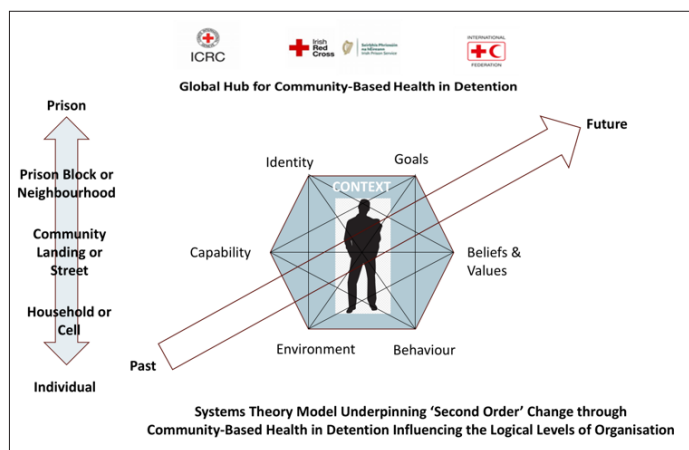


Figure 16: Change model derived from a linear model by developed by the author as the basis for the changes that occur through the CBHinD transformative learning process at all logical levels, through time, from individual to prison level.

The emergent CBHFA in Action methodology published by IFRC in 2009 integrated action-learning that encouraged transformative learning and this was adapted to the Detention context.

Prior to this, the approach was used between 2000 and 2005 as a strategy for training and implementation of a process model of Vulnerability and Capacity Assessment (VCA) for community-based disaster preparedness and risk reduction.

These programmes were based on models developed in educational research between 1987 and 2008 in the fields of disaster response training, military pre-hospital care and nursing management programmes.

It is important to acknowledge that the CBHinD programme is a process model and not a simple content model. Evidence is drawn from the national programme and in replications in Norway and Australia, that the process of implementing the second order change occurs over time.

Second order transformation is a necessary for successful CBHinD which is a complex process resulting in ‘learning about learning’ why changes in health behaviour are relevant. This is different to first order change where people simply comply with instructions from professionals.

Complexity reflects the relationships between the parts of the Prison system, the sum of which are greater than the whole of the system and all parts of the system are connected [22].

Implementing and embedding CBHinD involves a complete change in one part of the prison system by introducing inmates as health education volunteers.

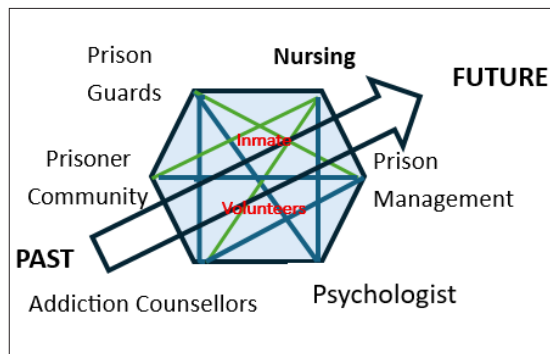


Figure 17

Living Through Time Model (Betts-Symonds in IFRC 2006; 2007; 2009 derived from a linear model by Dilts 1991 Inducing second order change where changes on one part of the system leads to changes in the whole system. Changes in behaviours will be influenced by changes in the higher levels of capabilities, beliefs & values, Identity and goals. This affects all parts of the human systems in figure 17 to change to embed CBHInD within the prison system. Each of these disciplines needs to change their belief sand values (figure 18) about how they accept, and therefore, support the role of inmates as Red Cross volunteer Peer educators in prison.

Experience has shown that providing a one-off training to other jurisdictions in Ireland alone, is not conducive to the actual successful implementation of CBHInD in the home countries. Equally, experience of providing one-off trainings in the home country without preparation and follow-up as in the 2014 Honduras project, led to similar programme failures.

Further evidence has emerged from the IRC bilateral support trainings that were conducted in Ireland between 2014 and 2019. In this period, Irish Red Cross/Irish Prison Service provided several international CBHInD trainings in Ireland attended by up to thirty country national societies.

Of these, only Norway, Australia, Northern Ireland and Wales (UK) progressed to implement CBHInD. In all four cases, there had been some prior informal preparation activities before attendance at the training in Ireland. These countries were also provided with post-training remote consultation meetings, at their request. Evaluation indicated that successful programme implementation was partially due to this factor as well as joint attendance at the Irish training by both national Red Cross society and their respective prison service representatives.

The evidence-based learning from this period logically contributed to the design of the Three-Phase training/implementation approach of the Global Hub. This learning and the evidence of the five-year timeframe required for the Irish national programme to become an embedded part of the Irish Prison Service system, supports the logic of the three-phase training within longer-term strategies.

The need for longer-term approaches is also related to the complex nature of prison operations and the human systems involved where changes in the way that prisoners are perceived by different disciplines and levels of organisation must be facilitated.

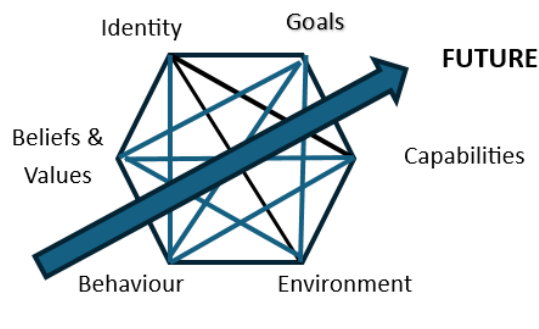


Figure 18

Volunteers, the prison community and staff need to change as demonstrated in figures 16 and 17 and this can only occur inductively over time. However, it is important to recognize that changes in how inmates are perceived as credible parts of the prison health system requires a shift in beliefs and values (figure 17)) as part of the whole system in figure 16. CBHInD is more than simply delivering a simple package of training and implementation rules to inmate volunteers in a limited timeframe. It is about changing all of the parts of the system in figure 16.

There are perceived challenges to professional territory, such as the role of nurses, and experience in Ireland and other jurisdictions require these issues to be addressed over time.

With the implementation of CBHInD, there is a complete change to long-established beliefs and values about the perception of prisoners, staff and the role of inmate volunteers. Historically, prisoners have tended to be disempowered but with the advent of CBHInD, empowerment is central to success and this can be threatening to staff.

Theoretical Underpinning of CBHInD

The overall context of the process change model of CBHInD is based on Systems theory (Butz 1992) and its subsets of chaos theory and complex adaptive systems applied to learning and organisational behaviour.

The Action Research in the history of the development of the process training strategy in CBHInD, has identified two distinct models. These reflect the second order changes apparent in different training contexts and at all levels of organisation.

Change that is embedded and sustainable requires a longer-term approach as all parts of the system need to be connected, with gradual change in terms of accepting and supporting inmates as Red Cross volunteer peer educators. Theoretically, Logical Levels of organisation is relevant to the idea of whole-system change at individual, community and prison level (Figure 3) [23].

To be able to create second-order change in the prison system to support CBHInD, it is useful to consider chaos theory applied to organisational change. Argues that it provides a useful theoretical framework for understanding the dynamic evolution of industries and the complex interaction between industry actors [24].

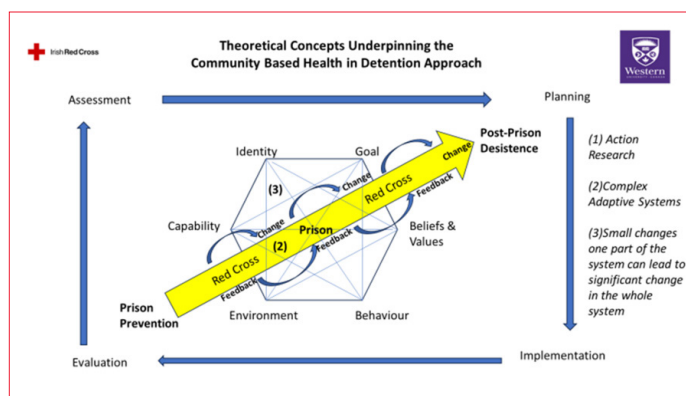


Figure 19: Theoretical Underpinnings

As a system, prisons are complex in which the co-existence of both order and chaos need to be accepted as a normal model of human systems reality [25].

In terms of education and training, this is a novel approach. Traditional models of training are essentially linear with fixed curricular models and training programmes reflecting order (Betts-Symonds 1994). Key to the success of the Global Hub CBHInD model is the integration of orderly principles such as the ‘Building Blocks’ of CBHInD and the chaotic elements of reality as part of the whole prison system. Chaos is not the enemy of order but its complement, sustaining diversity, resilience, and novelty.

Within the CBHInD methodology there is evidence that innovation often emerges at the intersection between order and disorder, facilitating a dynamic zone described by Zimmerman et al (1998) as ‘the edge of chaos’.

Examples have been seen where unpredictable situations in volunteer activity, related to a specific health campaign, splinter-off to innovative ways of problem-solving and impromptu improvements [26]. Within these conditions, CBHInD facilitates a form of distributed leadership that accommodates emergent, peer-driven responses [27].

A key factor in such complex adaptive systems is the constant feedback systems leading to the corrective actions illustrated in figure 6, enabling both innovation and the timely achievement of training and project targets.

The Complexity of CBHInD Planning and Implementation

Whilst the Global Hub supports the three-phase plan, the national society and prison service need to continue the model over time, following the completion of the three-phase training/implementation period. Experience has shown that a period of three years of programme activity is needed to properly evaluate the impact of the training and community change in terms of health and wellbeing.

Systems-Level Imperative

Suggests that for CBHInD to function not just as a promising intervention but as a sustainable system reform, it must be integrated into institutional logic, rather than merely appended[28].

Embedding CBHInD into staff training, operational planning and outcome evaluation ensures both sustainability and impact. This attention to staff training improves the potential support for volunteer roles. Success is dependent on whether inmate

volunteers are recognized as credible messengers, not just by their peers, but also by officers, nurses, educators and administrators. Volunteers trained without legitimacy risk being dismissed or ‘extensions of the institution’.

Literature on complex systems and implementation science affirms that innovations are more likely to be sustained, when they are congruent with existing routines and goals, rather than positioned as externally driven reforms [29-30]

Conclusions

This Global Hub for CBHInD Review covers the operating period 2023-2025 and has suffered a chronic funding situation for both core Global Hub and budget to assist national societies in setting up pilot projects. In addition, the Global Hub has only just achieved a full-time manager in October 2025, previously operating on part-time staff.

Whilst there have perhaps been a perceived lack of ‘trainings’ in a ‘wheel-barrow’, it is hoped that there is now a better understanding of the complexities involved in CBHInD as a process in which the ‘delivery of training’ in Ireland is simply one part of the whole system of sustained and embedded CBHInD.

Transformative change as the central tenet of sustainable CBHInD, requires a longer-term approach where behavioural change is required to be induced not only in inmates as RCRC volunteers, but their communities, staff and management structures. Beliefs and values control both capabilities and behaviours of the human systems engaged in CBHInD and these require time and experience to effect the prison environmental changes.

The review has provided detailed information about the transformative nature of the CBHInD approach. The unique processes described in creating change in prisons are derived from proven strategies, built on educational and organisational theories that address ‘whole systems’ rather than piece-meal trainings that cannot be sustained.

Whilst many Red Cross and Red Crescent specialist Regional Centres and Hubs exist globally, it is only Irish Red Cross that has the honour of being the only specialist Global Hub that is representative of all three parts of the Red Cross Movement – National Society, ICRC and IFRC.

The review has indicated that there is significant interest in the CBHInD programme of Irish Red Cross and opportunities exist for Irish Red Cross and Ireland, in its year of EU Presidency, to promote a highly replicable programme that can lead globally in improving health and wellbeing of people deprived of their liberty as partners to both ICRC and IFRC.

The Global Hub now has a full-time manager with the experience needed to take the Global Hub forward over the coming years. To achieve this the Programme needs renewed commitment from IRC management, IFRC and ICRC, a long-term outlook and creative funding streams that can guarantee support for at least three-year operating periods [31-37].

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