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Health promoting prisons: an overview and critique of the concept

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The notion that prisons should become more 'health promoting' is a policy agenda that is gaining increasing momentum, particularly in England and Wales¹, Scotland² and across other European nations. The political strides made in this regard have been recognised globally, especially in the United States, where penal health reformers are attempting to replicate successful policy initiatives in Europe³. Despite the favourable rhetoric, the extent to which the concept of a 'health promoting prison' is fully understood and implemented 'on the ground' by prison staff and managers in England varies⁴. The primary aim of this article, therefore, is to open up and stimulate discussion on the World Health Organisation's (WHO) concept of a health promoting prison, as the extent to which this idea has been critically considered and debated is minimal. To encourage this wider discussion, the paper has three primary aims. It will first seek to introduce the origins and principles underpinning the health promoting prison; it will then set the health promoting prison within a political context. The paper will go on to explore some drawbacks to the approach, including the underlying conceptual and practical challenges.

The concept of a health promoting prison is one which has been located in public health and health promotion discourse for almost the past two decades. It is an idea which has germinated from the 'healthy settings' philosophy which originated from the Ottawa Charter⁵. The Ottawa Charter was an influential health promotion strategy document in the late 1980s, which indicated that health needed to be more than just about healthcare. It proposed that people's health was influenced by the environmental

'settings' of everyday life. This idea of a 'settings approach' embraces the perspective that health and well-being is influenced by a number of determinants, not just simply individual choice of whether to smoke, take drugs etc. Health, it is proposed, is determined by an interaction of social, political, environmental, organisational as well as personal factors within the places that people live their lives. Guided by the WHO, and stimulated by the enthusiasm created by the Ottawa Charter, interventions focussing on settings and a holistic view on health began to be implemented in the late 1980s.

The premise of the settings approach is, therefore, that investments in health should be made in social systems where health is not their primary remit⁶. Initially, these developments in settings happened in schools (where their primary remit is education) and workplaces (productivity and profit) and, over time, other geographically bound locations began to come under the 'healthy settings' umbrella. In the mid 1990s prisons were also recognised as a 'setting' and seen as a distinct opportunity to promote health. Indeed, whilst prisons are not necessarily in the primary business of promoting health⁷ there is a clear rationale for their inclusion, as they do provide an opportunity to access marginalised (often unhealthy) groups who would otherwise be classified as 'hard to reach' in the wider community. This means that prisons stand as a prime setting to contribute to tackling inequalities in health⁸.

Theoretically, the health promoting prison concept does not only concern prisoners who '(temporarily) live' there, they also seek to consider staff need. Health promoting schools, for example, have developed a 'look after the staff first' approach⁹, which addresses quality of life, health and productivity

1. HM Prison Service (2003) Prison Service Order (PSO) 3200 on health promotion. London, HM Prison Service.
2. Scottish Prison Service (2002) The health promoting prison. A framework for promoting health in the Scottish Prison Service. Edinburgh, Health Education Board for Scotland.
3. Weinstein, C. (2010) The United States needs a WHO health in prisons project. *Public Health*, 124, 626-628.
4. Woodall, J. (2010) Control and choice in three category-C English prisons: implications for the concept and practice of the health promoting prison. Unpublished PhD thesis. *Faculty of Health*. Leeds, Leeds Metropolitan University.
5. WHO (1986) Ottawa Charter for health promotion. *Health Promotion*, 1, iii - v.
6. Dooris, M. (2007) Healthy settings: past, present and future. Unpublished PhD thesis. *School of Health & Social Development*. Victoria, Deakin University.
7. Smith, C. (2000) Healthy prisons: a contradiction in terms? *The Howard Journal of Criminal Justice*, 39, 339-353.
8. Baybutt, M., Hayton, P. & Dooris, M. (2010) Prisons in England and Wales: an important public health opportunity? IN DOUGLAS, J., EARLE, S., HANDSLEY, S., JONES, L., LLOYD, C. & SPURR, S. (Eds.) *A reader in promoting public health. Challenge and controversy*. 2nd ed. Milton Keynes, Open University Press.
9. Mason, J. & Rowling, L. (2005) Look after the staff first - a case study of developing staff health and well-being. *Promotion & Education*, 12, 140-141.

for employees. In work on health in prisons, the focus has been almost exclusively on prisoners¹⁰; yet, it is axiomatic that for prisoners to be rehabilitated and released into the community as law abiding, healthy citizens, prison staff need to feel valued and in good physical, mental and psychosocial health¹¹. One of the underpinning principles therefore, includes a focus on all those within the setting and a 'whole prison approach' to health and well-being.

Underpinning principles

Although the concept of a healthy setting includes all those who live and work there, at the core of the health promoting prison are arguably prisoners' rights. It was acknowledged in England and Wales, for instance, that imprisonment should not remove the rights of prisoners to receive a good level of healthcare and it should not make it more likely that they become ill or experience deterioration in their health status¹². Also linked to prisoners' rights, is the principle of health service equivalence. The premise is that individuals detained in prison must have the benefit of care equivalent of that available to the general public, this would include health promotion interventions. Though government policy for prison health is saturated with references to these laudable goals (e.g. equivalence), this does not reflect the complexity and reality of delivering health services in the setting. To reflect this, a definition of a health promoting prison, taking into consideration the complexity of this environment, has been offered. It states that the health promoting prison is:

...a place of compulsory detention in which the risks to health are reduced to a minimum; where essential prison duties such

*as the maintenance of security are undertaken in a caring atmosphere that recognizes the inherent dignity of all prisoners and their human rights; where health services are provided to the level and in a professional manner equivalent to what is provided in the country as a whole; and where a whole-prison approach to promoting health and welfare is the norm.*¹³

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According to some, the health promoting prison should include all facets of prison life from addressing individual health need through to organisational factors and the physical environment¹⁴. Current guidance from the WHO suggests that the health promoting prison should be underpinned by four key pillars¹⁵. These pillars acknowledge that prisons should be: safe; secure; reforming and health promoting; and grounded in the concept of decency and respect for human rights.

Political context

Whilst political developments have been apparent in other countries, such as Scotland¹⁶, the focus here is specifically on England and Wales, where it has been argued that policy developments are considerably ahead of other nations¹⁷. However, despite being at the forefront, a dedicated health promotion strategy for prisons in England and Wales did not emerge until 2002¹⁸, despite original consultations happening much sooner. However, the publication in 2002 of 'Health Promoting Prisons: A Shared Approach' legitimised and championed a health promotion focus in prison healthcare, advocating the prevention of deterioration in health as well as encouraging prisoners to adopt healthy behaviours. The strategy advocated the need to view prisons as healthy settings

10. Woodall (2010).
11. Bögemann, H. (2007) Promoting health and managing stress among prison employees. IN MØLLER, L., STÖVER, H., JÜRGENS, R., GATHERER, A. & NIKOGOSIAN, H. (Eds.) *Health in prisons*. Copenhagen, WHO.
12. HM Prison Service & NHS Executive (1999) *The future organisation of prison health care*. London, DoH.
13. Gatherer, A., Møller, L. & Hayton, P. (2009) Achieving sustainable improvement in the health of women in prisons: the approach of the WHO Health in Prisons Project. IN HATTON, D. C. & FISHER, A. (Eds.) *Women prisoners and health justice*. Oxford, Radcliffe.
14. de Viggiani, N. (2009) *A healthy prison strategy for HMP Bristol*. Project report. Bristol, University of the West of England.
15. WHO (2007) *Health in prisons. A WHO guide to the essentials in prison health*. Copenhagen, WHO.
16. Scottish Prison Service (2002).
17. Gatherer, A. & Fraser, A. (2009) Health care for detainees. *The Lancet*, 373, 1337-1338.
18. Department of Health (2002).

with the potential for health improvement, rehabilitation and reform and enhancing the life chances of all who live and work there.

'Health Promoting Prisons: A Shared Approach' set the foundations for the introduction of a Prison Service Order (PSO 3200) on health promotion in 2003¹⁹. The PSO was considered a major breakthrough for health promotion within the prison setting because the translation of a Department of Health strategy into an auditable prison document was a crucial step forward as it provided a level of commitment to health promotion within the offender management system²⁰. The PSO sets out required actions for prison governors to promote health as part of a whole prison approach. This includes focussing on: mental health promotion and well being; smoking; healthy eating and nutrition; healthy lifestyles and drug and other substance misuse. Prison health performance indicators have also been developed which focus on the delivery of health promotion in prisons through PSO 3200²¹. Although not obligatory, the performance indicators provide guidance on the arrangement of health promotion action groups and offer direction in relation to how success may be measured.

The accumulation of strategy documents, PSOs and policy drivers has shown a great deal of promise within the health promoting prisons field. Nonetheless, there has been minimal investment in fully embedding and evaluating the approach²² and some are unclear as to the impact these documents have made to prisons and prisoners' health²³. Some

would even suggest that these policy reforms are actually making very little difference in regards to prisoners being able to make consistently healthy choices²⁴.

Conceptual and practical challenges

The translation of policy rhetoric to practice may be inhibited by several conceptual and practical challenges. This is not surprising, as the prison environment ultimately undermines the values associated with health promotion. The question of how key values within health promotion, such as empowerment, free choice and control, can be applied in a setting where security must govern all activities is always going to be problematic. Indeed, critics have suggested that health promotion in prison is a contradiction in terms²⁵, an oxymoron²⁶ and simply incompatible²⁷. Moreover, in a study by Douglas et al.²⁸, women prisoners described a prison environment which was very much 'at odds' with the notion of the health promoting prison. A starting point for examining some of these

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challenges within the health promoting prison is to scrutinise how 'health' itself is defined and applied within the setting. How are professionals meant to 'promote health' if there is not a common understanding of what 'health' means?

Historically health in prison has been aligned with a biomedical perspective²⁹, with a focus on the prevention of disease and illness. Morris and Morris³⁰, in their study of Pentonville prison, encapsulated the

19. HM Prison Service (2003).

20. Baybutt et al. (2010).

21. NOMS, HM Prison Service & Department of Health (2007) Prison health performance indicators. Guidance booklet. London, Offender Health.

22. Dooris, M. (2009) Holistic and sustainable health improvement: the contribution of the settings-based approach to health promotion. *Perspectives in Public Health*, 129, 29-36.

23. Douglas, N., Plugge, E. & Fitzpatrick, R. (2009) The impact of imprisonment on health. What do women prisoners say? *Journal of Epidemiology and Community Health*, 63, 749-754.

24. Condon, L., Hek, G. & Harris, F. (2008) Choosing health in prison: prisoners' views on making healthy choices in English prisons. *Health Education Journal*, 67, 155-166.

25. Smith (2000).

26. McCallum, A. (1995) Healthy prisons: oxymoron or opportunity? *Critical Public Health*, 6, 4-15.

27. Greenwood, N., Amor, S., Boswell, J., Jolliffe, D. & Middleton, B. (1999) Scottish Needs Assessment Programme. Health promotion in prisons. Glasgow, Office for Public Health in Scotland.

28. Douglas et al. (2009).

29. Sim, J. (1990) *Medical power in prisons*, Milton Keynes, Open University Press.

30. Morris, T. & Morris, P. (1963) *Pentonville: a sociological study of an English prison* London, Routledge.

predominant discourse which surrounded prison health:

For the prison, health is essentially a negative concept; if men are not ill, de facto they are healthy. While most modern thinking in the field of social medicine has attempted to go further than this, for the prison medical staff it is not an unreasonable operational definition.

More recently, reviews of prison health services have described a reactive and inefficient approach which is underpinned by a medical, rather than social, model of health^{31,32}. Defining health through a biomedical lens has notable implications; primarily, health is defined by its absence of disease and not the attainment of positive health and well-being. Applying a biomedical view to health promotion can also result in an emphasis on prevention of disease instead of the promotion of good health. This perspective also has the danger of obscuring the wider political, social and environmental determinants that can impinge upon offenders' health, such as poverty, education, employment and housing.

Since the introduction of PSO 3200 by HM Prison Service, practical action has been taken to displace the medical model. For example, a member of the senior management team (a non-health professional) must chair health promotion committee meetings³³. However, an evaluation of the implementation of PSO 3200 with prisons in the North West of England showed that healthcare workers still remained in

control. Of the sixteen prisons that completed the audit, eleven were carried out by the healthcare manager and a further prison response completed by a public health nurse. Only two audit responses were completed by non-healthcare workers³⁴. In addition, there is no mandate within PSO 3200 for prisoner representatives to participate within the health promotion group even though earlier policy developments recommended that their voice should be central to the development of interventions and programmes³⁵. This is in contrast to the Scottish Prison Service which encourages active prisoner involvement on Local Health Promotion Action Groups (LHPG)³⁶.

Courtenay and Sabo's³⁷ perception is that prisons are not generally about wellness and that healthcare delivery is about treating illness after not before it occurs. Their view is epitomised when mental health promotion in prison is considered, as interventions are often targeted as a way of coping with existing mental health problems (illness) as opposed to promoting positive mental well-being and advancing the health status of individuals³⁸. This is despite commitment from the WHO in acknowledging that the mental well-being of prisoners and staff is vitally important³⁹. Initiatives

often launched under the rubric of health promotion remain reactionary and individualistic, addressing specific disease prevention targets that respond to the physical, psychological, emotional and social needs of individuals in only a partial way^{40,41}. The 'upstream' health promotion emphasis (quite simply focussing on the determinants of health) which should be integral to prison health has often been neglected by a preoccupation with acute healthcare provision.

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31. HMIP (1996) Patient or prisoner? A new strategy for health care in prisons. London, Home Office.

32. de Viggiani (2009).

33. HM Prison Service (2003).

34. Baybutt, M. (2004) PSO 3200 health promotion baseline audit. Report of findings. Preston, University of Central Lancashire.

35. WHO (1995) Health in prisons. Health promotion in the prison setting. Summary report on a WHO meeting, London 15-17 October 1995. Copenhagen, WHO.

36. Graham, L. (2007) Prison health in Scotland. A health care needs assessment. Edinburgh, Scottish Prison Service.

37. Courtenay, W. H. & Sabo, D. (2001) Preventive health strategies for men in prison. IN SABO, D., KUPERS, T. A. & LONDON, W. (Eds.) *Prison masculinities*. Philadelphia, Temple University Press.

38. Bird, L., Hayton, P., Caraher, M., McGough, H. & Tobutt, C. (1999) Mental health promotion and prison health care staff in Young Offender Institutions in England. *International Journal of Mental Health Promotion*, 1, 16-24.

39. WHO (1998) Mental health promotion in prisons. Report on a WHO meeting. Copenhagen, WHO.

40. de Viggiani, N. (2006) A new approach to prison public health? Challenging and advancing the agenda for prison health. *Critical Public Health*, 16, 307-316.

41. de Viggiani, N. (2006) Surviving prison: exploring prison social life as a determinant of health. *International Journal of Prisoner Health*, 2, 71-89.

Caraher et al.⁴² similarly note that health promotion in prison is often influenced by a mechanistic approach to health with an underlying preoccupation and concern with practical dangers such as self harm and the prevention of suicide. These interventions are perhaps aimed at the effective management of the prison population, rather than for promoting health benefits *per se*.

As well as conceptual, there are a number of practical challenges that inhibit the development of the health promoting prison. First, health promotion, like in other organisations, remains under resourced, under funded and an activity on the periphery of the organisation's priorities. Some prison healthcare assessments, for example, have indicated that limits on staff numbers have been insufficient to provide a complete health promotion service for prisoners⁴³. Second, prison staff working closely with offenders often view health promotion as constituting additional work, something which is perceived as being outside their professional remit or something to do when time is available from their regular daily duties⁴⁴. Bird et al.⁴⁵, for example, found that mental health promotion was not seen as being a core duty of prison staff. Activities in relation to promoting mental health were seen as being 'nice to know' rather than 'essential to know'. Healthcare staff also perceived health promotion as a specialist activity and not part of their role.

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Future challenges

The development and future of the health promoting prison is currently unclear within England and Wales, as the Department of Health has recently widened its focus towards focussing on 'offender' rather than 'prison' health. This concentrates on all those who come into contact with the criminal justice system as opposed to focussing solely on the prison population^{46,47}. Consequently, policy movements are shifting from discrete action in prison settings in favour of a more 'healthy criminal justice system' perspective. Indeed, Lord Bradley, in his recent report on offenders with mental health problems or learning disabilities, highlighted the value of a whole criminal justice system approach⁴⁸.

If the health promoting prison concept is to progress, several theoretical and practical issues require further thought. Prisons irrefutably contribute to addressing the acute and immediate health needs of many prisoners; however, prison policy seems preoccupied with disease prevention activities. If a settings approach is to be fully realised, a more radical, upstream and holistic outlook is required in prisons. First, the notion of a prison setting should be reconceptualised, moving away from a purely instrumental view which considers the prison as a convenient venue for addressing the health lifestyles of offenders, towards making health integral to the institution's culture. This includes considering

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42. Caraher, M., Dixon, P., Hayton, P., Carr-Hill, R., McGough, H. & Bird, L. (2002) Are health-promoting prisons an impossibility? Lessons from England and Wales. *Health Education*, 102, 219-229.
 43. de Viggiani, N., Orme, J., Salmon, D., Powell, J. & Bridle, C. (2004) Healthcare needs analysis: an exploratory study of healthcare professionals' perceptions of healthcare services at HMP Eastwood Park, South Gloucestershire. Bristol, South Gloucestershire NHS Primary Care Trust and the University of the West of England.
 44. Caraher et al. (2002).
 45. Bird et al. (1999).
 46. Department of Health (2009) Improving health, supporting justice: the national delivery plan of the health and criminal justice programme board. London, Department of Health.
 47. Rennie, C., Senior, J. & Shaw, J. (2009) The future is offender health: evidencing mainstream health services throughout the offender pathway. *Criminal Behaviour and Mental Health*, 19, 1-8.
 48. Bradley, K. (2009) The Bradley report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London, Crown.

architecture, policies, structures, prisoner-staff relationships and how these impact on individuals. Furthermore, whilst managing modern prison systems is complex, there is a need for enlightened leadership for the settings approach to truly flourish, as previous research has noted how health promotion within prison can prosper when there is active support from senior figures in the setting⁴⁹.

Conclusions

Prison based health promotion is not an easy task to execute and those who are currently working and delivering successful health promotion in this setting are doing so within an environment of paradoxical values and philosophies. We need to learn from these examples in order to truly embed health promotion within prison settings. The aim of this paper was to spark debate and critical thinking in relation to the health-promoting prison, as in comparison to research and commentary surrounding other 'mainstream'

settings, prisons have a long way to come. Due to the nature and background of the prison population, the prison undoubtedly offers a unique opportunity to address the health needs of vulnerable members of society and the proposed model of a health promoting prison by the WHO and Department of Health may be a viable approach to address this. However, there remain several conceptual and practical challenges that inhibit this implementation. Whilst the notion of a settings approach in prison is not currently fully understood, it was the intention of this paper to draw awareness to the concept. More discussion about the health promoting prison is needed from a range of stakeholders, including: academics; prison governors and staff; policy makers and, perhaps most importantly, the prison population. There needs to be some urgency about this as, in theory, the health promoting prison not only has benefits for prisoners and staff, it can contribute to improving the health of society as a whole.



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49. Caraher et al. (2002).