Should we use a direct regulation to implement the Healthy Prisons Agenda in England? A qualitative study among prison key policy-makers.

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ABSTRACT

Background The Healthy Prisons Agenda seeks to reduce prisoners' health risks, balance prisoners' rights with a security regime, ensure equivalent prison health service provisions to community health services, and facilitate the whole-prison approach. There is an established assumption that legislation will ensure better implementation of health promotion programmes. This study aimed to examine whether a legislative framework, via a direct regulation, could lead to enhanced implementation of the Healthy Prisons Agenda in England.

Methods A qualitative study design was conducted using semi-structured interviews with 30 key prison policy makers in England.

Findings Our findings contradict the established assumption that legislation improves the implementation of health promotion programmes. A direct regulation was perceived as restrictive, manifesting excessive compliance, and encouraging a risk-averse culture, whilst preoccupation with security, order, and discipline amongst prison governors and custody staff was deemed an internal institutional barrier to implementing the Healthy Prisons Agenda. External barriers included diminishing resources, lengthier or delayed sentencing, and an unsympathetic public and political stance towards prisoner rehabilitation.

Conclusions A direct regulation should not be used to operationalise the Healthy Prisons Agenda. Rather, self-regulation, along with proactive solutions for the identified barriers to implementing the Agenda, is the most appropriate path forward.

Introduction

The Healthy Prisons Agenda was first established by the World Health Organization (WHO) in 2007. It addresses the reduction of prisoners' health risks, recognition of prisoners' human rights while maintaining a security regime, equivalence of prison health service provisions compared to community health services, and adoption of the whole-prison approach to promoting health and welfare in prisons.[1] Moreover, the WHO's core principles of a healthy prison, as used by HM Inspectorate of Prisons, are that they should be safe, secure, reforming, health promoting, and grounded in the concept of decency and respect for human rights.[2]

However, evidence shows that the health of prisoners in England has not improved significantly. Along with the plethora of physical and mental ailments that prisoners experience,[3–5] penal institutions have started to take on a more robust caretaker role for populations with complex needs, including long-standing illness or disability, severe or enduring psychiatric morbidity, and social or welfare needs.[6,7] The efficacy of health and well-being interventions may be further curtailed by overcrowding; since the end of May 2017, the prison population had reached 84,319, which is 2% below the full usable operational capacity.[8]

Meanwhile, there is a growing body of academic literature that theorises the use of the law to implement public health agendas, arguing that the law can establish legal structures that enable supportive environments and empower behavioural change,[9] which Parmet has hailed as the 'chief tool of public health.'[10] For these scholars, 'law makes public health possible',[11] and the failure to integrate law and public health creates gaps both in policy and in the translation of evidence into widely deployed public health interventions.[9]

Moreover, the legal framework is capable of strengthening the status of prisons as health-promoting settings. Prisons are a modifiable determinant of health. This point is congruent with the Ottawa Charter, which states: 'Health is created and lived by people within the settings of their everyday life.'[12] While framework such as the Prison Service Order on Health Promotion (PSO 3200)[13] existed to establish health provisions in prisons, such framework suffered from poor implementation.[14,15.] Ensuring that the Healthy Prisons Agenda becomes a statutory measure will address these gaps whilst guaranteeing that England fulfils its existing international legal

commitments to safeguard prisoners' health and wellbeing.[16–18] Furthermore, the burgeoning political discourse around prisoner rehabilitation based on recent wholescale prison reform by the UK Government indicates a will to push for the implementation of the Healthy Prisons Agenda in England on a statutory footing.[19,20]

This qualitative study aimed to examine whether a direct regulation could lead to enhanced implementation of the Healthy Prisons Agenda in England. A direct regulation is defined as a piece of legislation that sets minimum standards and addresses a collective issue.[21]

Methods

Study Design

Grounded theory, which builds theory from qualitative data, was used to construct the meaning of this research.[22] Such a methodology ensured that the thesis was grounded in data that emanated from participants who had experience in the prison policy-making field. The data were collected through face-to-face and telephone interviews using a topic guide. This semi-structured interview format was considered appropriate to enable participants to discuss in confidence their views and to explore the issue from their specific standpoint.[23]

Sample and data collection

In total, 30 participants took part in this research, selected using the following four inclusion criteria: the specific perspective or standpoint of participants, the richness of their experience, their decision-making capacity, and geographical coverage. Participants belonged to an 'elite' part of the community, in that they engaged in policy-making activities and occupied authoritative positions in the prison field.[24] Gathering their perspectives on this research topic was a prerequisite since they represent the expert community for policy imperatives regarding prison health. Recruitment of participants included purposive, theoretical, and snowball sampling methods.[25]

Transcription and analysis

All interviews were audiotaped and transcribed verbatim. Interviews lasted between 21 and 65 minutes (average 37 minutes). NV audited the audio interviews to identify errors and, when applicable, provided feedback to improve NI's interviewing technique and demonstrate the reliability of the research.[26] The analysis stage was conducted in an iterative cycle. Each transcript was read four times prior to coding to enable full immersion in the content and become empathically introspective.[27] Data were imported into NVivo 11[28] for coding and retrieval. To ensure consistency with grounded theory, three stages of coding were performed: open coding, focused coding, and axial coding.[29] Transcripts were analysed until reasonable data saturation was achieved, which was reflected by the absence of new themes appearing in the interviews.[30]

Findings

The findings are presented according to three themes: (i) perceived limitations of a direct regulation as a statutory measure; (ii) internal factors perceived to inhibit the full adoption of the Healthy Prisons Agenda; and (iii) external factors perceived to inhibit the Agenda in England.

Participant backgrounds

The participants were selected from different key organisations that are pertinent to prison work, including organisations with public protection mandates (such as the National Offender Management Service and the National Probation Service), commissioning of prison health services (such as NHS England, Public Health England, and voluntary organisations), and advocacy groups to protect the collective interests of prison stakeholders (such as the Prison Governors Association). Emphasis was placed on participants with a background in both prison and health (Table 1), and with either strategic or operational decision-making capacity.

Table 1 Background of participants

Participant Professional 'Location'	No. of participants
Health	24
Prison	17
Voluntary and Community Sector	9
Probation and Community Rehabilitation Companies	5
Academic	3
Regulatory	3

The limitations of a direct regulation as a statutory measure

Most participants identified limitations that a direct regulation would bring to implementing the Healthy Prisons Agenda. The core sentiment was that the somewhat broad and dynamic nature of the Agenda could not be reduced to Black Letter Law (Box 1). Given the diverse meaning and potentially far-reaching impact of healthy prisons, participants believed that this boundary should not be constricted by the restrictive nature of legislation. The significance of the Agenda is also shaped by core health promotion values, such as empowerment and participation (Box 1),

which enable prisoners to make choices and affords them greater responsibility to take charge of their lives within the limits of a security regime. Recognising the complex interrelationships between the nature and values of the Healthy Prisons Agenda, participants were ambivalent as to whether a direct regulation could create uniformity across England's prisons whilst maintaining the flexibility to meet the needs of different populations.

Whilst uniformity is capable of setting minimum standards, such standards may force rules to be prescriptive (Box 1). Furthermore, some people may adopt an interpretation of the statutory instrument that is too literal and restrictive, and the true essence of the Healthy Prisons Agenda would be lost. The implementation of the Healthy Prisons Agenda through statutory measures requires a degree of compliance (Box 1). On the one hand, those who operated *outside* the prison structure were in favour of a direct regulation from the perspective of accountability. On the other hand, those who were heavily involved in the day-to-day delivery of services opposed to such a draconian measure. Frustration was typically directed at unnecessary 'red tape' and disproportionate monitoring.

When the delivery of the Agenda is not in line with the expected standards, a direct regulation can increase exposure to litigation (Box 1). Those operating within the advocacy sphere of prison health attached great importance to service improvement and perceived lawsuits to be particularly useful instruments. This view was less pronounced, however, amongst those who were involved in the delivery of health and wellbeing activities in prisons, where the statutory imperatives could create resistance and anxiety amongst the prison workforce. It is thus clear that although there are some advantages to implementing the Healthy Prisons Agenda using a direct regulation, they are outweighed by the disadvantages of such a measure.

Though the status quo is untenable, implementing the Agenda through a statutory measure is seen as disproportionate. In this context, most participants suggested that the existing system of self-regulation—a tripartite agreement between NHS England, Public Health England, and the National Offender Management Service, which is scrutinised by HM Inspectorate of Prisons and the Care Quality Commission[31]—should remain. This can be strengthened by reinvigorating the

partnership through fostering greater collaboration between partners and stakeholders, introducing joint targets and strategic objectives across the justice health system, and sharing best practices via peer collaboration to achieve a more sustainable Healthy Prisons Agenda.

Box 1: The limitations of a direct regulation

1.1 Broad and dynamic definition of healthy prisons

A healthy prison is one which promotes the wellbeing of the prisoner … that means health and social care wellbeing, as well as working, learning, paying back to society. … [They have] to have a reasonable environment to live in. Prisoners have got to have enough time out of the cell to get fresh air and take exercise. … They need to be meaningfully occupied and learning skills or qualifications that will enable them not to come back to prison … (Participant 3, Head of Service at a Prisons Inspectorate)

The [statute] probably doesn't provide a vehicle to promote the best of practice. It's a level below which you should never drop [to], isn't it, rather than a level to which you should aspire? (Participant 9, Deputy Chief Inspector of a regulatory organisation)

1.2 A system of values

So, if they knew, for example, that there was a fight [going to] come or a member of staff was going to be attacked or drugs were being delivered, I wanted prisoners to tell staff that … in the same way that if you lived in a village, that everyone was involved in that community … and really, a prison when it functions at kind of its highest point … is a small village with a liked police force and engaged population. That is essentially what a prison is when it's working at its absolute peak. The difficulty is that that peak isn't seen very often now. (Participant 22, former Prison Governor)

1.3 Prescription of restrictive behavioural rules

[If the statutory measure says] … people should have access to at least two hours' social activities to promote health and wellbeing, then there is a danger that people would think, 'Eh, two hours is enough!' and that they're actually ticking on the boxes … (Participant 15, Prison Service Manager)

1.4 A degree of compliance

If it's mandated, they bloody well have to do it is what I would say! Excuse my language! [laughs] … You get this old-school mentality with a lot of governors: 'It's my prison, it's my jail, what I say goes. No, it's not happening.' But actually, if it was mandated, they'd have to do it … (Participant 21, Regional Commissioning Lead, NHS England)

[Yet] another list of things you've got to have been talked to about … (Participant 6, Service Development Manager, national Voluntary and Community Sector organisation)

More monitoring … more returns … to prove that you're implementing the legislation. (Participant 24, World Health Organization Health in Prisons Programme Project Lead)

1.5 Increased exposure to litigation

[On] one level, it worries me … because if we can't deliver on all the things we are supposed to deliver at the moment, with the legislation that we have, how is that legislation going to make things more effective? … It may not necessarily help the workforce in terms of recruitment and retention of staff, especially if you move to a model where litigation becomes more common. … Most people who work in health do so because they want to help people, and the risk of litigation I think is something that would frighten them. (Participant 7, Health and Justice Lead, Public Health England and former Prison Health Care Manager)

Internal factors inhibiting the full adoption of the Healthy Prisons Agenda

Internal factors perceived as inhibitors of the Healthy Prisons Agenda were identified at managerial and operational levels within prisons, more specifically, the discretion available to governors over prison health, management cultures that prioritise discipline, security and public protection over health and welfare, and the scepticism of prison staff who can inhibit health promotion, health improvement, and health protection for prisoners and the workforce.

Although a direct regulation would be a compulsory requirement, its implementation would still be operationalised by prison governors and the prison workforce. Essentially, as street-level bureaucrats[32] they use their discretion to mediate government policy. Prison governors, with overall responsibility for management and security of prisons, are critical to the delivery of public health and health promotion. However, participants viewed this concentration of authority negatively, given a common lack of appreciation for and understanding of the Healthy Prisons Agenda (Box 2), perceived to be both intentional and unintentional on the part of governors. Some participants spoke of difficult occasions where they had experienced powerlessness, anxiety, or even fear when trying to persuade governors to implement health promotion activities in prisons. Those who were not directly working with prisons felt that fixation on prisoner micromanagement reinforced inequalities, therefore running contrary to the Healthy Prisons ethos. This anxiety was compounded by the Government's prison reform agenda that advocates increased concentration of authority.[19]

The role of the wider prison workforce in implementing the Healthy Prisons Agenda is equally crucial, given that staff across prisons interface directly with prisoners on a daily basis. Some participants perceived that the prison workforce was less invested in health care policies, attributing higher priority to 'command and control' imperatives, given the prevailing security culture and the need to manage large populations within an overcrowded estate (Box 2). Likewise, prison staff were less amenable to health promotion policies designed to improve health, several viewing sceptically the 2017 smoke-free policy (Box 2).

The need for education for these 'street-level bureaucrats' was most pronounced in narratives relating to prison governors and staff, where it was emphasised that the Healthy Prisons Agenda should run in tandem with security and public protection measures; education could bring about a paradigm shift. Certainly, commitment from those who

directly manage and work with prisoners is likely to sustain the longevity of the Healthy Prisons Agenda in its quest to promote, improve, and protect health.

Box 2: Internal factors inhibiting the full adoption of the Healthy Prisons Agenda

2.1 The unfettered discretion of Prison Governors

> Prison governors [are] … leader[s] … so our role is to create a culture and an environment. … So if you are talking around the healthy prison environment, I decide, as the governor of the prison, if that is my priority. And if it is my priority, then I create the culture of a healthy prison by my leadership. (Participant 17, Prison Governor)

> I would say that some governors completely get it and are totally on board, but others do not get it. … Ultimately, as you well know yourself, if a governor says, 'no' … You can chip away and I always do. So chip, chip, chip, but if they say, 'No', no means no! [laughs]. (Participant 21, Regional Commissioning Lead, NHS England)

> So, are prisons ready [to implement the Healthy Prisons Agenda]? I'd say, probably not ... There are 116 prisons and not all governors will understand what is being asked of them. (Participant 16, Assistant Commissioning Director, NHS England)

2.2 Top-down prison management culture

> When we looked at the incentives in a privileges programme and how [it] can further reinforce inequalities within a prison [by] punishing the people who are really struggling … there's been huge resistance from a prison point of view [to reform this mindset]. … That's their way of thinking. (Participant 21, Regional Commissioning Lead, NHS England)

> It may be in the best interests that prisoners are able to go run around in the yard for an hour a day, but actually security might override and the Prison Officers might say, 'Well, we can't do that', and so, in that sense, … prison staff might reduce security as the be-all and end-all … (Participant 11, Manager of a Voluntary Organisation)

2.3 Scepticism of prison staff toward health promotion policies

> A number of prison staff openly said that they would turn a blind eye to prisoners who smoked. The reason for that was sometimes practical—they didn't have the time or resources to address that because they were dealing with more pressing issues, in their view. Secondly, they were smokers themselves, so they didn't really want to enforce a piece of legislation that they themselves didn't subscribe to. (Participant 12, Academic and former Probation Officer)

External factors inhibiting the full adoption of the Healthy Prisons Agenda

Despite the variation across the participants' backgrounds, all of them articulated a diminishing level of resources due to the Government's fiscal austerity measures as the key external factor inhibiting the Healthy Prisons Agenda (Box 3). Prisons are forced to choose between what they judge to be prioritised or discretionary activities. For most participants, the Healthy Prisons Agenda is discretionary and reduction in resources then demonstrates a genuine tension between strategic aspirations to achieve health-promoting prisons and operational realities of delivering such work on the ground.

While resource strains relate to the institution's supply side, sentencing policy is concerned with the demand side. Prisons must acquiesce to accepting higher volumes of prisoners, irrespective of the concomitant complexities, following the sentencing guidelines enforced by the courts (Box 3). Some participants had also observed the arrival of unprecedented numbers of prisoners presenting with complex health and social care needs, despite prisons not being equipped as secondary or tertiary therapeutic institutions. Whilst prisons can be health-promoting settings, all effort should be geared toward preventing imprisonment in the first place. In this regard, the new Liaison and Diversion Scheme[6] requires that offenders of all ages with mental health problems, learning disabilities, substance misuse problems, and other vulnerabilities are identified and assessed as early as possible, and directed to appropriate services. Similarly, community sentencing and provisional release are arguably more proportionate and constructive, and less disruptive to prisoners' families and social networks.

Finally, study participants exhibited a general lack of support for and confidence in the UK Government's rehabilitative agenda for prisoners (Box 3). Several argued that by appearing to be 'tough on crime', the Government was impeding the rehabilitation agenda. The media can also obstruct change and fuel public resentment toward prisoners, which feeds into the public's desire to punish rather than rehabilitate offenders. However, participants argued that engaging with politicians and with the media to promote the potential gains to be made from a Healthy Prisons approach could start to move things forward.

Box 3: External factors inhibiting the full adoption of the Healthy Prisons Agenda

3.1 Diminishing resources

I don't know where to start! I have to build in efficiencies year-on-year into all of my budgets, and that has implications on the way I deploy staff, the drugs I prescribe, the way I manage performance, [and] manage my teams. (Participant 29, Chief Executive, Community Interest Company)

Things like the peer mentors … unless people dedicate time into those posts, all of that stuff goes when you're short-staffed. … There's three-hour's worth of medication that needs handing out and mental health checks and the reception screens and discharges. So, all of the business-as-usual stuff goes because people are firefighting. (Participant 1, Head of Commissioning, NHS England)

Low positive drug test figures [are an] indicator that you've got a healthy prison, but all were progressively harder to provide. You know, we stopped drug testing at [a local] prison because it was too expensive. Well, if a prisoner says to you, 'I don't want to take drugs and I want to give you a voluntary test to prove that', and we say, 'Actually, mate, it's too much money', what message is that sending to the prisoner? (Participant 22, former Prison Governor)

3.2 Lengthy and uninformed sentencing policy

The population should ideally be 20,000 or 30,000 lower than it is. … In my judgment, [sentences] are too long. … There are too many people in prison without hope, extremely frustrated and, thus, dangerous. They're made dangerous by their circumstances … by the lack of hope that the system offers them. (Participant 18, former Chief Inspector of Probation)

You look at the proportion of people in prison who are actually there, either with a substance misuse problem or a mental health problem. … You take them out of the prison population, the prison population would be reduced probably by about 80 percent, and probably should be. (Participant 28, Chief Executive, Community Rehabilitation Company)

3.3 Unsympathetic political and public stance toward prisoners' rehabilitation

For the last 20 [to] 30 years, successive governments of the left and right have put pressure on the courts to pass longer and longer sentences. … And it's very difficult, once you've ratcheted up the length of sentences, politically, to unscramble that, because any government that says, 'Well, we're going to reduce sentences', is liable to be pilloried in this country by the Daily Mail … for being soft on crime. (Participant 18, former Chief Inspector of Probation)

I think [the media is] getting better at putting the right stories out there—to say, 'If we do this, we reduce reoffending'; therefore, there will be [fewer] victims of crime. Those are the stories that the public want to hear. … We've got to give the public the good news stories, but it's got to be in a way that they see it as a reduction in victims of crime. (Participant 30, Academic and former Prison Health Officer)

Discussion

Main finding of this study

To our knowledge, this is the first in-depth qualitative study to explore the role of a direct regulation in implementing the Healthy Prisons Agenda in England. The findings suggest that a direct regulation should not be used to implement the Agenda, contrary to the arguments that support integration of the law into public health programmes.[9–11] Indeed, participants articulated limitations of a direct regulation to capture the essence and ethos of the Healthy Prisons Agenda, identifying internal and external factors that are liable to inhibit full adoption of the Agenda.

What is already known on this topic

The existing literature appears to broadly support a direct regulation for establishing the Healthy Prisons Agenda in England,[9–11] recommending a legislative framework to reinforce prisons as health promoting settings,[11] and facilitating legal commitment toward supporting and improving prisoners' health.[16-18]

What this study adds

The Healthy Prisons Agenda is perceived as multifaceted, dynamic, value-laden, and outcome-contingent. These findings contradict the established assumption that a direct regulation could ensure enhanced implementation of health promotion in prisons.[9-11] Participants questioned the restrictive nature and value of a direct regulation. Furthermore, anxiety toward a prescribed set of behaviour rules was apparent. Paradoxically, an anxious and risk-averse culture will likely be present within the workforce when standards are breached since litigation is becoming increasingly normalised within the field of health care. Considering that a direct regulation could be 'a step too far', participants preferred a self-regulation model. The current tripartite agreement between NHS England, Public Health England, and the National Offender Management Service[31] resembles a self-regulation model that could be improved by forging stronger shared priorities, leveraging resources, and brokering multiple accountabilities across partner organisations, strengthened by the new Health and Justice Indicators of Performance,[33] which replaced the PSO 3200,[13] to enable more robust implementation and monitoring of health and wellbeing provisions in prisons.

The degree of discretion that prison governors and prison staff enjoy was identified as a conflicting internal factor that inhibits the implementation of the Healthy Prisons Agenda. Labelled as 'the old-school mentality', this anti-establishment view builds upon existing academic debates where values of security, discipline, control, and public protection, it is argued, remain the driving forces of the penal system.[34] Moreover, in support of existing literature,[15] these findings suggest that resistance of prison staff toward health promotion initiatives—such as the Smoke-free Prisons Agenda—is likely the result of the manner in which prison staff have been overlooked, undervalued, and under-resourced. Whilst there are diverse views concerning discretion of prison governors and prison staff, there is consensus that instilling better leadership amongst governors is necessary, especially when the success or failure of current prison reform plans will be primarily person-dependent and leadership-contingent. Echoing the Ottawa Charter,[12] only by enabling prisons to take shared ownership, responsibility, and control over prison health—through education, participation, and the creation of supporting environments—can they start to bring public health and health promotion into the core business of prisons. This requires debunking the 'tough on crime' myth and truly embracing the system-oriented Healthy Prisons Agenda. Further consideration of bottom-up approaches, such as fostering interagency partnership at the local level[35] and empowering prisoners to engage with health promoting activities that they might not otherwise do in the community,[36] can also improve their rehabilitation experience.

This study has also illustrated how austerity measures have increasingly influenced the implementation of the Healthy Prisons Agenda. It has highlighted the tension between aspirations for a broad prison health approach—which aims for a safe and supportive prison environment—and the reality of institutional instability arising from diminished resources and overcrowding. Lack of appreciation by politicians toward prisoner rehabilitation has led to lengthier, poorly informed sentencing direction and negative media portrayal of prison as a rehabilitative process. To address these issues, participants advocated the notion of 'engaging upwards'—using the media and politicians to convey appropriately framed messages around the benefits of prison rehabilitation.

Limitations of this study

This research drew a sample composed exclusively of 30 key decision makers in the English prison field. Although this exclusivity discounts the views of prisoners who are at the receiving end of the Agenda, their views are apposite since this research focuses on the legal and policy imperatives of the Agenda. These voices articulate that internal and external barriers require ongoing assessment and proactive action to successfully implement the Healthy Prisons Agenda across prisons in England, and that self-governance in this sector should be embraced, as opposed to the permanency of a legislative measure.

Conclusions

This study indicates that a direct regulation should not be used to operationalise the Healthy Prisons Agenda in England. Such a legal framework is not likely to address internal and external barriers that inhibit the implementation of such an Agenda, or result in improved implementation. Although the law can address health inequalities in theory, this study shows that, ultimately, the Healthy Prisons Agenda is a limited vehicle for creating meaningful change in this regard. Self-regulation, ongoing evaluation, and proactive solutions that address barriers to implementing the Healthy Prisons Agenda should be the path forward.

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Authors' contributions

N.I. and N.V. conceptualised the study. N.I. conducted interviews with participants. N.V. audited the audio interviews and checked the transcripts against the audio files. N.I. and N.V. developed the coding framework. N.I. coded the data and conducted initial data analysis. Both authors undertook data interpretation. N.I. prepared the first draft of the manuscript. Both authors provided feedback and contributed to subsequent revisions of the manuscript. All authors approved the final version of the manuscript.

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