The Reeman Unit at HMP Styal

Mary Eaton talks to **Stephanie Dulson** and **Eric Hunter** about the new mental health unit at HMP Styal.

In December 1998 HMP Styal saw the opening of the new mental health unit of the Health Care Centre. Under the direction of the Governor, Madeline Moulden, the new unit had been planned as an annex to be staffed solely by NHS personnel. The unit was built by the women prisoners. It was called The Reeman Unit in memory of a former long-serving member of the Board of Visitors.

In April 1999 I had visited HMP Styal and been impressed by the atmosphere and ethos of the new unit, by the obvious commitment of the staff and by the rapport between staff and patients. In July I returned to interview two significant members of the staff. The first interview was conducted with **Stephanie Dulson**, the Head of Health Care at the prison. She spoke of her vision for mental health care.

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Stephanie Dulson, HMP Styal

What I wanted was a unit where women were treated as women and as equal and as individuals. Having come from the NHS and worked in a therapeutic community prior to coming to Styal I wanted to employ the same concept as we used ... you know "I may be a nurse but as a patient you are equal to me and we bargain and negotiate with what it is you want". That's the vision I saw. I don't think we are there wholly for that reason, because we find that the constraints and restraints of the prison do impinge upon the unit, but not to a large degree. That's because the nurses are so good at what they do. They see things in the mental health way rather than the disciplinary.

The main achievement is actually recruiting good positive staff for the unit. We've been able to work with lots of women that are very, very disturbed or very damaged. We've been able to give back to those women some of the things that have been taken from them in different parts of the criminal justice system. Things like allowing them certain choice in what it is they do throughout the day and treating them as individuals. They're not a number in our eyes; they're actually an individual patient.

What sort of choices can you give?

We've started with one of the long term patients where we say "ok, you're stabilised now. Would you like to do evening cookery classes? Would you like to go out to education?". Other choices, like "tell us if you have something that will harm you, but we're not going to come in and turn your cell over. At the end of the day it's your choice if you self-harm". That's a big choice to give somebody. It's also giving them responsibility back so it's about making them realise that even though the choices to outsiders would appear to be limited, there are some choices that they can make and in that process they will learn to make bigger choices in the future. That's the hope anyway.

Have there been any problems?

There have been snags but the snags aren't within, they're from without really. Things like canteen. These women are very much into routine, like all of us are into routine. But, for example, if we think that canteen's on a Tuesday and we're geared up to believe that canteen's on a Tuesday then if you're a patient and you've got no cigarettes on a Tuesday afternoon and somebody says "no, your canteen isn't until Thursday" that's not fair. So we have been really campaigning overtly and covertly to get a regularised system going so that we don't have to say to them "sorry, but we can't get you these sweets or these toiletries". So it's systems failures really. And we haven't got enough space.

How many beds are there?

We've got ten and the unit is a credit to the women in the prison who built it, but we could do with "quiet" rooms, we could do with interview rooms, we could do with perhaps even a "snoozelum" so that women could go in and sort of chill out a little bit. We could do with a relaxation room, a group therapy room because we have an art therapist who comes in and we have no room for the art therapist. So we could do with a few additional tag-ons to it.

What have you actually got in terms of space?

We've got ten beds [in single rooms]. We've got a big day room - it's a sitting and eating area - a garden, a staff office, one shower and one bath. The garden's smashing; it's another room almost, but we could do with more rooms.

The 'snoozelum', what is that?

We use snoozelums quite a lot in learning disability, but they're not specific to learning disability. It's a room that would have coloured strobe-like fibre optic lights so that you would go into a semi darkened room with cushions and bean bags and close the door. Usually a member of staff would go into the room with a patient. You can have music playing as well. It's very, very

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therapeutic and the colours will stimulate the mood, as will the music. For some of our women who aren't able to verbalise to a great degree - and that's not saying they've got a learning disability, but they might not have been encouraged to verbalise in the past - they can actually start to experience stimulants that are different from perhaps drugs or alcohol. Things that will make you feel good other than chemicals. It would be a brilliant feature to have, so we're lobbying for that at the moment.

And the women you have in the unit, how do they come to be here?

We tend to get them from the criminal justice system. We've got one woman coming in this afternoon. We got a phone call today saying that she's got a severe personality disorder, would we take her, and that she was untreatable.

She was in the court. We have women who come from the remand centre, from reception, from other prisons spasmodically because if we started to take other prison's women we'd be snowed under and we wouldn't have enough for our own catchment area. So we get women from all over the place, absolutely all over the place.

Ten beds - and how many women are there in this prison?

About 480.

So that's a tiny, tiny proportion.

It is, so we have to be quite spot on with the admission criteria and we also have to watch that we're not used as a dumping ground for the discipline side. We are finding that women who present challenging behaviour to the discipline side can actually be taken to a pitch whereby they are perceived to be mentally ill, but actually they're not mentally ill, they're just very, very frustrated by the systems in situ.

With the ten women here, what types of disorders are present?

We have the full range of disorder. We have the schizo affected disorders; we have the psychotic women; we have women who have, I hate using the word, personality disorders; women who have been sexually abused, which results in acting out and challenging behaviour; we have women who grossly self-harm. Anything on the DSM classification on the psychiatric table of disorders we see in that annex. Lots of our women are moved to NHS hospitals, but it's becoming more and more difficult to get them moved over to the hospitals because there aren't the long stay wards there any more. A lot of these women don't need short, sharp, acute; they need quite a long time perhaps in therapeutic communities, but there aren't any. You've got Grendon in London for the men, a therapeutic community. I think what prisons need is a female therapeutic community whereby the women that you can see going on to something else could actually start to socialise with society.

In the beginning we talked about the nurses, they're all NHS. What's the ratio of men to women?

I think we're probably 50/50. I know there is the debate about normalisation, and it's male/female, but I'm also aware that some women do not want a male to nurse them. We do acknowledge, that males sometimes are not the best people to nurse females, but equally, sometimes a male is better at nursing a female. It's down to personalities more than anything else. We've got no macho culture down there.

What are the issues that need to be addressed for the future?

The movement of nurses in and out of the health care services. I think nurses have a sell-by date in prison nursing. For nurses to remain fresh and remain consistent with what we are doing I think we should be looking at, or working towards, moving staff out because there can be professional isolation. And I think this is what happens in prisons, because each prison is run in a different, unique way. This is where you get quite a lot of social and professional isolation. Probation officers only do a maximum of five years in prisons and then they have to go back out. I think nurses should come in for between three to five years and then go back out to an NHS establishment. They can even come back in at a later date if they want to, but there should be some two-way traffic for nurses, definitely.

The discussion concluded with a contribution from **Eric Hunter**, the Head of the Reeman Unit.

Would you tell me about the different types of nurses employed on the Reeman Unit?

At present there are eleven full-time nurses of whom six are RMN (Registered Mental Nurses), four are Registered Mental Nurse Handicap nurses (RMNH) and their background is dealing with people with mental handicap, and one is an Enrolled Nurse Mental Handicap. So we have a fairly even split, a cross-section of mental handicap and learning disabilities field. You have to appreciate that the skills needed in dealing with people with learning disabilities, even mild learning disabilities, are considerably different to those needed for somebody who's got symptoms of psychosis or depression.

We've been operational now since December 1998 so we've been open seven months. We are pretty successful in identifying and treating and giving direction to other people with mental health and learning disabilities. Even though we're based here on the

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Eric Hunter, HMP Styal

Reeman Unit and Health Care, we are a prison-wide service and we see people as in-patients and out-patients now and hopefully will continue to link with people who have been here and discharged from here. So it's an ongoing service. It actually provides a service to the whole prison.

You've got to expect that mental health, like any illness, is generally at an acute stage and then it goes on to where you need ongoing support. We will support people basically in the same way that a Community Psychiatric Nurse would see them in the community, by appointment on a weekly basis, or - where women have been seen regularly by a nurse here for a long time and is on first name terms with the nurse, then the officer will know to contact that nurse. It's that sort of system. And if the nurse isn't on we'll make sure someone else can see them, so there's always access to the health care system. The other thing is that it can be 24 hours a day. We operate a 24-hour day.

Because we're all health care professionals all our policies and procedures are on health care standards. We try to maintain NHS standards and by doing so it is easier to link in to after care for these people because you are talking the same language. The other thing we've put a lot of effort into is making contact with local services. We're networking, so you actually see the people and it makes life a lot easier. Again, a lot of my staff have worked in those units so we have contact all the way around.

The main problems - and they're not problems which are sorted out straight away, but general ones - are that there are not enough beds, so we have a situation where people will just tread water in prison for too long, waiting for a bed. I don't think that's unique to prisons, I think that's the case in many areas.

Are there any other aspects of the Reeman Unit that you would like to comment on?

We had a visit from the Prison Inspector, Sir David Ramsbotham. He was very impressed with the unit but he said "do you think you're being too successful for your own good?" and the more I thought about it the more I agreed with him.

What did he mean?

Basically we are doing such a good job that what's happening now is that people are going back to court and their solicitors are saying something to the effect of "thank goodness she's in secure psychiatric care where she's getting treatment" and the judges are saying "alright - fair enough. They're getting good psychiatric care where they've got good nurses, they can see a consultant psychiatrist once or twice a week, 24 hour facilities, they're getting a good standard of care. It's probably better than most psychiatric units. Why should I rush to get them out of there?" So, if there's a young man who's disruptive and unruly with no care in Strangeways, for instance, and a woman who's being supported admirably in Styal, who would you move on first?

Our long term objective is to continue to recognise that people with mental health problems, defined mental health, should never get into the criminal justice system. And if they do get here by default they should spend a minimum of time here. They shouldn't be left to rot and fester. One of our aims is to support, but also to get people out of the criminal justice and back into the mental health services as soon as practicable.

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