'We've all come together as one — prisoners, staff and managers'

Prison Dialogue as a means of facilitating patient/public involvement and implementing new standards in prison healthcare

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Introduction

The purpose of this paper is to share the learning from an innovative dialogue-based intervention that is currently being conducted at HMP Blakenhurst, supporting the implementation of new standards in prison healthcare.

Background

HMP Blakenhurst Healthcare Centre

HMP Blakenhurst is a category B local prison with an operational capacity of 880 male prisoners. Until August 2001 the prison was privately managed by UKDS, at which point the contract was taken over by HM Prison Service following a contract retendering exercise. Healthcare services have been provided by NHS trusts since the establishment opened in 1993, the contract now being held by Redditch and Bromsgrove Primary Care Trust, which has the lead for health improvement across Worcestershire. The prison Healthcare centre has a 29-bed in-patient facility and primary care centre with medical services provided by general practitioners contracted through a local GP practice. The service is managed and run by nursing staff with appropriate specialist, psychologist, psychiatrist, dentist and optician support.

Prison Dialogue

Prison Dialogue is a non-profit making organisation established in 1993 and registered as a national charity in 1995. It is a small group committed to deep cultural change in the penal system through working on the ground, at operational level, with all who live and work within prisons (that is, prisoners, officers, governors, nursing staff and other associated staff). It is placed within the context of a continuum from arrest to re-settlement and in consequence work extends into the community.

Throughout the past 10 years an extensive programme of dialogues in prisons, headquarters and the community has been delivered, including cultural change work, conferences, action-research and developing training programmes. The primary focus is not to lobby at a policy level about changing rules and regulations, but rather to address the way relationships are formed and sustained within existing regimes. The most significant place to work is at the sub-cultural interfaces: between headquarters and governors; governors and officers; officers and prisoners. A complete cross-section of the organisation is even more effective and this approach has been explored in HMP Blakenhurst over the past five years.

Framing the Healthcare intervention: identifying needs

The contractual change in management at HMP Blakenhurst had a significant cultural impact and this was particularly highlighted in the Healthcare centre. Nursing staff under UKDS management had not been responsible for managing the in-patient unit, they had provided clinical

advice and support. The re-organisation resulted in the nursing team taking ownership and responsibility for the unit as a whole with the exclusion of discipline staff. This had a huge impact on prisoners and staff in terms of their new roles and responsibilities which challenged normal practice.

Prison Dialogue had been involved in Blakenhurst's main residential units for some time but had not been active within the Healthcare centre. The advent of change within the establishment seemed an ideal time to introduce dialogue to the unit. There was a shared feeling that this would help to address issues around relationships and cultural change. In the Healthcare centre, staffs' and managers' main concerns were about marginalisation and isolation from the rest of the prison. Extending the conversation into another part of the system enabled Prison Dialogue to work both at the interface between Healthcare and the rest of the prison, as well as between the positional groups within the unit itself.

Process

What dialogue is and what it involves

Dialogue is a relationship-based approach that entails thinking and learning together (Bohm, Factor and Garrett 1991). The starting point is listening in an agenda-free conversation (Garrett 1997). It is a different space than any other; a chance for conversations that are not always possible because of potentially unhelpful barriers to communication such as the absence of respect, poor listening and difficulties associated with giving and receiving feedback.

Dialogue sessions provide opportunities for participants' voices to be heard; for sharing ideas about how the Healthcare unit and prison operates; and about how people behave. Dialogue works at many levels, from the individual, through the interpersonal to the organisational; it affects conversations and relationships beyond the sessions. Dialogues are not action groups but a place to wonder about how things occur and how they might happen differently (Garrett 1995). It is here that cultural change can begin through working closely together to raise and explore issues of concern.

How we are working, what we have done and who has been involved

Following the development of a joint agreement between Prison Dialogue, HMP Blakenhurst and Redditch and Bromsgrove Primary Care Trust, the intervention began in October 2002 with a series of conversations between managers, officers, nursing staff and Prison Dialogue staff. This was followed, in November 2002, by the introduction of a sequence of weekly dialogues between prisoners, nurses, associated staff and managers, each lasting about two and a half hours.

Our intention has been to include as many patients/prisoners from the unit as possible and the average number of patients/prisoners attending each session has been 10. This broadly represents 70-80 per cent of the total number of prisoners who are resident on the unit when the dialogues are taking place. Nursing staff assess individuals' physical and mental health prior to each session. At times there are people who we cannot accommodate because they are too unwell. Together, we discuss how to draw people into the sessions and provide space for individual prisoners to experience the dialogues.

On occasions, individuals have left or been escorted from sessions when they have become distressed or disruptive because of their mental health needs. Importantly, the open and inclusive nature of the dialogues has resulted in this being a rare occurrence.

As a consequence, we are learning about how a group of people with diverse needs, some with severe mental illness, can develop understanding, mutual support and a way of being together that is 'healthy'. Consequently, once individuals have joined the sessions they have participated well and enjoyed the experience. Here are some comments:

> *I'm glad I came out of my cell. I was going to stay in there because I was very upset. I knew I'd have to come out eventually. The dialogue helped that. Sorry I disrupted things. (Patient/Prisoner)*

> *I was feeling really bad in my cell but I joined the dialogue and I'm glad I came out. I'd almost given up but I feel different now, thanks to you. (Patient/Prisoner)*

> *I'm amazed that they've all concentrated for two and a half hours..... (Nurse)*

On average, two nurses have participated in the dialogues. This is despite shortages of staff on the unit. The Healthcare manager has also joined the sessions at least once a month and more frequently whenever possible. The deputy governor, head of industries, education manager and prison based CARAT (drug service) team leader have also participated in individual sessions.

Opportunities are provided for staff to participate in preparatory pre-session briefings. At the start of each everyone is asked to introduce themselves; this is a form of 'check-in' where all participants are invited to say as much or as little as they want. It provides airtime and space for individuals to be heard without interruption or comment. During the dialogue, as themes begin to emerge they are explored together (see examples below). Facilitators and participants pay particular attention to core practices, for example, voicing, listening, respect and suspension; bypassing, naming and engaging.

As the intervention develops, opportunities are provided for individual nurses and patients/prisoners to develop their understanding of the role and application of these practices in their interactions with others and to learn more about what underpins the facilitation of the sessions. Learning opportunities are further extended for staff (without patients/prisoners) through a process of debriefing with facilitators at the end of each session.

A closing round or 'check-out' concludes the dialogues. The purpose of this is similar to the 'check-in'; each individual is invited to make a closing comment which is recorded so that they can be shared with staff and prisoners throughout the rest of the prison. Comments may be about how individuals have experienced their participation in the dialogue or may focus on particular things that they have learned.

Progress: What we are achieving

Overall, the intervention has had a positive impact on relationships between differing staff groups and staff and patients/prisoners. Dialogue sessions have provided an excellent forum in which patients/prisoners can not only explore their own personal issues, but be allowed an active voice in the provision of Healthcare at HMP Blakenhurst. What follows is a detailed account of what we have achieved together during the initial six months of the development.

Practice: Activity on the unit

Through the exchange of ideas possible changes in practice have been explored and levels of activity on the unit have changed. Recently, patients/prisoners talked about how they would like to have more time to talk with staff; particularly during association time.

> *Staff being here is really important. I would like them to be in here more in the week as well as in the dialogues, more interactive rather than in the office, joining us in association more. That's when we all talk. Staff need to get to know prisoners more. (Patient/Prisoner)*

Previously, staff had thought that prisoners preferred to spend association time interacting together without a member of staff being present. Prisoners had thought that staff were either too busy or that they did not want to take time to talk with them in association. By talking together the misunderstanding was resolved. As a consequence, it appears that some members of staff have been spending more time interacting with prisoners. Similarly, following the participation of the education manager, two prisoners commenced training programmes in the education department and one began an open learning course. The need for further thought and planning in relation to providing appropriate work-related activities on the unit have also been clearly identified and the head of industries recently joined a dialogue to explore scope for providing patients/prisoners with work opportunities.

Care and discipline

> *The nurses have helped me a lot here but I wonder whether this unit should be run by nurses under prison rules. (Patient/Prisoner)*

Issues relating to the dilemmas nursing staff often face in managing the boundaries between care and discipline have frequently emerged. For example, nursing staff want to encourage socialisation for mental well-being but can encounter limitations for security reasons, for example, needing to stop prisoners from talking together in the corridors of the unit. These challenges are also present in the context of policy (for example, hospital/prison, NHS/Prison Service) role (for example, nurse/officer) and internal structures (for example, in relation to perceptions of people as patients/prisoners).

Further difficulties in care boundaries have emerged from patients/prisoners and staff alike as they have talked about their perceptions of the environmental and resource limitations on the level and type of care they can give and receive.

> *When the doctor comes round, you know he's got lots of people to see... he asks you how you are... you just say 'fine'.... even though you feel far from fine... How can you tell him in the five minutes you have? (Patient/Prisoner)*

I am trained to work therapeutically with prisoners; I would like to be able to spend more time working with individuals one to one but I just never seem to have time to work with people. The turnover is so rapid that it makes it virtually impossible. (Nurse)

Recognition has also been given in conversations to the ways in which managing such a diverse group of care needs can present many challenges. Yet, there also appears to be recognition that diverse needs can (and should) be perceived as an asset as well as a challenge. Central to this enquiry in the dialogues has been exploring how to allow everyone to be themselves within a culture built on mutual respect.

Going straight to action

Initially, we noticed a tendency for staff to move immediately towards action, for example, when individuals were challenging in the dialogues they were quickly removed. Also, at times when prisoners identified problems with particular issues, some nurses were quick to engage in problem-solving for the individual. This can be problematic for staff because they are often frustrated in their attempts to 'fix things' when they encounter difficulties in their interactions with other staff outside the unit or in the prison system. Patients/prisoners can also feel let down because they do not get a result. Moving too quickly to action can block opportunities for reflection and inhibit understanding about what is really needed.

More recently and where appropriate, individual prisoners have increasingly managed their own care in relation to participating in the dialogues. This is illustrated in how some of them have become more actively involved in decision-making about joining and leaving the sessions. This represents a shift away from a nurse focused 'you ought to leave' or 'you can't come in'.

Bypassing

At times, we have also observed a propensity for 'bypassing' on the unit. By this we mean there is a tendency towards avoidance rather than naming particular issues, interactions and behaviours and/or engaging with them. This is illustrated in the use of humour which is a coping strategy but one that can also mask other feelings.

Other examples have included unease with silences and evading whole group conversations; quick reactions to disruptions (from the radio or 'events' on the unit); avoiding bringing the 'self' to the sessions (although this has been shifting); sitting in the office and communicating with the patients/prisoners through the windows that separate the office from the association room — the latter accompanied with frequent expressions of frustrations with lack of time and pressures of workload. Humour can be an effective form of communication however the challenge is to learn to use it appropriately, not as avoidance.

Relationships and connections: Mutual learning

Nursing staff, managers and prisoners are beginning to recognise how much can be achieved through sharing information and learning from each other, for example, about the importance of trust in the relationship between patient/prisoner and nurse, and the value of talk in a prison setting where opportunities for conversations can be limited.

We've all come together as one — a group as one, prisoners and staff and managers. Good to hear different views about who is here on Healthcare and how it works. (Nurse)

The impact of this is described in more detail below.

Individual/group skills and relationships

Individual prisoners have developed their ability to listen and engage in relationships. As a result, they have begun to understand their own behaviour, as well as that of others.

People are listening a bit more, partly because it is been so interesting sharing stories, hearing stories which give us things to reflect on, to get feedback. I'm glad the sessions are weekly, you can't wait until the next time. I feel totally relaxed. It is a bit of space for me. (Prisoner Orderly)

Together, we are developing understanding of what is going on behind what we see in the dialogues. This is illustrated in how having one group conversation has presented challenges to participants, in part because of a tendency to return to one-to-one conversations. This distraction may also be because patients/prisoners and staff have heard an individual's story many times before, or because they are not prepared to listen to someone because they have been kept awake all night by them. Similarly, when conversations are more difficult, some participants lose interest and some

appear to revert to existing one-to-one relationships and patterns.

> *It has felt different today. It is been difficult to keep track because there have been lots of small conversations but after the break there was more of a flow. (Patient/Prisoner)*

> *I don't know why we've been going off at a tangent. I noticed myself doing it. (Nurse)*

The dialogues are also providing a space for prisoners to share poetry and express feelings, ideas and thoughts with respect and without judgments.

> *The honesty in these sessions is far beyond anything else I've experienced. You may be quiet the first couple of weeks but then you realise you won't be judged and then you join in. (Patient/Prisoner)*

Similarly, patients/prisoners who are new to the unit or who are in prison for the first time are being further supported through their participation in the dialogues. It is a place for them to get to know other prisoners, have their story heard, be accepted publicly and increase their confidence to interact with others in the prison.

Staff involvement in the dialogues

Many of the Healthcare nursing staff and agency nurses have expressed a genuine will to be in the dialogues communicating and developing appropriate relationships with patients/prisoners. They have also asked questions and expressed concerns about how to do this, for example, engaging in group conversations whilst believing in the need to avoid revealing personal information (see 'bringing self' below). Subsequent feedback about their experiences in the dialogues has been positive. The importance of having opportunities to talk with prisoners about the subtleties of relationships and what makes a difference to them is illustrated in the following quotations:

> *Hearing other people's opinions has been good. Learning something as staff too, things we don't normally think about, like the thing about keys; how the way that you open the cells can set the tone for the day on the unit. It really makes you think and feel. There will be times when individuals have differences in the group. (Nurse)*

Individual nurses have also asked to develop group facilitation skills and the potential to develop and implement a communication/awareness model and learning agenda that is particular to the Healthcare unit, and focuses on improving skills, is being explored.

Bringing self

> *I've really enjoyed today. We've talked about a whole range of things, about the prison and the unit. What's changing is how we all seem to be bringing out people's stories and the stories about the unit. (Healthcare Manager)*

Some individual staff and managers have begun to model bringing the 'self' into the dialogues by telling personal 'stories'. While security awareness is important, non-specific and non-identifying stories can make a big difference, in part because of how the personal emphasis is more interesting to people so they listen more closely and energy levels rise.

Connections with the rest of the prison

There is strong sponsorship from all Healthcare staff and at senior management level. However, they have not been able to bring officers into sessions because of low staffing levels. Whilst this requires further work, foundations have been laid for further strengthening relationships between Healthcare and main location through bringing managers and associated staff from the main part of the prison to the sessions.

> *I've really appreciated coming down here and sitting with you; talking about what people want to talk about. Healthcare can be very isolated in the prison. It'd be good to open it up and get more staff and managers from other parts of the prison to come to the dialogue to think and learn together. (CARAT drug service worker)*

To illustrate this further, in response to a suggestion from one of the prisoners on Healthcare, feedback sheets and monthly reports from the dialogues on main location and Healthcare are being shared.

Transition of prisoners between Healthcare to main location

Issues relating to the transition of prisoners to and from Healthcare and main location have surfaced. Individuals have described how they can feel much safer on the unit and how they appreciate an

atmosphere which enables them to feel contained and cared for. Stories have also emerged about how some prisoners abuse the system by behaving in particular ways to get put down on the unit. We have also learned about how the transfer back to main location can feel like a punishment.

> *Why would you put someone who was vulnerable and self-harming on Houseblock — isn't that a punishment? (Patient/Prisoner)*

To sustain patient/prisoners' connections to the dialogues we are also tracking them when they move to main location and inviting them to sessions that take place there. As a result, one of the things that we have learned is that when 'vulnerable' prisoners move to main location they can feel as though they 'disappear'; they lose attention and some will 'act out' in order to regain it. 'Acting out' can include self-harming, refusing medication and exhibiting 'odd' behaviours, all of which present particular challenges to wing staff in managing them.

Next steps

This review of the initial phases of the intervention in the Healthcare centre at HMP Blakenhurst has revealed how dialogue can provide an effective way of facilitating patient/public involvement. Moreover, how they can provide a means of supporting the challenges that lie ahead in implementing new standards in prison healthcare. As we move beyond the pilot phase of the project we hope that the next stages will include the following:

- Development of a feedback and learning agenda with individual programmes meeting different needs of staff and managers on the unit. This will enable them to further improve relationships and interactions with patients/prisoners, with each other and with colleagues throughout the prison.
- Work with issues surrounding the Healthcare unit in relation to the rest of the prison by bringing other staff and managers into the Healthcare dialogues.
- Exploration of particular themes in greater depth, such as care and support re: moves to main location, managing self-harm, how to further strengthen connections between the unit and the rest of the prison, dilemmas in care and discipline, use of humour, inclusion and exclusion.
- Work with staff; a 'staff only' dialogue between Healthcare managers/staff and one between Healthcare managers/staff and managers/officers from main locations.
- Support for the development of the Clinical Governance agenda within the establishment as a whole; Prison Dialogue will continue to play a proactive part in this, particularly in facilitating the prison's patient/public involvement initiative.

We would also like to explore potential for developing the initiative as part of a wider intervention within the Redditch and Bromsgrove Primary Care Trust that is, in HMP Brockhill, HMP Hewell Grange and HMP Long Lartin. In addition, we are keen to respond to interest being expressed by other prisons about how to 'do' patient/public involvement (PPI) which is central to the Clinical Governance agenda. We would welcome the opportunity to run a dialogue conference that focuses on PPI in prisons. However, to accomplish these aims we need to ensure a consistent presence and to do this we urgently need funding. Whilst we are committed to continuing to develop, maintain and evaluate the intervention in HMP Blakenhurst, this is where our current challenge also lies.

References

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