

## **Why has the health promoting prison concept failed to translate to the US?**

There is clear evidence which shows that the health of the prison population is poorer than groups in the wider community in relation to physical, mental and social dimensions of health (1). However, the response to address the inequalities faced by prisoners has varied considerably across countries and continents (2). Work in Europe, spearheaded by the World Health Organisation (WHO), for example, has been committed to addressing prison health. Two decades ago, WHO Europe outlined its view of health promotion in prison which was underpinned by values such as empowerment and operationalized through a ‘settings approach’ (3) – the premise that efforts to improve prisoner health should not only focus on individuals but also on the environment and organisational infrastructure of the prison itself – to achieve health gains and improvements. In-depth critique of the work by WHO Europe and the health promoting prison has been provided elsewhere (4), with conclusions suggesting that while much has been achieved in relation to lobbying European countries to integrate prison health into public health systems (e.g. Norway, France, and England), there is more that can be done in relation to addressing the needs of this marginalised group (5).

Despite challenges, WHO Europe remain one of the few organisations developing the health promoting prison concept at a macro-level with some countries within Europe, such as England and Wales and Scotland, adopting clear strategies for health promotion in prison (6). Much of the prison population can be described as ‘transient and mobile’ in that they frequently shift between imprisonment and free society serving multiple and relatively short-term sentences. Health promoting prisons, therefore, have the potential to reduce health inequalities through building the physical, mental and social dimensions of prisoners’ health and enabling prisoners to adopt healthy behaviours that can be taken back into the community

(7). One predicted indicator of success for the health promoting prison movement was the expansion of activity beyond European borders (5); yet two decades since the European model was put forward there has been very limited global activity. Prison health advocates in the US have shown interest in the health promoting prison concept, but it has not been operationalised. Shelton (8, p.194) makes this point:

*“Given that the US is a world leader for incarcerating people of color, the mentally ill and other disparate populations, why then are we not leaders in health promoting prisons (HPP)? The concept of HPP, introduced in England and Wales and Scotland has peaked interest in the US, but it has not become a reality.”*

This paper does single-out the US for lagging Europe in its health promotion prison agenda, but recognises that other regions are lacking as well. However, some areas may have more obvious arguments to explain their deficiencies in policy and practice. Dixey et al. (9) discussing the situation in the African continent, point to resource challenges and extremity of health need which has meant that African prisons have been unable to engage in health promoting actions. The reluctance in the US, however, to move forward with a health promoting prison agenda remains puzzling – especially given that the health issues in prisons in Europe are similar to the US and moreover the US has embraced other healthy settings-based agendas (10). This paper seeks to advance several potential explanations for the hesitancy of the US to embrace both the concept and practice of the health promoting prison.

The first explanation relates to the sheer magnitude of the incarcerated population. There is no doubt that imprisonment rates in the US are far higher than any other country in Europe. Currently the US imprison 698 per 100,000 of the population which overshadows the rate in other highly-industrialised nations, such as England and Wales (148 per 100,000), Spain (136

per 100,000), France (95 per 100,000) and Germany (78 per 100,000) (11). The scale of the prison population may in itself be a barrier to progressing the health promoting prison philosophy. Indeed, overcrowded facilities were exposed as one of the key reasons why parts of Europe had struggled to implement the health promoting prison (5).

The second explanation relates to public and political perceptions about who is deserving and undeserving of health promotion intervention. Arguably, health practices in prison populations are often ‘imported’ into the correctional system and so are heavily influenced by poverty, marginalisation and deprivation. Manifestations of these influences results in behaviours which the general population may find unpalatable, such as injecting drug-use and hazardous alcohol use (12). Additional spending on correctional health is not always publically endorsed and there have been previous instances where the US Government has blocked progressive prison health policy (13). There is currently no politically-powerful advocate for progressive prison reform in the US and indeed political arguments to gain additional resource for the health promoting prison may be difficult to justify given that over \$39 billion is spent on corrections in the US, the equivalent to \$30,000 on average per prisoner (14). 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 (4).

Third, the WHO itself has been criticised for its excessive regionalisation in addressing global health concerns (15). A unified voice for prison health has not been heard and yet the health of those detained and incarcerated is an issue for all continents, especially as the prison population has grown by 25-30% across the world (11). It has been surprising that only one WHO region has actively engaged with this and moreover a greater surprise that sharing good

practice with other WHO regions has not been seen through, for example, global conferences or symposia.

Fourth, there is little robust evidence that suggests that the health promoting prison concept improves health or addresses other outcomes. Although the accumulation of strategy documents and policy drivers in relation to the health promoting prison have shown some promise in shifting perspectives on prison health away from a medical model toward a more holistic, social perspective of health (16), there has been minimal investment in evaluating the outcomes of the approach (17). These problems perhaps stem from the difficulties and challenges in evaluating health promotion interventions *per se* (18) and the complications in evaluating settings based strategies which are inherently holistic and ecological. However, unlike evaluative efforts in other health promoting settings, such as schools, there is little evidence to suggest that the health promoting prison model works or indeed pays dividends for health and well-being. This may be exacerbated by a reluctance of funding agencies to support a health promotion research agenda in prisons. This lack of research and evidence may be a further reason why the US have been reluctant to replicate work in Europe.

In conclusion, there is little doubt that the health of the prison population is of global concern and requires immediate attention. One suggested approach to tackle the disproportionate health and social issues faced by people in prison is to adopt a settings approach – a model which recognises that health is created in the places which people live their lives. In prison, a settings approach has been espoused in Europe as a way to address health inequalities, but uptake in other parts of the world has been slow, particularly in the US. One of the indicators of success in prison health in Europe was the translation of the concept to other parts of the world. However, this has failed to occur with this paper offering several potential

explanations for why uptake in the US particularly has not occurred. It is hoped that the paper will stimulate further debate and dialogue on the issues so that best approach to tackling the health of the prison population is found.

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