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ORIGINAL ARTICLE

Disrupting 'healthy prisons': Exploring the conceptual and experiential overlap between illness and imprisonment

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Abstract

Our aim in this conceptual article is to theoretically reimagine the concept of 'healthy prisons' in a way that more thoroughly grounds it in the everyday experiences of prisoners. Our point of departure is the observation that there seems to be an intriguing conceptual and theoretical overlap between first-person oriented empirical studies of two spheres of human experience that are normally seen as separate: serious illness and imprisonment. Our analysis leads us to reimagine the term 'healthy prisons' in a way that increases its usefulness for anyone interested in making prisons healthier and more constructive and reinventive institutions.

KEYWORDS

experience of health and illness, experience of imprisonment, health, healthy prisons, phenomenology

1 | INTRODUCTION

The idea that prisons should be healthy institutions has been around at least since the English prison reformer John Howard (1726–1790) travelled the world to study institutions of confinement and share his vision on purity, cleanliness and good air circulation to help eliminate contagious

diseases in penal institutions (P. Smith, 2008; Vander Beken, 2016). According to Howard (cited in P. Smith, 2008, p.66), prisons at the time were so unsanitary and unhealthy that people who went in healthy were soon 'expiring on floors, in loathsome cells, of pestilent fevers and the confluent smallpox'. Despite Howard's pioneering efforts, however, the reality of prison life has often had little to do with the ideals of health and cleanliness; in fact, prison Inspectorate reports have frequently, up to this day, highlighted prisons as places of disease and squalor. In recent years, however, the idea that prisons can, and should, be healthy institutions has gained considerable traction.

Following an increased focus on 'healthy settings' since the mid-1980s, the World Health Organisation (WHO) introduced the so-called Healthy Prisons approach in 1995 (Gatherer, Moller & Hayton, 2005) as a strategy for protecting and improving the health of prisoners. Since the late 1990s and early 2000s, the WHO has followed up on this important first step with the development of what has become known as the Healthy Prisons Agenda (HPA) (World Health Organisation, 2007). Researchers have followed suit, and today there is growing literature on the idea of healthy prisons (Ismail & de Viggiani, 2017, 2018; Ismail, Woddall & de Viggiani, 2020; Jewkes, 2018; C. Smith, 2000). Regarding practical implementation, government initiatives have often focused on the prevention and treatment of different kinds of specific illnesses in prison, the successful deployment of quality health services in prison, and, more broadly, the promotion of health and healthy environments in institutions of confinement.

These positive developments notwithstanding, the term 'healthy prisons' still seems a contradiction in terms (C. Smith, 2000), given the large body of research documenting that prisons are harmful and unhealthy, and that prisoners as a group are statistically over-represented when it comes to numerous health problems compared with the general population. Serious health issues, including, but not limited to, mental health problems (Fazel & Seewald, 2012), substance use disorders (Pape, Rossow & Bukten, 2020), health issues resulting from isolation (P.S. Smith, 2006), self-harm, and increased mortality due to suicide or overdose (Zhong et al., 2021) are all common in prisons around the world.

Our aim in this conceptual article is to theoretically reimagine the concept of 'healthy prisons' in a way that might be useful for anyone interested in making prisons healthier and more constructive and reinventive institutions (Jewkes, 2018; Crewe & Ievins, 2019; Liebling et al., 2019). We believe that prisons, despite their many inherent dilemmas and damaging effects, can be more or less un/healthy institutions. If this is true, it makes sense to try to make them as healthy as possible. Our perspective differs from many current initiatives in that we want to suggest a broader and more first-person oriented approach (as opposed to the third-person or 'objective' perspective that underpins the field of medicine) to examining the meaning and experience of 'health' in prison settings.

Our point of departure is, first, that there seems to be an interesting field of overlap between first-person descriptions of two different but related spheres of human experience; and, second, that an enhanced understanding of this overlap may help us reformulate the concept of 'healthy prisons' in what we believe is a more sophisticated bottom-up way. The first sphere is the experience of serious illness, which includes a wide range of long-term, chronic, debilitating mental or somatic illnesses. The second is the experience of imprisonment. Once you start looking closely at the first-person oriented studies focusing on these different human experiences, the similarities are striking. Consider, for instance, the resemblance between Toombs's (1987) description of shared features of illness experiences as a series of five 'losses' and Sykes's (1958) analysis of the common experience of imprisonment as characterised by five 'pains' resulting from deprivation. Toombs highlighted the loss of wholeness, certainty, control, freedom and the familiar

world, while Sykes pointed to the deprivation of liberty, goods and services, relationships, autonomy and security. The experiences of 'certainty' and 'security' seem connected, as do 'control' and 'autonomy' on the one hand and 'freedom' and 'liberty' on the other. There also seem to be clear connections between 'the familiar world' and 'goods and services' and 'relationships'. The implications of these similarities and connections are explored in this article.

Toombs (1987) and Sykes (1958) both inspired a string of successors to engage in what we may call first-person oriented phenomenology-informed study of how human beings experience illness and imprisonment, respectively. The reader should note that we are referring to phenomenology in the wide and applied sense here (Burch, 2021; Zahavi, 2019; Zahavi & Martiny, 2019), as distinct from the more strictly delimited philosophical tradition associated with the philosopher Edmund Husserl (2017), to refer to empirical studies of everyday human life from the first-person points of view of human actors situated in specific lifeworlds, with the aim of understanding their experience of some phenomenon. According to Houston (2021), applied phenomenological social science at its most fundamental 'privileges study of the "world" – situations, events, living beings, places, objects, ideas, etc. – as it is experienced' (pp.37–38). In what follows, we base our argument on empirical studies of how the phenomena of illness and imprisonment, respectively, are experienced by the ill and the imprisoned. Our goal is not to provide a comprehensive review of these two research fields (a task that would be impossible within the limits of any one article) but rather to selectively explore the partial overlap between them; nor do we intend to explore the literal empirical overlap between illness and imprisonment. The experience of illness in prison is an important topic but one better conceived as the object of empirical study.

Rather, our interest is how phenomenological (or perhaps phenomenology-informed) studies of the experience of illness and the experience of imprisonment seem to have developed concepts and analytical foci that have a lot in common. We will first briefly introduce the two separate strands of research. Subsequently, we will draw lines between the two literatures and closely examine the conceptual overlap between them. Finally, we attempt to reimagine the idea of healthy prisons in a way that is based on a first-person perspective on health as an experiential phenomenon.

2 | THE EXPERIENCE OF ILLNESS AND HEALTH

Here, the terms 'disease', 'illness' and 'sickness' will be used in accordance with their common usage in the broad field of humanities and social science-oriented studies of medicine (Carel, 2016; Svenaeus, 2019). 'Disease' refers to observable biological processes in the body, 'illness' describes the subjective human experience of disease, and 'sickness' refers to the social role ascribed to those defined as diseased and/or ill. There is often a more or less clear overlap between the three, but this is not necessarily the case: disease without illness, as in undiagnosed cancer, and illness without disease, as in some forms of mental illness that lack an observable biological element, exist. Furthermore, it is frequently possible to hide disease/illness from other people. Consequently, it is possible to experience illness or to be diagnosed as having a disease without adopting the social role of the sick person.

Our understanding of all three concepts is connected to our understanding of 'health'. This is true within the field of medicine, where the 'normal' and the 'pathological' are co-constituted dimensions (Canguilhem, 1989), but it is also true of the everyday lived experience of our more or less healthy bodies. Health is one of those terms that may seem self-explanatory at first glance, but it turns out to be more complicated once examined closely (Van Hooft, 1997). The phenomenon of health and the experience of being healthy do not present themselves to us in any straightforward

way (Kottow, 2017). Is health the absence of any sign of disease whatsoever, a state of 'organic innocence' (Canguilhem, 1989)? Or is a healthy body one that is able to respond to external stimuli and heal itself when necessary? Perhaps health refers to the ability to do the things that one wants and needs to do and reach desired goals? Or is 'health' simply, as Illich (1974) has argued, a word that is used to describe the ability of individuals to cope successfully with internal states and environmental conditions?

Within the field of medicine, one paradigm has enjoyed hegemony since the 19th century (Blaxter, 2010). The so-called biomedical model has been hugely successful in combating disease, lengthening lives and removing or alleviating human pain and suffering. From this perspective, health can be defined pragmatically and independently of the experience of any particular patient as a situation in which the body exhibits values within the normal range on all relevant tests. Therefore, this model is closely connected to the methods and principles of the biological sciences, including scientific objectivity and neutrality, third-person orientation (the 'view from nowhere' of objective science), and a certain way of conceptualising causality. It takes as its core assumption that all ill health is a deviation from the norm, and the science of medicine then tries to identify specific causal factors to treat disease or manage symptoms. As part of this process, medical practitioners take the experience of illness and use it as one source of data among many to reduce the individual to a member of a category that is placed somewhere in the taxonomy of diseases (Gergel, 2012). Once an individual exhibits symptoms of disease (including, but not limited to, the experience of illness), medicine tries to diagnose.

According to critics, the success of the biomedical model has come at a cost. Kottow (2017) concluded that: 'The living body's narrative is often ignored and bypassed in favour of disease-oriented objective exploration' (p.409). According to Baron (1985): 'It is as if physicians and patients have come to inhabit different universes, and medicine, rather than being a bridge between us, has become one of the major forces keeping us apart' (p.606). Dehumanisation has been described as endemic (Haque & Waytz, 2012). As an alternative or supplement to the biomedical model, some researchers have worked within a more first-person-oriented and phenomenology-informed tradition that places the lived experience of illness at centre stage (Toombs, 2001). This literature includes studies of the experience of living with illness, encounters with the health care system, being diagnosed with disease, mental disorder, or disability, and life with such conditions (see, inter alia, Bury, 1982; Charmaz, 1983; Madsen, 2021; Williams, 1984). In what follows, we show that qualitative studies of experiences of illness – both mental and physical in nature – reveal that patients' concerns reach far beyond the biophysical in the narrow sense and, in fact, have many striking similarities with the experience of imprisonment.

3 | THE EXPERIENCE OF IMPRISONMENT

According to Foucault (1977, 1989), prisons and hospitals are historically closely connected. They are both disciplinary institutions that share the aims of surveillance and scientific 'objective' data gathering. This shared origin is still visible today. An analogue to modern medicine, understood as a more or less pure biomedical endeavour, can be found in the practical field of correctional work when seen as an exercise in evidence-based risk management and rehabilitation interventions. Third-person oriented terminologies, such as 'criminogenic needs' and 'risk scores', continue, to some extent, to challenge a first-person informed understanding of the experience of imprisonment (Hannah-Moffat, 2005). A similar third-person oriented logic may be found wherever the effectiveness of prisons are measured according to some external standard (such as post-release

recidivism), and, arguably, where human rights standards are applied as an 'objective' benchmark (Liebling, 2011).

The same is, to some extent, also true of penological research; just as in the scholarly discipline of medicine, a significant proportion of research on prisons and prisoners is third-person oriented, based on ideas of scientific objectivity and neutrality, and interested in identifying causal factors. This should come as no surprise, given that parts of the field for a long time have been influenced by medical research. Evidence-based penology and criminal justice research, in many ways, are mirrored explicitly on medical research. The most pertinent example, perhaps, is how the so-called randomised controlled trial is seen as the only kind of 'proper science' in some penology circles (Hollin, 2008; Hough, 2010).

In parallel with the first-person oriented and phenomenology-informed health and illness literature described above, there exists another first-person oriented penology literature that studies the lived experience of living and working in prisons, including studies of the experience of life in prison, encounters with the prison system, and living with the after-effects of imprisonment. This literature is probably better known to readers of this journal, and will therefore require a less detailed introduction. We are referring to studies that take the first-person perspective of prisoners and/or prison officers as the point of departure. There is no direct equivalent to the established difference between the terms 'disease' and 'illness' in penology – the closest thing is, perhaps, the symbolic differences between the terms 'inmate' and 'prisoner', and the more recent suggestion that researchers should use first-person language when describing the incarcerated (Cox, 2020). The relationship between the objective search for evidence-based interventions and the removal of criminogenic needs, on the one hand, and studies of the lived experience of imprisonment, on the other, clearly overlaps with the divisions that shape the medical field.

4 | FIVE DISRUPTIONS

The experiential overlap between illness and imprisonment has, despite what we believe are obvious similarities, so far largely gone unnoticed. We have been able to find three notable exceptions. The first is a book chapter in which Jewkes (2005) compared the experience of long-term indeterminate imprisonment with the experience of incurable terminal illness. For the 'lifer', Jewkes (2005) argued, loss of control over significant life events disturbs taken-for-granted assumptions about the future in a way that is similar to the experience of people being diagnosed with chronic or terminal illness. The second is Jose-Kampfner's (1990) work on how women who receive long sentences go through something similar to the mourning process experienced by people diagnosed with a serious illness. She described six stages: denial, anger, depression, mourning, acceptance and hope for the future. According to Jose-Kampfner (1990): '[t]he similarities between dying patients and women in prison are that both grieve their termination with the world' (p.122).

The third exception is Leder's (2018) work on the similarities between chronic pain, illness and incarceration. He argued that there is an interesting overlap between the experiences of those suffering from chronic pain or illness and long-term incarceration. According to Leder (2018), experiential commonalities include:

> (1) a constriction of lived space and the range of possible actions; (2) a disruption of lived time, such that one is trapped in an aversive 'now', or ever trying to escape it; (3) isolation, as meaningful social contacts diminish or are ripped away; and (4) disempowerment and depersonalisation, especially when the ill person feels caught

> within a medical system that can be dehumanising in ways that echo prison life. (p.113)

In this article, we build and expand on these analyses in the following ways: Jewkes's (2005) and Jose-Kampfner's (1990) analyses, although undoubtedly groundbreaking, are both limited in their scope in the sense that they compared the experiences of very specific subgroups. Our aim in the following is to widen the perspective and draw on research on prisoners and the seriously ill more broadly.

For Leder's part, we are clearly inspired by his four-part model of experiential common ground to the extent that we have adopted, modified and extended it. His thought-provoking analysis is arguably imbalanced, however, in that it is based on a survey of the academic literature on the experience of illness on the one hand and only on Leder's own experience as a volunteer philosophy teacher in prison on the other. It connects to penology only tangentially: there is a single reference to Guenther's (2013) analysis of the experience of solitary confinement, which is clearly relevant. Apart from that, the only other prison-related sources referenced are his own (Leder, 2000) collection of philosophical discussions with prisoners and Foucault's (1977) classic *Discipline and punish*, which was hardly an analysis of the experience of imprisonment. Thus, following and modifying Leder's (2018) model, we will structure our exploration of these similarities into five main parts that focus on disruptions characteristic of the experiential overlap between illness and imprisonment: (i) disruptions of embodiment; (ii) spatial disruptions; (iii) disruptions of self-image; (iv) social disruptions; and (v) temporal disruptions.

4.1 | Disruptions of embodiment

Human experience is inherently embodied. We experience the world and the things of the world through our bodies and through the ways in which the world impacts and reacts to our bodies (Merleau-Ponty, 2002). An important similarity between the practice of medicine and imprisonment is that the bodies of the ill and the imprisoned both become the projects of other people. According to Gallagher (2001): 'if one eliminates the body one eliminates the subject and object of medical science and practice' (p.147). Similarly, from a certain perspective, a prison is, fundamentally, a technology created to limit and contain human bodies, to make them observable and governable and, if possible, available for behaviour modification. Nurses and medical doctors, on the one hand, and prison officers, on the other, both have the human bodies of others as the indispensable objects of their professional activities. The process when one's body is made the object of the professional gaze of another creates a shift of perspective when patients and prisoners are forced to see their bodies through the eyes of the professional party, which may lead to a sense of alienation.

Illness has been described as the experience of losing control over what is happening to the living body (Kottow, 2017). Furthermore, serious illness and imprisonment will both frequently disrupt the taken-for-granted ability to move around and impact the physical world. Carel (2016) described an ill individual's starting point as one characterised by limitations and the need to find ways to overcome the challenges and problems caused by the illness. The seriously ill often have to stop doing meaningful activities that they have become accustomed to and enjoy. Living with an illness, then, often means being regularly reminded of the limitations that the illness creates. According to Carel, ill people, beyond the limits the illness forces them to live with, may choose to change their bodily routines and fields of action even further to avoid everyday micro-reminders

of their situation. They often voluntarily limit themselves and their movements to what little they expect to be able to do.

This experience is similar when someone is put into prison. Things that are usually taken for granted or ignored are suddenly moved to the forefront of attention. The imprisoned individual's starting point is also one limitation, not necessarily located in one's physical body itself (although imprisonment may in some cases have a negative impact on the imprisoned body directly, e.g., when a low-quality mattress causes back pains which then limit movement), but regarding the field of possible activity within the confines of physical space. Leder (2018) described how those suffering from chronic pain and illness, and those serving long-term or life sentences both inhabit a shrunken world. It is common for patients with physical disabilities to describe feeling imprisoned in their bodies, or that they feel their bodies are not their own; a sensation that is all the more acute for individuals who previously enjoyed good health and were active but who have suddenly or rapidly become severely limited due to pain or infirmity. Similarly, and in a very fundamental sense, being imprisoned is to experience one's field of possible movements as curtailed and highly constrained. Furthermore, everyday life in prison is full of reminders of the limitations imposed on prisoners' bodies, from the space one is permitted to occupy and move around, to the clothes that one must bodily inhabit, to the food and medication that are put into the body (Ugelvik, 2014).

4.2 | Spatial disruptions

The ill or imprisoned body that becomes the project of other people, and the prescribed limits to corporeal movement described above, are enabled by the architecture of prisons and hospitals. In both environments, spatial layout confers differential entitlements and status and, for the prisoner or patient, the lack of control over one's schedule – when you get up and at what time you eat – and the geographically bounded space within which one is permitted to move will serve to remind them of their relative powerlessness.

It is easy to forget that prisons, like hospitals, have historically been places of human(e) experimentation. During the 20th century, a therapeutic discourse emerged during which prisons became influenced by a raft of professional experts, including psychologists, health professionals, social workers and academics. The new emphasis on treatment and therapy permeated discussions about what prisons should look like no less than it has influenced the design of hospitals and health care centres. Both types of building limit autonomy, agency and freedom of movement. They 'fix' the body in a particular discourse, requiring prisoners/patients to submit to the authority of professional 'others', a feat partially achieved through spatial rules and classifications.

In the current epoch, as many Western nations continue to expand and refurbish their penal estates, architecture practices are increasingly diversifying and it is common for architects to take on new prison contracts having never designed a custodial facility before, but perhaps being experienced in the field of health care, including forensic mental health and elderly care. Yet, as Jewkes (2018) points out, (dis)embodiment plays a part here too because, while architects can envisage a time when they will become aged and frail (or observe growing infirmity in their parents and other family members), and design health care buildings accordingly, the same is not true of prisons. Put simply, architects rarely imagine themselves, or anyone they know, in the prison spaces they create. This lack of bodily empathy not only results in buildings where security, control, order, discipline and (bodily) safety are paramount, but it produces environments where experiential qualities that promote good health and well-being (creativity, spontaneity, curiosity, the exercise of personal choice, etc.) are effectively designed out.

4.3 | Disruptions of self-image

According to Toombs (2001), there is a symbiotic relationship between the body and the self. This suggests that limitations imposed on the body necessarily affect individuals' self-image. Our bodies often go unnoticed in our everyday lives. For those of us privileged enough to be more or less healthy and reasonably fit most of the time, our own physical capabilities are often taken for granted. Our sense of the world and of our physical selves usually comes from a starting point of relative freedom and physical capacity.

Illness and imprisonment are both experiences that disrupt this state of benign oblivion. A serious medical diagnosis and a prison verdict can both rupture the lifeworld and propel a stable subjectivity into uncertainty and dread. Illness has been described as a way of being in a world where the loss of the familiar pervades the everyday lifeworld. According to Carel (2016, pp.14–15), the disruption of habits, expectations, and abilities leads to the destabilisation of meaning structures and, in extreme cases, the breakdown of the overall coherence of the ill person's life. The very self-identity of the ill may seem to fall apart. According to Svenaeus (2013):

> To be ill means to be not at home in one's being-in-the-world, to find oneself in a pattern of disorientation, resistance, helplessness, and perhaps even despair, instead of in the homelike transparency of healthy life. … Health, in contrast to this, consists in a homelike being-in-the-world. (pp.232–234)

Cohen & Taylor (1972) touch on some of these issues in their classic study, *Psychological survival*. They say that some problems that beset people in life are so extreme that 'one's physical existence, one's sense of self or one's whole view of the world is at risk' (p. 42). Such shattering events, by disturbing the orderliness of life, may bring the meaning of life into question. But they tend to happen in one part of one's life, in one domain, which means that other domains can be called into service in compensation, or to re-establish credibility. This is not the case with long-term imprisonment or prolonged (especially chronic or terminal) illness. The long-term prisoner and newly diagnosed patient must come to terms with the fact that they are starting on a new life, wherein all the norms and routines they have followed up to this point are transformed. Life cannot be reassembled at some future point; it is forever altered.

Importantly, in prisons, the wedge driven between the self and the familiar world is explicitly part of the institution's point. According to Goffman (1961), total institutions, such as prisons, are designed to remove the social roles of new arrivals through an initiation characterised by what he calls a mortification process. Once the self-identity of the new prisoner has been stripped away, the goal of the prison is to rebuild it according to the goals and logics of the institution. This process seems to necessarily entail a period of alienation similar to what Svenaeus (2011) has called, in the context of serious illness, 'unhomelikeness'.

For various quite different reasons, the seriously ill and the imprisoned are both initially 'displaced' and 'banished' to an unfamiliar, foreign and frightening existence that disrupts the normalised relationship between the self and their surroundings. Illness and imprisonment can be both life-changing and disidentifying, in the sense that they are experienced as disruptions of the self-image. As a result, in both cases, a period of loss and mourning will often result (Jewkes, 2005; Jose-Kampfner, 1990), followed by a process of reconstruction in which the ill and

the imprisoned somehow try to integrate their new status into their biography and a new self -image.

4.4 | Social disruptions

There is a connection between subjectivity and intersubjectivity in the sense that people partly situate their sense of self in their social relationships and networks (Houston, 2021). Imprisonment and chronic illness define people socially, and both may lead to social exile to some degree. This may, in some cases, happen quite literally, as in the examples of quarantine and solitary confinement, but the experiences of exile and exclusion go beyond these very literal examples. Illness and imprisonment both have implications for how one may relate to other people. When the struggles of people's illness challenge their ability to contribute to relationships or participate at work, they are likely to experience augmented social isolation. In one study (Fernandez, Breen & Simpson, 2014), women with bipolar disorder described the loss of their former, independent identities, as the diagnosis necessitated the adoption of a patient identity vis-à-vis other people, loss of relationships, and loss of credibility, leading to identity conflict and the need to conceal the gravity of their illness from other people. In short, illness negatively affects relationships with other people in several ways. Reduced physical ability and mobility can complicate social activities, and feeling negatively valuated by others can cause emotional isolation.

Current and former prisoners may lose contact with their friends and family members for a variety of reasons. Establishing new relationships may also prove difficult. The need to conceal this specific part of their background might feel acute, but in some cases hiding their prison background may be impossible. Prisoners may also decide to limit their social lives beyond what is strictly enforced by the institution. Some prisoners, for instance, choose not to accept visits by friends and family members because they cannot accommodate the feelings of stigma and do not want to give the institution the power to take something away from them (Ugelvik, 2014). They choose to limit their options beyond the limitations imposed by the prison to avoid the painful reminder of the restrictions put on them.

Although a prison background and serious illness may both be experienced as stigmas (Goffman, 1963), the two are slightly different in this respect. If a hospital is an institution that symbolically and physically separates people diagnosed with a disease from the healthy, the prison is an institution that separates those who have been convicted by the courts from the law-abiding. From such a perspective, there seems to be an important moral difference between the status of the 'guilty' criminal and the 'innocent' ill person, but studies suggest that this is more complicated in real life. According to Leder (2018), many illnesses come with a moral stigma, including obesity, diabetes, cardiovascular diseases, and other so-called 'lifestyle diseases'. It is worth noting that 'pain' and 'punishment' has the same etymological origin (the Latin *poena*), and that many suffering with chronic pain, and other chronic illnesses, feel that they are somehow being punished, even when this is unwarranted. Douglas (1966) describes how the 'disgrace' of certain types of illness becomes personified, generating fear and avoidance in the so-called healthy when exposed. The ill individual is abnormal, 'matter out of place', which strikes fear into those around them about the possibility of being 'polluted' (Douglas, 1966). Society tries to quell this fear by removing deviant individuals. Justifications for doing so in today's age are often couched in perceptions of risk rather than outright contagion:

prisoners are seen as unilaterally dangerous and ill persons at risk of harming themselves and/or others.

4.5 | Temporal disruptions

Both illness and imprisonment are experiences that are structured around the concept of time. In the everyday lives of most adults, the fact that time slowly but steadily moves on is seldom reflected upon. Birthdays and anniversaries provide opportunities to step back and contemplate the passage of time, but these special occasions provide only brief punctuation of the ongoing temporal flow. Serious illness and imprisonment may result in a change in temporal perception from the abstract to the acute (Leder, 2016, 2018). As a result, one's ongoing flow of lived time is disrupted. Both experiences may insert themselves into the lifeworld as boundary markers: after illness and imprisonment, there is a new before, a new present, and, hopefully, a new after. These experiences reconfigure the temporal flow of individuals; they become major life course events that irreversibly change the understanding of one's own biography. In both cases, the future may be seen as uncertain and precarious.

Chronic illness can lead to an acute awareness of fragility. According to Madsen (2021, p.7), the lifeworlds of people with *osteogenesis imperfecta* ('brittle bone disease'), for example, are haunted by mental and bodily memories and fearful future scenarios, which makes the 'past and the future collapse into the present'. The experience of serious illness often puts the ill face to face with their own mortality. According to Bury (1982): '[c]hronic illness involves a recognition of the worlds of pain and suffering, possibly even of death, which are normally only seen as distant possibilities or the plight of others' (p.169).

The experience of fragility is shared by many prisoners, who often report experiencing being put in a high-risk situation against their will. Recall that the loss of security is identified as one of the five original pains of imprisonment described by Sykes (1958). Prisoners may not be more fragile than most people, but they live in a setting that many see as more physically dangerous and mentally challenging than most other environments. According to King & McDermott (1995), people are more likely to worry about their health when incarcerated. Sometimes, even prisoners who are quite young and healthy, for seemingly no specific reason, report being afraid that they might die in prison.

Some prisoners experience prison life as living in stasis while the world around them moves on. Jewkes (2005) described how some prisoners experience themselves as perpetually remaining the same age as they were when they went to prison – the world moves on around them, but they remain the same, locked in a temporal bubble where nothing really changes. According to Jewkes (2005), chronic illness and indeterminate sentences result in a disrupted life course – life, as previously envisaged, is derailed, and one is placed in a permanent liminal status. In the case of serious illness and long-term or indeterminate imprisonment, the feeling of in-betweenness may be experienced as more or less permanent, or at least characteristic of a situation that will apply to the foreseeable future.

Furthermore, the experiences of serious illness and imprisonment often have in common an imposed excess of time, in the sense that the imprisoned and the ill may both experience a sudden reservoir of empty time forced upon them. The pace and rhythm of everyday life changes, and one has no choice but to adapt to these changes. Again, time forces itself on the ill and the imprisoned alike and refuses to be ignored.

5 | DISCUSSION: REIMAGINING 'HEALTHY PRISONS'

Prisons, should they aspire to deserve the 'healthy prison' label, need to provide prisoners with high-quality physical and mental health care services, nutritious and sufficient food, clean and hygienic conditions, and the opportunity for appropriate physical exercise. We argue that these are necessary but not sufficient conditions, and that proponents of healthy prisons need to look beyond questions of hygiene and indicators of disease and ill health and ask how prisoners may experience health.

As described above, the experience of health is elusive. Van Hooft (1997) suggests a four-fold model of subjectivity that can be used to empirically make sense of health as a human experience: the material, the pragmatic, the conative and the integrative. The material mode refers to the processes of the organism that are necessary for biological life. When these processes function well or even just adequately, they are rarely part of our conscious lives. The pragmatic mode is the sphere of life that encompasses all the deliberate practical things we do for a reason. This is the realm of goal-oriented and rational actions with specific purposes. When these goals are frustrated for reasons considered related to our biological lives and the five disruptions described above, the subject may experience this frustration as an illness. When things go smoothly, however, again, we often fail to recognise that we are experiencing health.

The central concepts that characterise the conative mode are desire and care. Desire is the reaching out of subjectivity towards the world and the objects and organisms in it with a view to possess and absorb. Care is similar; however, the goal here is not possession or absorption but enhancement. 'Subjectivity cannot attain full selfhood without developing a concern for others and for things. Love is a constitutive part of our being', according to Van Hooft (1997, p.26). This mode of subjectivity allows Van Hooft to describe health from the point of view of the subject as a positively given phenomenon, not just as a lack or an absence. When we are able to reach out and interact with the world in ways that help us fulfil our desires and show care towards others, it is a pleasurable experience. These are the parts of life that give us nourishment and make life enjoyable.

This leads to the fourth and final mode of subjectivity—the integrative mode. This is the mode in which we strive for unity and meaning in our lives:

> It is not enough that we survive [material mode], succeed in our pragmatic tasks [pragmatic mode] and experience positive emotion and stimulation [conative mode]. We also need to feel that these achievements and experiences form part of a meaningful life. We need to feel that there is a point to it. (Van Hooft, 1997, p.26)

The four modes of subjectivity constitute a unity, according to Van Hooft. It follows from his model that, to experience health, an individual needs to have a body that functions well, biologically speaking, and they must be able to plan for and reach everyday goals. From the perspectives of these two modes, health is equal to a lack of limitations. But this is not enough. The experience of health as a positive phenomenon is connected to the conative and integrative modes.

We have shown that there seems to be considerable overlap between the lived experiences of illness and imprisonment, including how both phenomena frequently result in disruptions of embodiment, space, self-image, social life and temporality. We believe that this overlap – far from just an interesting observation – should have consequences for how prisons are designed and managed, and for the way we conceptualise prisons as more or less healthy institutions. We

believe that a prison is healthy when it successfully removes or limits the impact of the five disruptions described above. Furthermore, we believe that prisons should strive to allow prisoners to experience health not just negatively but, where possible, positively as well. Such a view has some consequences.

First, a healthy prison is one that allows prisoners appropriate levels of agency and user involvement. These institutions are designed to limit and take control of prisoners' bodies. Thus, autonomy is often severely limited, which may lead to a sense of helplessness and a general lack of control. In the case of illness and imprisonment, where many of the taken-for-granted actions we all do and expect to be able to do without much thought are made difficult or impossible, restrictions and limitations inevitably come into focus. Being ill and being imprisoned have in common the experience of having to think about what one cannot do in ways that the healthy and the free are spared. A healthy prison is a prison that allows prisoners healthy and constructive outlets for their agency. Given that prisons, at their core, are designed to limit and shape the agency of prisoners, this would involve giving up a certain degree of control. The kind of leeway afforded to prisoners and the meaningful choices that can be given them in practice would have to be tailored to the specific institution and the degree of security staff is expected to uphold, but in general, we believe that in a healthy prison, staff have to be both able and willing to give prisoners the opportunity to make meaningful decisions about their own lives and the situation they are in. This seems necessarily to involve the willingness to place a certain level of trust in prisoners where appropriate (Ugelvik, 2021).

Second, a healthy prison manages to create a homelike and self-confirming atmosphere. If the practice of medicine can be reimagined as the art of providing patients with a new home (Svenaeus 2011), healthy prisons should be seen as places that are capable of supporting prisoners in their search of a home, both in the literal and the metaphorical sense. It is true that the experience of imprisonment still needs to be integrated into the biography of prisoners. Prisoners, and long-term prisoners in particular, often feel that they exist in a limbo of stagnation and wasted opportunities. We believe healthy prisons should offer prisoners arenas for constructive change, hope and the possibility to envisage a future life worth living. This orientation towards potential positive futures is an important part of what Leder (2016), in an attempt to imagine what constructive prisons may look like, has called 'enlightened prisons'. Following Leder, we believe healthy prisons allow prisoners constructive and positive arenas for the renegotiation of the self, including a selection of meaningful and future-oriented activities.

This aspect highlights the fact that prison institutions never should be seen in isolation. The call for future-oriented reinventive prisons where genuine growth and hope can develop seems hollow in a world where the use of very long-term and indeterminate sentences is on the rise many places. It is nigh impossible to foster genuine hope for a better future when prisoners are facing sentences of 20 or 30 years or more. It is also painfully obvious that all prisons do not aspire to be reinventive institutions. Indeed, some prisons have been designed to simply warehouse prisoners, or even to punish them harshly for the ills they have caused society. The impact of different penal philosophies on everyday life in prison is another topic better suited for empirical study, but we want to state unequivocally that we believe that healthy prisons need to exist within a healthy regime of punishment, and that this would entail significant penal policy and sentencing reforms in many, if not most, jurisdictions. In many cases, the whole overarching logic of the system would have to change, not just the culture and set-up of specific institutions. We find it hard to believe that a punishment and retribution oriented prison system will ever produce healthy prisons in the sense we are developing in this article.

Third, a healthy prison is one that can foster constructive relationships and contribute to reducing the effects of stigma. Schön, Denhov & Topor (2009) argued that the success of health care services should be determined by, among others, the individual's experience of having a meaningful social life and relationships. Sells et al. (2006) claimed that the social life and network of the ill individual should be given a more prominent role in thinking about individual recovery. We believe that this is true of healthy prisons as well. Such institutions should help prisoners create and maintain positive social relationships within and beyond the prison.

Fourth and finally, a healthy prison gives prisoners a sense of transparency and predictability. This involves efficient communication, clear rules and staff who are willing and able to follow these rules. Antonovsky developed the concept of 'sense of coherence' as fundamental to understanding the experience of health (see Blaxter, 2010). Such a sense includes the extent to which individuals perceive the world as comprehensible (ordered, structured, predictable), manageable (given available resources), and meaningful (making emotional sense). Important decision-making processes should be as transparent and predictable as possible to create a sense of coherence and procedural justice (Tyler, 2003). According to Liebling (2011), prisons are experienced as more punishing and painful where staff are seen as indifferent and lazy (and thus unpredictable) in their use of authority. A prison that seeks to nurture a sense of coherence should try to foster a mutual sense of purpose and validation among prisoners and staff. Meaningful interaction between prisoners and officers is likely to be the most efficient way to create a predictable, respectful and transparent environment for all.

6 | CONCLUSION

Our description of normal medical practice as dehumanised was, perhaps, too simplistic. We acknowledge that there are important rehumanising countercurrents in the field of medicine today. Patient autonomy has been on the agenda of health care professionals for decades. Recently, concepts such as 'service user perspective', 'service user rights', 'service user involvement', 'co-production', and 'recovery' have risen to prominence. This language has also permeated the criminal justice field: More prisoner-centred approaches that privilege first-person perspectives and lived experience exist and within penal establishments, incarcerated offenders have been re-cast as service-users for whom rehabilitation – in both its senses as a healing or recovery process and a pathway to desistance from crime – are regarded as the ultimate goals. Our impression is, however, that these examples are often isolated pockets of good practice, and that the field as a whole has a long way to go before it reaches the level of the medical field regarding listening to the people directly affected by prisons, be it the prisoners themselves or their friends and families.

According to Leder (2018), illness and imprisonment may both act as case studies in the study of the human capacity to weave meaning in the face of the absurdity of the human condition. Following Jewkes (2005), studies of imprisonment and research on serious illness may have in common the revelation of what it is to be human. We believe that imprisonment and illness have in common the fact that to fully understand these phenomena, they must be studied as lived experiences. Disease described in the language of medicine is different from the lived experience of illness in the same way that punishment described in the language of law and policy documents is different from the lived experience of imprisonment.

Delivery of high-quality health services, prevention of specific diseases, and the promotion of health through various interventions are all necessary parts of an institution worthy of the 'healthy prison' label – necessary but not sufficient. We believe that healthy prisons, in addition to specific

services and interventions, are designed and managed in a way that lets prisoners experience health positively as often as possible. This means that, beyond disease prevention and health promotion, healthy prisons also need to target the parts of the prison lifeworld that lead to experiences that resemble what ill people typically undergo. The goal is not that prisons should be more comfortable, luxurious, or 'plush'. We believe that healthy prisons, conceived in this wider and more experience-led way, are more likely to be reinventive institutions where growth and positive change are possible.

Prisons can be, and frequently are, unhealthy in many different ways. Even the most welfare-oriented prison systems, where rehabilitation, positive change and growth are taken seriously, have to acknowledge that prisons, to varying degrees and in different ways, are institutions that seem to be experienced as akin to illness. Prison officers and managers, on the one hand, and health care professionals, on the other, would both do well to reflect on the overlap between illness and imprisonment experiences, and on what it suggests about the nature of their different enterprises. From the point of view of prisons, which has been the focus of this article, it seems important for healthy prisons to give prisoners the resources they need to minimise the aspects of life in prison that are experienced as akin to illness. This will, we believe, give more prisoners the opportunity to experience health positively as well as negatively through the absence of pain and physical limitations, the ability to reach everyday goals, and the presence of friendships, love, and purpose.

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