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A critical examination of the health promoting prison two decades on

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ABSTRACT

Two decades since the WHO Regional Office for Europe outlined and published a report on health promotion in prison, which stimulated further debate on the concept of the 'health promoting prison', this paper discusses the extent to which the concept has translated into practice and the extent to which success has been achieved. This paper primarily focuses on why there has been a gap between the strategic philosophy of health promotion in prison and practical implementation, suggesting that factors such as 'lifestyle drift' and public and political opinion have played a part. A further argument is made in relation to the overall commitment of European countries and more broadly WHO in their support of settings-based health promotion in this context. It is proposed that there has been a weakening of commitment over time with a worrying 'negative trajectory' of support for health promoting prisons. The paper argues that despite these challenges, the opportunities and potential to address the needs of those who are often most vulnerable and excluded is colossal and acting to tackle this should be a greater priority.

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Introduction

It is over 20 years since the WHO Regional Office for Europe published a report on health promotion in prison which has since stimulated further debate on adopting a settings approach in this context (WHO, 1995). The settings approach embraces ecological perspectives, challenging a reductionist focus on single issues towards a holistic vision of health which is determined by an interaction of environmental, organisational and personal factors within the places that people live their lives (Dooris, 2009). The WHO's report, published in multiple languages, was a response to the disproportionate rates of ill health and social disadvantage faced by prisoners and the growing prison population (Woodall & South, 2012).

This discursive paper outlines the developments made over this 20 year period and highlights some of the challenges which overshadow the delivery of settings-based health promotion in prison and in creating 'health promoting prisons'. This paper expands existing critiques (Ross, 2013; Smith, 2000; de Viggiani, 2006; Woodall, 2012) by specifically discussing the mismatch between the policy rhetoric of settings-based health promotion in prison and operational activity. Moreover, a further argument is made in relation to the overall commitment of European countries and more broadly WHO in their support of health promoting prisons. Examples from across Europe are drawn upon; however, a significant focus is on the practice in the UK. This is for two reasons; first, the author's research and associated

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experiences have been set within this context and second, commentators have argued that it is the UK that presently leads Europe in its policy developments and its integration between prison and public health services (Gatherer & Fraser, 2009).

Context

Evidence demonstrating that prisoners face disproportionate levels of chronic ill health, disease and disability has been overwhelming and conclusive (WHO, 2014). In order to address the inequalities in the prison population, WHO Europe convened a group to consider how this should be tackled. In October 1995, an international meeting with senior prison health representatives from eight selected European countries agreed that the public health importance of prisoner health had been neglected (Gatherer, Møller, & Hayton, 2005). The settings approach to health promotion was recognised as a way of addressing the health of the prison population after observing the effectiveness of the settings approach in schools, workplaces, hospitals and cities. It was suggested that prisons could be regarded as 'another setting in which to advance public health in pursuance of target 14 of WHO's European health for all strategy' (WHO, 1995, p. 1). Six key conclusions emerged from the meeting:

- (1) The prison is a valid and feasible setting for health promotion.
- (2) Key elements of health promotion in prison include:
 - (a) Prevention of deterioration in health
 - (b) Enablement and empowerment
 - (c) Physical and mental components
 - (d) Duty of care to the whole community
 - (e) A multidisciplinary and holistic approach
- (3) All participants recognised health in prison as a priority area for action despite limited resources.
- (4) Prison services have a duty of care for prisoners and prison staff and to take account of the public health of the wider community.
- (5) It is important to listen to the views of prisoners and prison staff in order to meet their needs through a range of effective health promotion strategies
- (6) A coordinating centre should be established.

The first international conference on Healthy Prisons in 1996 (Squires & Strobl, 1996), proved a catalyst to foster discussion, along with opportunity for WHO to reaffirm their commitment. A presentation at the conference, delivered by a WHO official, stated:

In the World Health Organization (WHO) we have for too long now overlooked the problem of health in prisons ... The Healthy Cities Project has now been running for over ten years and there was no way, ten years ago, we could have predicted the potential of that project. Healthy Cities has become a movement, a global movement ... And I would like to think at an occasion like this that it is possible to start a similar movement as we did for Health Cities but now for prisons. (Goos, 1996, p. 20)

The consensus for change acted as a platform to launch WHO's Health in Prisons Project (HiPP) with the overarching aim to improve all aspects of health in prison through changes in prison health policies (Gatherer et al., 2005). Whitehead (2006) has argued that the HiPP is a practical framework to guide activity under the health promoting prison umbrella. In 2005, a frank appraisal of the progress made by the WHO in prisons argued that their leadership had accomplished a more noticeable recognition of prison health on the public health agenda. Nevertheless, they concluded that formidable barriers remained including overcrowding, rising prison populations and resource restrictions (Gatherer et al., 2005). Given that a further decade since the inception of the health promoting prison has passed, it seems timely to review progress since Gatherer et al.'s initial analysis. Some of the challenges remain, as overcrowded prison systems are still a barrier in creating healthy environments. During the period since the health promoting prison concept was proposed by the WHO, the prison population has increased, almost without exception, across Europe (Walmsley, 2013). This paper then focuses on two challenges,

not originally noted by Gatherer et al. (2005), that have inhibited progress towards prisons as health promoting settings. These will be discussed in the following section.

The gap between strategic philosophy and practical implementation

The distance between the rhetoric of health promotion in prison, which adopts a settings-approach, and translating this into practical guidance to aid delivery has been a major barrier. The UK has been one of the leaders in developing health promotion in prison, with the health promoting prison concept comprehensively outlined in the English and Welsh strategy 'Health Promoting Prisons: A Shared Approach' (Department of Health, 2002). This document used the discourse of a 'whole prison' approach with a core philosophy of creating environments that were supportive of health, with an emphasis on the wider determinants of prisoner health (Department of Health, 2002). The strategy was subsequently converted into practical guidance through means of PSO 3200, a Prison Service Order on health promotion in 2003 (HM Prison Service, 2003). While the translation of the strategy into a practical prison document was a crucial step forward for health promotion in prisons (Baybutt, Hayton, & Dooris, 2010), the document was largely reductionist in approach, focussing on individually centred lifestyle interventions.

Concurrently, the Scottish Prison Service developed their strategic position for the health promoting prison (Scottish Prison Service, 2002). Based on core values, such as integrity, honesty and justice as well as principles such as empowerment, equity, partnership and sustainability, their approach was aligned coherently with the original WHO rhetoric and resonated with a broader healthy settings philosophy (Brutus et al., 2012). Action plans resulting from the framework, however, failed to match the rhetoric, with individual lifestyle issues dominating core actions (Scottish Prison Service, 2002). This inability to move from strategy rhetoric to practical action was conceded by the Scottish Prison Service who stated:

This framework is keen to drive a holistic approach to a healthy prison but the reality is that work is often topic based ... we recognise that the approach taken could increase the risks around 'silo thinking' and be less conducive to supporting local working between and within agencies seeking to promote healthy lives. (Brutus et al., 2012, p. 14)

The WHO have themselves acknowledged that policy formulation at a strategic level may not always be implemented properly in practice (van den Bergh & Gatherer, 2010), but the key question is why, in the UK, a holistic and values-based strategic vision could not be implemented or translated into practical implementation. Four explanations are proposed.

First, the issue of 'lifestyle drift' has prohibited the translation of strategy to actual delivery. Lifestyle drift is the inclination for policy that recognises the need to act on upstream social determinants only to drift downstream to focus on individual lifestyle factors (Popay, Whitehead, & Hunter, 2010). In 'Health Promoting Prisons: A Shared Approach', for instance, the document states that promoting health in prison requires that inequalities are addressed through tackling wider determinants of health. Nonetheless, operationally through PSO 3200 a downstream focus is clear with a focus on smoking, healthy eating etc. (HM Prison Service, 2003). The reasons underpinning why lifestyle drift has occurred in this setting has not been explored, although practical factors may be an issue. For example, lifestyle interventions are easier to devise than 'upstream' interventions (Carey, Malbon, Crammond, Pescud, & Baker, 2016) and the Scottish Prison Service themselves suggested that 'pragmatism' was a key factor in developing their approach to health promoting prisons. Moreover, in a culture where monitoring prison performance against benchmarks is common, lifestyle interventions are significantly easier to evaluate (Baum & Fisher, 2014). As an illustration, indicators developed to monitor the delivery of health promotion in prisons in England and Wales operated on a 'traffic light' indicator system which measures success against targets such as the completion of smoking cessation programmes and the number of referrals to prison exercise programmes (NOMS, HM Prison Service & Department of Health, 2007).

Second, to operationalise the strategic vision of health promoting prisons there needs to be coherent partnerships with organisations not traditionally seen to have a 'health' focus. Strategic vision for a health promoting prison focuses on creating supportive environments for health and in recognising 'the relationship between prisoners and the external world' (Department of Health, 2002, p. 28). In

order to do this effectively, Dooris (2013) has suggested that settings should connect 'beyond health' making linkages to alternative agendas to maximise the contribution that settings can make to health and well-being. While the notion of partnership working and sustainability are explicitly referenced in Scotland's framework for a health promoting prison (Brutus et al., 2012; Scottish Prison Service, 2002), traditionally prisons have not been effective at working across professional domains or boundaries. Exemplifying this, an article by Palumbo (2015) on the situation of health management in Italian prisons argued that prisons struggle with the process of building collaborative arrangements with other organisations due to the nature of prisons being 'closed' institutions.

Third, strategic policy implementation may breakdown at the stage where it is meant to be implemented by those 'on the ground' – a point alluded to, but not explored in-depth, by Gatherer et al. (2005). Studies have shown, for example, that prison staff disregard health promotion, frequently perceiving it as constituting additional work or something which is outside their remit (Caraher et al., 2002). This may, however, be a broader symptom of understaffed prisons and recruitment not keeping pace with growing prison numbers (The Howard League of Penal Reform, 2009). Indeed, a further critique of health promotion in prison, has been the omission of prison staffs' health and well-being from the agenda. Bögemann (2007) argues that in order for prisoners to be rehabilitated and released as 'healthy citizens', prison staff themselves need to feel valued and in good health. Health promoting schools, have developed a 'look after the staff first' approach (Mason & Rowling, 2005), but this has been seen less in prisons where the focus has been predominantly on prisoners (Woodall, 2010).

Fourth, the assertion that prisons are the most 'unpopular' of the settings-based environments (Whitehead, 2006) creates further difficulties. Unlike settings where there exists a clear logic between settings-based health intervention and individual and societal gains – for example in schools – the arguments are more 'thorny' in a context whereby ideological views on prison vary. Improving prison health does not generally gather political capital or public endorsement. This may be compounded by the fact that many of the health issues that manifest in the prison population often emanate in behaviours that may be associated with social stigma and criminality (Whitehead, 2006). Wider public perceptions about who is 'deserving' of support has created challenges in providing equivalent health services in prison (Baybutt et al., 2010), including health promotion where ideas such as the 'empowerment' of prisoners sit uneasy in parts of the public and political domain. Those tasked with translating the rhetoric of health promoting prisons into reality have therefore had to navigate a delicate and difficult policy path in which wider public and political opinion is an ever present force (Tabraham, 2014). This kind of influence has arguably tempered strategic values from being implemented.

Determining the commitment of European nations and WHO

The realisation of the health promoting prison concept is incumbent on the commitment of individual countries and the WHO itself. Yet, in some parts of Europe there is neither strategic vision nor practical guidance on health promotion in prison. In Eastern Europe, policy is far less developed with several countries not having any resource for health promotion in prison (MacDonald, Rabiee, & Weilandt, 2013). This uneven resource allocation for 'upstream' health promotion activity has been recognised for some time and has resulted in some Eastern European countries having to prioritise resource towards the control of disease (Gatherer, Møller, & Hayton, 2009). This means that salutogenic principles of health promotion which resonate with settings-based approach are rarely considered. Nevertheless, even in countries outside of Eastern Europe, policies and strategies on health promotion in prison do not exist. In Norway and in Ireland, for instance, there are no dedicated policies for health promotion in prison (MacNamara & Mannix-McNamara, 2014; Santora, Arild Espnes, & Lillefjell, 2014). These examples do bring in to question the priorities that countries have on developing prisons that are 'health promoting' rather than 'disease preventing'.

The overarching role and leadership of WHO in their efforts to embed health promotion in prison and supporting a settings-based approach is also worthy of exploration. Key publications by the WHO outlining their approach to the health promoting prison have seemingly been less vociferous over

time. In 1995, values emphasising empowerment and enablement were clearly set-out and yet such language has not been seen in later iterations. Arguably WHO's decreased 'voice' and seeming waning of advocacy for health promotion in prison has coincided with broader changes within the organisation. This is not to say that WHO have not remained active in prison health (see e.g. WHO, 1998, 2001a, 2001b, 2003a, 2003b, 2008), but their explicit focus on health promotion and values such as enablement and empowerment have gradually been eroded. The declaration on prison health as part of public health, held in Moscow, offered an opportunity to reaffirm commitment but this makes no reference to health promotion or settings-based approaches (WHO, 2003a). Commentators have suggested that WHO have had a diminishing role in global health (Lidén, 2014) and in relation to settings-based health promotion, questions have been raised in relation to WHO's role in facilitating co-ordination between settings and providing ongoing support (Dooris, 2013). Whether this negative trajectory will continue is unknown, but this may mean that for health promotion in prison to move forward on a European and global level other macro-organisations will need to engage with the agenda.

WHO have conceded that more must be done in relation to health in prison both globally and within Europe (Gatherer et al., 2009). There remains a need for enlightened leadership for the health promoting prison concept to truly flourish (van den Bergh, Møller, & Hayton, 2010) and yet it seems there has been less importance placed on the health promoting prison concept over recent years from WHO. As a crude illustration, WHO Europe's publication on prison health published in 2007 placed a chapter on the health promoting prison prominently and ahead of other chapters focussing on addressing acute health challenges (WHO, 2007). Moving forward seven years, WHO's updated publication of prison health saw this chapter relegated to the end of the guide (WHO, 2014).

Concluding remarks

This paper did not seek to underplay the challenges that are inherent in embedding health promotion in the prison context; however, since the idea was initially proposed and supported by WHO, progress remains slow. This paper has highlighted some of the factors impinging the development of the health promoting prison. The gap between the rhetoric of settings-based health promotion in prison and the reality has been discussed, with a number of influences potentially acting to prohibit this translation. Moreover, the overarching commitment both of individual nations and of the WHO is questioned. On the latter point, it is proposed that there has been a weakening of commitment over time with a worrying 'negative trajectory' of support for health promoting prisons. Unlike evaluative efforts in other health promoting settings, such as schools, there is little evidence to suggest that the health promoting prison model would or does 'work' or indeed pays dividends for health and well-being. It is a priority that continued efforts must be made to ensure that the relevance of settings-based health promotion within prisons is demonstrated in order for its future sustainability.

The development and future of the health promoting prison is unclear, particularly within England and Wales, as the discourse has shifted towards '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 (Department of Health, 2009). Consequently, policy movements are shifting from discrete action in prison settings in favour of a more 'healthy criminal justice system' perspective. While the idea of joining up the key settings of which offenders are part is laudable, the concern would be that the progress specific to the prison setting is not lost or further diluted. Despite the limitations of health promotion in prison and the shifting discourse away from prisons towards healthy criminal justice systems, the opportunities and potential to address the needs of those who are often most vulnerable and excluded is colossal and acting to tackle this should be a greater priority.

Disclosure statement

No potential conflict of interest was reported by the author.

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