Climbing the walls: prison mental health and community engagement

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Abstract

Until recently, treatment for mental health conditions has focused on medical and psychological therapy. The role and significance of social and community interventions and initiatives in fostering recovery, resilience and a sense of 'flourishing' is now being recognised. This paper seeks to explore how these principles, which are usually community-based, can be successfully applied within a prison setting, and how such interventions may have a positive effect on the mental health of prisoners through successfully engaging them with the communities they are set to return to after release while still in custody.

Key words: Prison mental health ■ Exclusion ■ Community engagement ■ Biopsychosocial paradigm ■ Stigma

It has long been recognised that there is a direct relationship between mental health problems and rates of reoffending (Social Exclusion Unit (SEU), 2002). The introduction of Mental Health Inreach Teams (MHITs), and improvements in prison healthcare facilities has gone some way to addressing the mental health needs of prisoners (Department of Health/Her Majesty's Prison Service, 2001). However, on release, many find it hard to cope without the support they have received in jail, and others do not meet the criteria to receive statutory mental health services in the community. The important role of bridging this gap often falls to third sector, voluntary and specialist organisations within the community.

Ex-offenders often have difficulty finding housing and employment and resettling and reintegrating themselves back into the community. Family and social ties, which they enjoyed previously, may have been broken as a result of their time in custody (Caie, 2011a). The experience of exclusion, which is likely to have begun before entering the prison system, may be felt even more acutely on release. These difficulties are compounded if the ex-offender also has mental health difficulties.

While the joint issues of social inclusion and community engagement are high on the agenda in community settings and of community mental health teams, the task is made harder for nurses working in prison mental health teams by the physical and mental barriers that separate prisoners with mental health problems from the outside world (Caie, 2011a). Physical barriers are perhaps obvious. However, mental barriers are less tangible and even harder to overcome. Stigma, suspicion, fear and mistrust make it difficult for those on both sides of the prison walls to establish meaningful and productive links and build the necessary bridges to help prisoners back into their communities as productive and active participants rather than sidelined and excluded observers.

In light of this, there is much to commend any initiative that seeks to break down the barriers between mental health care within prisons and the outside community.

There is much literature and research on community engagement and mental health within the community setting. Having carried out a literature search on community engagement and the custodial setting, there appears to be a dearth of information. As such, there is perhaps scope not only for further research to be conducted but also for gaps in our knowledge to be plugged by practice-based evidence. This paper will give one example of this taking place within the mental health nursing team at HMP Manchester.

Community engagement

Community engagement may be defined as more than merely access to services and facilities in the community, but rather:

> **'Active participation in the community as employees, students, volunteers, teachers, carers, parents, advisors and residents' (National Social Inclusion Programme, 2009).**

In his foreword to the *Independent Living Strategy*, the then Prime Minister, Gordon Brown, states that:

> **'Our vision for Britain is of a society where all citizens are respected and included as equal members, and where everyone has the opportunity to fulfil their potential' (Office for Disability Issues, 2008).**

Mental health problems require more than medical or psychological approaches to ensure successful outcomes. The role of occupation and employment, and housing and social opportunities are also vital to ensuring quality of life, guiding recovery and developing resilience.

Mental health nurses have adopted a biopsychosocial model of assessing and meeting clients' needs. This notion was first introduced by George Engel (1977) who advocated a shift from traditional biomedical practices to one, which seeks

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Accepted for publication: March 2012

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Mental health services in community settings place a strong focus on community engagement

to encompass the patient as a whole, acknowledging that factors other than biology or emotion might have a bearing on that person's mental wellbeing. Within our mental health nursing practice, to ignore the social component of the biopsychosocial paradigm is to neglect a significant and influential part of the client's world view. It limits opportunities to address existing emotional and mental health difficulties as well as to promote positive wellbeing and flourishing.

Mental health services in community settings place a strong focus on community engagement, actively supporting clients to seek out social and economic opportunities. However, is it possible to begin the journey towards community engagement from within the prison walls themselves? The role of providing mental health care to prisoners involves actively seeking opportunities to engage with the local community, to work towards empowering and informing prisoners as to what is available to them on release, and how to access it, in order to begin to build meaningful and satisfying lives, and continue their journeys of recovery.

This is a two-way process. In the first instance, as stated above, prisoners need to be aware of what is available to them, and how they can access it, but community services and resources also need to be aware of this highly excluded group, and move towards actively seeking to engage with them.

There are a number of organisations that straddle the prison and outside community. Organisations, such as Jobcentre Plus, Age UK, local education providers, chaplaincy services and Partners of Prisoners (POPs), work effectively both inside and outside the prison walls. There is further scope for this type of work to be carried out. Mental health teams can build effective working relationships with their counterparts in the community, and support the establishing or maintenance of effective therapeutic relationships before release. However, when clients are deemed not to meet the criteria of community mental health services, nurses and other clinicians within the prison walls must then think more creatively about how to bridge the gap between prison and the community.

The impact of successful community engagement

Any nursing intervention will have a specific aim or outcome. So what outcomes can we, as nurses, expect when we begin the process of community engagement, and in particular, community engagement with clients in custody?

Improving levels of social capital

Improving the individual's levels of social capital has been shown to have a positive effect on mental health and wellbeing. There are many varyingly complex definitions of social capital, however, in this paper, it refers to the benefits (in this case, to emotional health) reaped by an individual of being part of one or more societal groups or networks (Hawe and Shiell, 2000; Farr, 2004). It carries with it strong implications of mutual trust, coordination and cooperation for mutual benefit (Baum, 1999).

Social capital may be viewed either as that of the individual or community or sector of society, e.g. a specific ethnic group (Kawachi et al, 2004). However, the concept of social capital has, at its root, the notion that as human beings, we are more than just atomistic individuals, and that, for our

continued wellbeing, we require a sense of belonging or connectedness to some form of community or collective. This is a view borrowed from the work of Emile Durkheim in the 1890s (cited in Elstad, 1998). It would appear then, that it is impossible to address the issue of social exclusion on a purely individual or case-by-case basis. It becomes necessary to take a broader view and look at the problems in terms of places and whole communities (i.e. contextually) rather than as a single person (Kawachi et al, 2002). This is described by Cattell (2001) as the 'third way' of reducing health inequalities, looking at places and neighbourhoods rather than just the individual as a driver for improving levels of inclusion in society.

Upon release from custody, people have often lost their housing or employment, and owing to the stigma of being an 'ex-offender' and having a criminal record, find it difficult to regain these things in the community. Occupation, possibly undertaken while in custody, often affords little in terms of transferable skills that are relevant to the job market (Durcan, 2008). Existing work skills may be out of date, and the client may have no employment history (Sainsbury Centre, 2006).

Therefore, what can be seen, both from the literature and the experiences of clients, is that people are coming from excluded groups in the community into custody, where their problems are compounded, and are then released back into the community with more problems than they began with, finding themselves further excluded owing to stigma around their criminal record. Such circumstances make for an increased risk of reoffending upon release (SEU, 2002). This truly is a vicious cycle.

Building resilience

By focusing on the positives, highlighting achievements and capabilities and building on these, clients may develop better skills in coping with life's ups and downs without compromising their mental health. In the long run, this is beneficial not just to the client but also to already over-stretched mental health services, and to employers and taxpayers if it empowers more people to find work.

Ensure that nursing practice is recovery-focused

Such a focus, by necessity, removes the constrictions of the medical model, and looks at the person through the biopsychosocial paradigm as the embodiment of their thoughts, feelings, experiences, relationships and circumstances. Recovery is made possible through supporting the client in looking at every area of their lives, helping them to build on strength and success, and learn from failings and times of weakness, and to instil in them a sense of hope and optimism (Basset and Repper, 2005). Furthermore, it is essential that nurses maintain hope and optimism. The prison environment, by its very nature, can be foreboding, claustrophobic and dehumanising. Nurses working with prisoners, have a role in maintaining something of the outside world; simply referring to someone by their first, rather than last, name can have a significant impact on how that person views themselves, reminding them of their identity outside the prison walls.

Concepts, such as hope, recovery and resilience, need to be as much part of daily nursing practice within prisons as in the community, perhaps more so. These factors can have a major influence on the ability and willingness of the individual to re-engage with life outside prison and to become a functioning member of the community.

Box 1. Case study

George (not his real name) had been in custody for around 8 months. He began attending therapeutic groups after he became depressed. He participated in several sessions around social roles and opportunities, including a creative writing workshop with a writer from the local community, designed to highlight the 'arts and culture' segment of the Inclusion Web. Despite being initially resistant to this experience, and reluctant to share his work, George used this session to explore in a creative way where his emotions came from, problems he had experienced in the past, and how he could rebuild his life in the future.

George's focus became more positive over the weeks and months that followed, and he began to acknowledge that he was thinking much more about what he could do and achieve when he was released than on what he felt he had lost when he came to jail. He felt that his experiences in the group had helped him to see that there were several facilities and organisations in the community he could access.

Before his release, George had gained knowledge and insight into what was available in his local community, and had made contact with several organisations and groups there. He had also used links he had made through the group and invited speakers to arrange some voluntary work for himself. George was optimistic about being able to build for himself a meaningful and fulfilling life in the community, which in turn would reduce the likelihood of his re-offending and returning to jail, and felt confident and optimistic about his future.

Promote flourishing

As Keyes (2002; 2005) suggests, we should promote not just mental health but also flourishing. Keyes states there is a continuum of mental health, which goes from mental illness or languishing right through to positive mental health or flourishing. It is perhaps not enough to support clients in achieving some degree of mental wellbeing but we also need to aim to support them in flourishing. Flourishing entails the attainment of a high level of social functioning and also to experience high levels of hedonia, satisfaction and positive affect. In this way, Keyes suggests that clients will be enabled to function to a much higher level than people who are moderately mentally healthy or languishing. The inference is that by fostering flourishing in our clients within the prison walls with a view to enabling them to re-engage fully with the communities they will re-enter upon release, their lives are more likely to be purposeful and fulfilling, and their mental health will continue to flourish outside prison. This may reduce the likelihood of recidivism and dependence on the welfare system (SEU, 2002).

Community engagement in practice

The author has made use of the Social Inclusion Web, which is a tool based on a variety of life domains that helps people to map their activities and contacts with a view to highlighting areas of good social capital and areas that may require further consideration (Bates, 2007). This can help clients to focus on the various areas and aspirations within their lives (*Box 1*), bringing representatives of outside services and organisations into the prison for informal discussion and information-giving sessions. In this way, clients can begin to consider how and where they might find help, support and

opportunity in rebuilding the different areas of their lives that have been affected by either their time in jail, or previous experiences of exclusion. Focus is also drawn away from the experience of what has been lost by coming into jail to what can be gained both now and on release.

Links and joint working with the local healthy prisons coordinator (someone who works within the jail to provide health promotion information and to encourage and promote access to healthcare treatments and interventions) have also been used to provide health promotion sessions and increase clients' awareness of what physical and mental wellbeing is and how it might be achieved in their own lives. Through the healthy prisons coordinator, workshops have also been run by a local writer, encouraging clients to explore various aspects of their own lives, experiences and wellbeing in a creative and non-stigmatising manner. Two peer-facilitated support groups have been affiliated with the Depression Alliance organisation, which maintains regular contact to support the evolution of these groups. Also, links are being made with community agencies to provide input into work promoting positive wellbeing and reducing isolation among older prisoners, a group particularly vulnerable to social isolation and exclusion (Caie, 2011b). The case study in *Box 1* highlights how valuable interventions such as these can be to clients who are about to be released back into the community.

Spurred on by a number of successful projects and initiatives like these, the author continues to actively seek opportunities to 'climb the walls', developing links with community agencies and services, which may go some way towards bridging the gap between services within the prison walls and those outside in the community.

Conclusion

Biological and social interventions are commonplace in our daily practice and the links between physical and mental health, and health and socioeconomic factors are well documented (Friedli, 2009). An emphasis on the biopsychosocial paradigm, however, brings into focus the importance of the provision of socially-focused interventions to our mental health practice.

Interventions carried out in custodial settings, which have a strong focus on community engagement may well begin to bridge the gap between support services within jails and those that exist outside. Such interventions address the social, environmental and economic issues that have a bearing not just on the individual's rehabilitation back into the community, but also on a successful and meaningful recovery from their experience of mental ill health.

It is part of the role of mental health nurses in prisons to foster resilience, recovery and flourishing in clients, keeping them focused on a world outside prison at times when they may feel hopeless and worthless. One way to do this is to consider ways in which people, agencies and services in the community can become more involved and engaged with those in prison prior to release. This requires creativity, imagination and good professional social capital on the part of the mental health nurse in prison.

Services both inside the prison walls and outside, must work together to develop effective ways of supporting prisoners with mental health difficulties to engage, interact and more fully participate in the communities to which they return upon release. Only then can we say that we have successfully found a way of climbing the walls, which physically, mentally and socially exclude those within. BJN

Conflict of interest: none declared.

KEY POINTS

- People enter custody from groups that are already excluded in society. The custodial setting then compounds this and releases them with a further layer of exclusion by way of being an ex-offender
- Prison excludes people from society physically, mentally and socially, all of which can have a negative impact on the mental health of prisoners
- The social aspect of the biopsychosocial paradigm provides opportunities for mental health nurses to improve outcomes for clients on release from custody through community engagement
- Mental health nurses in prisons need to promote hope, recovery, resilience and flourishing
- Further efforts by mental health nurses in prisons and services in the community are required to provide a bridge from custody back into the community in order to promote positive resettlement in clients

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