My life: in safe hands?
Dedicated women’s medium secure services in England

“All the work I’ve done and they say ‘don’t run before you can walk’. I’ve just come a long way, I’m at the end of the tunnel now and it’s true, there is light, there is light!” Woman service user

Georgie Parry-Crooke

Penny Stafford

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Acknowledgements

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Georgie Parry-Crooke

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### Acronyms used in the report:

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<td>BPD</td>
<td>Borderline Personality Order</td>
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<td>BME</td>
<td>Black and minority ethnic</td>
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<td>CAMHS</td>
<td>Child and Adult Mental Health Services</td>
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<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<td>CFT</td>
<td>Community Forensic Teams</td>
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<td>CJS</td>
<td>Criminal Justice System</td>
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<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<td>HCA</td>
<td>Health Care Assistant</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>MDT</td>
<td>Multi-disciplinary Team</td>
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<td>MHA</td>
<td>Mental Health Act</td>
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<td>MSU</td>
<td>Medium secure unit</td>
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<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
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<td>NOG</td>
<td>National Oversight Group</td>
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<td>NOMS</td>
<td>National Offender Management Service</td>
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<td>PTSD</td>
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<td>PALS</td>
<td>Patient Advisory Liaison Service</td>
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<td>RMO</td>
<td>Responsible Medical Officer</td>
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<td>SHA</td>
<td>Strategic Health Authority</td>
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<td>TEMSS (W)</td>
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Summary

Introduction
In 2000, there were 39 medium secure services in England. Of these, almost all were mixed provision with only 14 NHS and 79 independent sector medium secure beds in dedicated women-only services. By January 2009, there were 27 dedicated women-only medium secure services (nine independent and 18 NHS) with a total of 51 wards and providing 543 beds (261 in the independent sector and 282 within NHS services). There was at least one service in each health region of the country; with six in the North-West and only one in the South-West. Of the 27 services, 19 had a gender-specific care pathway with either a women-only rehabilitation or pre-discharge ward, or a women-only low secure or step-down service. Four of the 27 services were women-only sites with five on mixed sites but with no regular mixed activities. Seventeen were on sites where some activities were mixed.

The overall aim of this study was to evaluate established, new and emerging dedicated women’s medium secure mental health services that cater for women with complex needs. The evaluation involved 50 women service users and over 60 professionals in looking at the way in which services have developed and their impact on women’s lives.

Sections of the report are referred to in the text below.

Setting the scene
The quality and safety of secure mental health provision for women has been the subject of wide ranging discussion noting that women in mixed-sex services have been disadvantaged by their minority status (1.2). They have also experienced the adverse effects of gender and other inequalities on their treatment and care. Successive policies across the Criminal Justice System and mental health have argued the need to provide gender sensitive services which help to reduce women’s offending rates, respond to the specific needs of women and ensure women’s safety in single-sex provision. The more recent development of medium secure services for women, supported by the Department of Health (1.3), was a response to the perceived vulnerability of women which has resulted in a variety of research studies, policy developments and operational changes in service provision. Developments included the closure of all but one high secure service for women, the opening of three Enhanced Medium Secure Services for Women, the setting up of four pilot residential high support therapeutic services for women, the expansion of women-only medium secure services.

Service provision in England
Two separate mapping exercises for this evaluation (in 2006 and 2009) showed there was considerable variation across women’s medium secure services in terms of the type, size and range of provision. In January 2009 there were 15 NHS Secure Services and eight independent hospitals providing medium secure care for women in single sex wards (2.1). These were women-only services or women-only units within mixed secure settings providing a total of 386 beds across 38 wards.

Independent sector services tended to provide a higher number of beds for women. However, they also had more than the recommended number per ward/unit.

The case study services, selected on the basis of organisational structure and location, illustrated some of the different ways in which the women’s mental health policy agenda has been implemented (2.2).

Women’s journeys through the service
Key factors affecting women’s routes to recovery (3.1) were determined through the use of repertory grid technique to elicit the elements (people involved in enabling their care) and constructs (how women discriminated between their experiences of and relationships with all the elements/people). Women’s most frequently referenced factors were:

- Relationship with staff
- Trust
- Positive expectations
- Empowering approach
- Reducing isolation
- Good daily support
- Relational security
- Holistic approach
- Meeting emotional needs
- Offering a range of interventions
There was consensus among service users and professionals about the most important attributes of a women’s medium secure service in relation to recovery.

**Philosophy, models and policies in practice**

Essential to service provision was the development of a coherent and thought-through *model or philosophy of care* (3.2). The case study services had adopted a variety of approaches including Attachment Theory, Mentalisation, models of therapeutic communities, gender-sensitive approaches, the Tidal Model and RAID (Reinforce Appropriate, Implode Destructive). Where there was no clear model in place, staff and women described more tension, confusion and a higher number of difficult incidents. Staff in these services were also less likely to receive regular support and supervision.

Even with a clear model, services demonstrated the difficulty at times of turning philosophy and policy into every day practice for a variety of reasons (3.3). Core to this process was an understanding that working in the service and reflecting on theory needed to be integrated. Policy implementation was hindered at times by lack of staff; time; awareness and, in larger mixed medium secure services, understanding.

**Single sex policy and provision**

At the centre of the DH Women’s Mental Health Policy was the importance of offering women safe places to work towards their recovery including access to women-only services where appropriate which meet their needs (3.4). There was agreement across women and professionals about the importance of single sex provision although this varied across case study areas. Some women preferred single sex wards but wanted the opportunity to mix with men in off-ward areas. Male staff were considered important in providing positive role models although it was not always easy to find men who wanted to work with women.

**Women’s safety and security**

Women and professionals involved in their care were clear, regardless of terminology, about the importance of a number of key factors and in particular *relational security* which underpinned what services should work towards (4.1). For this study, relational security was defined as embodying high staff-to-patient ratios, time spent in face-to-face contact, a balance between intrusiveness and openness and working towards high levels of trust between patients and professionals.

However, the initial survey showed that policies about relational security were only in place in half of services. In the case study areas, services described ways in which their practice aspired to or was already consistent with this definition even if they did not use the same language to define what they experienced. However, there was considerable inconsistency and even where a policy was in place, staff were sometimes unclear about what this meant in practice.

Women described what they valued about the service in terms consistent with the ideas underpinning relational security (4.2). This included:

- Being able to talk to staff
- Being on a women-only ward
- Being able to address specific issues safely
- Being able to just be with staff
- Being able to form and sustain good peer relationships

Some women were frustrated by the level of physical security but in particular, inconsistency of security policy implementation was a cause of complaint. Staff identified factors which hindered embedding relation security including practical implications of low staff levels, physical and procedural obscuring relational security and where trust was difficult to achieve among staff a well as women service users. Continuity and staff changes were also identified as potential barriers. Staff attitudes and the use of patronizing language sometimes inhibited relational security in practice (4.3).

**Day-to-day for women**

Women who participated in the evaluation rarely referred to an *admissions* policy (5.1) but described the process and their arrival. Moving to a medium secure setting was often seen as an improvement on where they moved from and a route to recovery. Key to a smooth transition were speed, effective consultation with women, provision of information, maintaining contact pre-admission, keeping a woman’s outside connections and ensuring continuity of staff through admission and arrival at the new service. Professionals had to make decisions based on individual women’s needs but in the context of the balance of women and levels of support available in the unit at the time.

The *physical environment* (5.2) was important to women and staff. While new buildings were off-putting to some initially, most women appreciated...
efforts made to make the unit look and feel homely. Some would have liked more say in design and décor. Single rooms with en-suite bathrooms as well as access to communal areas including a gym, activity rooms, gardens and visiting areas were all noted by women as contributing to their well-being. For staff, design which incorporated zonal observation was welcomed and the reduction in, what were seen to be intrusive, one-to-one observations helped to ensure staff were available to provide escorts and be involved in on and off-ward activities.

Services offered a range of interventions, treatments and therapies (5.3). They were concerned that women found ways of talking about their traumatic experiences despite varied views about the type of psychological therapy to provide and when it should be offered. In addition to psychological therapies, some offered specialist therapies from healthy living to eating disorders. Formal, structured timetables were mixed with informal leisure activities and across services responding to the initial survey almost two thirds of women took part in community outings, shopping and social events.

Women and staff recognized the value of ‘informal’ activities (5.3). Women wanted to do what was ‘ordinary’. Some staff and other professionals saw this as having a therapeutic potential in the same way that more formal interventions were intended to have.

A dedicated Occupational Therapy (OT) service was valued where it was available. OTs worked with women to increase their levels of independence and confidence through education, training and work opportunities. Mixed-sex services aimed to provide some women-only activities. Social Work was another important source of support to women who wanted contact with their families. This was sometimes seen as a separate area of provision but one social worker wanted to see ward staff involved in traditional social work issues as a means of supporting women and building team relationships.

Access to sufficient and appropriate physical healthcare was not always provided (5.3). Women service users were particularly concerned that their needs were not being met in relation to seeing a GP or other doctors.

Advocacy was provided in some but not all services and rarely was this gender-specific. Few of the women interviewed had sought out support from an advocate. This may have been due to the under-resourcing of advocacy services and thus time-limits placed on those offering to support women. However, advocates were involved in supporting some women in a range of ways including practical problems and in issues relating to the unit or ward environment.

A further aspect of day-to-day life for some women was their involvement as service users in provision and governance (5.4). The level and type of opportunity ranged from unit/ward meetings, patients’ councils to representation on clinical governance groups and membership of a regional service user involvement strategy group. Women were encouraged to be involved but motivation to do so was a problem for some. Others were deterred by concerns that change did not appear to result on the basis of service user involvement.

Care pathways, planning and discharge
The Care Programme Approach (CPA) provides the overarching framework for the provision of mental health services in England. Implicit is the involvement of the person using the service and where appropriate, their carer. The key to successful Care Planning and Care Pathways lay in the relationships between women service users, their care coordinator and the team involved in the care overall.

Not all services invited women to attend the whole of the CPA meeting and some did not always want to attend (6.2). However, women did want to believe that they had made a significant contribution through their own and others’ reports. Staff and women service users reported inconsistencies of approach to care plans and input to CPAs which had resulted in some women challenging the content of reporting to care teams and at review meetings (6.3). Women’s involvement was patchy and ranged from one case study area where women said they had little or no involvement in their Care Plans to one area where women were invited to provide a weekly report to ward meetings about their care and progress. It was not clear that the impact of gender was being considered consistently in care planning, review or with care coordinators.

Women service users and professionals agreed that there was a lack of suitable move-on accommodation (6.6). Access to rehabilitation wards or low secure services was severely limited. This had resulted in a bottle-neck situation until such time as appropriate
provision could be provided. In January 2009, only 12 of 27 women’s medium secure services provided a rehabilitation ward and just over half (14) had access to their own low secure services. There was some evidence of increased support provided by community forensic teams to enable women to move into the community. Four pilot community therapeutic residential services have been established for women many of whom will come from medium secure provision.

Day-to-day for staff
Women’s experience of medium secure services was shaped by the staff and other professionals who they came into contact with. The composition of the workforce, the provision of a multi-disciplinary team and offering training and support to staff were essential in the delivery of services. Services wanted to work with dedicated, stable staff teams with an appropriate gender mix. However, given difficulties of recruitment and retention in areas, it was rare that this was achieved (7.1). Services looked for staff who were motivated, committed and empowered in their work (7.2). In mixed-sex services it was not always possible to apply to work with women only. Thus there was an element of uncertainty about the recruitment of appropriate staff. Services tried to build up a regular pool of agency staff in the interests of consistency on the unit.

Although staff at all levels considered training and supervision key to effective delivery, there were considerable gaps between policies and what happened in practice resulting in many staff receiving no gender awareness training (7.3). Reflective practice, supervision and access to counselling and support were recommended in the service specification. These were on offer and usually required in the case study services. However, due to shift patterns, the demand on qualified staff, limited time for ‘supervisees’ and sometimes lack of confidence among newly qualified/unqualified staff to seek support, supervision frequently took second place to service delivery (7.4).

Building on experience
The evaluation identified many ways in which services had addressed the specific needs of women and indeed, some providers had been invited to advise men’s services on their philosophy of care and specifically relational security. Good practice was identified in a variety of ways (8.1).

Delivery of differential care to meet the specific needs of women

1. **Philosophies of care** for working with women were embedded within the daily practice of most case study services based on gender sensitive practice, promoting a psycho-social approach taking account of the context of women’s mental distress and acknowledging the impact of trauma and abuse on women’s mental health.

2. **Staff recruitment policies** aimed to achieve a 7:3 female to male gender ratio, with male staff providing positive role models for women, although not all services had managed this yet. They also sought to appoint ward staff with an active interest in and desire to work with women, and in most areas, the induction and on-going in-service training included women’s mental health issues and gender specific practice.

3. **Dedicated psychologists for women’s services** were able to undertake formulation-based assessments and treatment planning incorporating psychological and social perspectives acknowledging the importance of the woman’s story and life experiences and seeking collaboration with the woman, with her views and objectives being noted.

4. **Purpose-built facilities** as stand alone or attached to main mixed-units usually offered structured programmes of therapeutic gender specific activities as well as women being able to access mixed-sex sessions if available and appropriate.

5. **The Assessment and Care Planning Approaches** in place suggested that some were formulation-based encompassing a biological, psychological and social perspective and acknowledged the woman as an expert in her own “story” providing a basis for women to feel they were involved in their care planning.

Maintaining women’s psychological and physical safety

1. **Relational security** was well provided for in most case study areas within regular professional practice by staff members on the wards and the strong therapeutic relationships they built with the women. Staff were provided with opportunities to develop reflective practice and were supported to develop therapeutic relationships within appropriate professional boundaries through regular group and individual supervision.
2. **Extra Care, Intensive Nursing Suites or High Support Areas** on women’s wards allowed women who were acutely ill to be cared for away from the main ward area. These areas were used as a short term facility only. They provided women who were acutely distressed and at risk of harming themselves or others with a safe but comfortable environment without the need to isolate them completely, but where intensive nursing input and emotional support from staff was available to them.

3. **Clinical nurse and other specialists** were employed within some women’s services providing risk assessment, care planning, support and therapeutic and educational interventions for women who, e.g. self injure, as well as advice and support to members of the care team involved in their care.

4. **The gender sensitive practice** developed on wards supported staff to work towards de-escalation using means other than control and restraint techniques for managing women’s behaviour and it was reported that the use of control and restraint techniques had become less frequent.

5. **The physical layout of the women’s wards** was more likely to have been designed to allow zonal observation within the main day areas as an alternative to intensive one-to-one observations, which women often found intrusive.

6. **Team nursing approaches** were developed across most women’s wards so there was always a member of each woman’s team on duty who was familiar with her care plan and individual formulation.

Facilitating recovery for women, rehabilitation and resettlement

1. **Seamless care pathways** Having identified the need for a gender-specific route out of medium secure care for many of their women service users, some services have worked with regional teams and commissioners to develop a seamless care pathway for women. Several wards worked with **internal care pathways** for women with markers for progress. One service began the process pre-admission. Another described its access to a Community Forensic Team for women who required this support once discharged from the inpatient service.

2. **The therapeutic treatment approaches** on some women’s wards meant that women were supported to develop knowledge and awareness of their own mental health needs. This was facilitated by the women being given the opportunity to explore their life stories and experiences in their own time and within the context of a trusting therapeutic relationship, to reach a shared understanding of how this impacted on their mental well-being.

3. **Women service user involvement** in service planning and development had enabled some women to take on responsibility for facilitating user group meetings and being representatives at external user networks and meetings.

4. **Social and vocational opportunities** In one service, women had access to a voluntary organisation commissioned to provide education and work-related training and social opportunities including, for instance, office work, desktop publishing, participation in the running of a social club/café for service users and advice about external training and career opportunities. Women were also contributing to decision making about ward and other activities in some areas.

5. **Provision of family/child visiting suites** appropriate for children were seen as a considerable improvement on previous facilities.

Structural and organisational factors

1. **Multi-disciplinary teams** brought key staff and women service users together in decision-making processes. Staff across case study areas appreciated the value of this model of working.

2. **Streamlining administration** wherever possible from referral to discharge helped to ensure a smooth pathway into and through a service. This included new computerized systems for recording information and completing CPA documentation. One service worked with staff on how they wrote reports to reduce judgmental language and improve the overall balance of their reporting.

3. **Monitoring activity** was required in all services to provide data to commissioners and/or parent organisations. Several had introduced additional ways of capturing service delivery, e.g. through satisfaction surveys in one case designed with women service users, staff training needs analysis and take up of training and support, as a means of service development. Two case study services were developing research to determine meaningful ways of measuring outcomes.

Professionals and women service users also identified significant gaps and areas where there was room for
development and improvement (8.2). On the basis of the case studies and review of documentation, we have listed a range of areas which policy makers and service providers may wish to consider for future development.

**CONSIDERATIONS: Processes**

**Models of care:**
- A written policy for relational security needs to underpin service provision as an aid to consistency of practice and essential to protect women at risk of suicide or self harm as well as aggressive behaviour.
- Models of care (whether single or based on a range of philosophical precepts) need to be supported by policy and operational practice documentation which articulate the approach and its use in the service for all staff.

**Referrals and admissions:**
- Women need to be able to access a bed in their own geographical area unless they require specialized care outside the remit of NHS provision, and it may be useful for levels of referrals and admissions and unmet demand for local women’s medium secure placements to be closely monitored and reviewed.
- Women were still not being appropriately diverted from the Criminal Justice System, and they were often remanded to prison even when clear history of mental illness. There was little in reach into women prisons, and delays in transfers to hospital settings.
- Admission processes need to reflect the woman service user’s situation and balance this with the composition of the unit.
- *Time is needed for effective admissions* including opportunities for women to visit the unit and be visited by staff to initiate the care planning process.

**Care plan development and implementation:**
- The development of individual care plans needs to be consistent within individual services. Training for staff on the care plan approach with clearer guidance would help to ensure greater consistency.
- The implementation of individual care plans needs to be consistent to avoid patchiness of provision, e.g. situations where rehabilitation for some women was compromised due to the lack of availability of staff.
- There is a need for gender sensitive risk assessments and for histories of abuse being adequately taken into account in the development of care plans.
- The recent guidance on CPA recommends that in future service users are placed at the centre of the CPA process and are fully involved in reviewing their own care plans.

**Discharge planning:**
- *Increased step down facilities* need to continue to be developed as soon as possible to unblock existing bottle-necks in some services.
- It would also be helpful for discharge planning to be commenced from day one of admission, with for example, home area care coordinators being asked to identify both possible future community placements for when a secure setting is no longer required by the woman, and for the responsibility for funding such future community placements to be agreed and planned for in advance.
- Home-area care coordinators and care team members could also be more actively involved in the CPA process during the women’s stay at the unit.

**Meeting diverse needs:**
- Where a single women’s ward forms part of the service (as in two case study areas), consideration needs to be given to the use of communal space and providing for women who may wish to be in quieter areas away from main ward areas.

**Practicalities**

**Environment:**
- Due to the new Standards for MSUs there is now a requirement for 5.2 metre perimeter fence for all medium secure units, including women’s services even if this is not seen as appropriate. However, environmental security is still important and should be emphasized due to the risk of self harm.
- Policies need to be implemented which address how to deal with environmental risk and its review.
- Services not in purpose build units need to consider how best to provide zonal rather than one-to-one observations.
- Wards need to have 10 and a maximum of 12 beds.
Activities/OT:
- Women’s services in mixed-sex units without dedicated OTs may wish to consider facilitating an increase in gender specific groups and activities and improve access to activities for women who are not able to leave the ward or are not able to, or choose not to, attend mixed-sex activities.

Service user involvement:
- All services need to consider ways of encouraging women to participate as part of their progress. They also need to ensure that feedback is provided to avoid tokenism.

Staffing:
- Services need to give consideration to recruitment and as far as possible recruit staff specifically to the women’s service.
- All services need to have job descriptions and person specifications which reflect their philosophies and gender-sensitive practice.

Training and supervision:
- Increased resources including time are needed by all services to ensure that training and supervision are always available and attended. Take up needs to be monitored by unit/ward managers to further ensure attendance.
- In some areas staff were not receiving appropriate gender training. Training on gender issues as they affect women on the ward and importantly in the community needs to be more consistently provided.
- Additional models for support need to be encouraged including (as already happens in some services) peer-support, mentoring and shadowing for new staff.

Primary care:
- Lack of access to primary health care services to meet the physical health care, public health and screening issues for women had been identified as a problem at some units.
- Standards and Criteria for Women in Medium Secure Care from the Quality Network for Forensic Mental Health Services requiring women medium secure service to provide access to a female GP and Practice Nurse, and to appropriate screening and well-women services.

The findings from the evaluation suggest that there are a number of ways in which the Service Specification could now be updated to reflect the learning from dedicated women’s medium secure services since the Implementation Guidance was published (8.3)


Forensic Directory (2009) St Andrew’s Healthcare

CSIP (2008) Refocusing the Care Programme Approach

1: Setting the scene: women’s medium secure services and the evaluation

Well, I suppose here it’s different from the high secure hospital I was in, you know? I can go out in the community, on trips, I can go shopping. It’s really normal compared to where I was, very normal. So when I came here it was a big change for me, I’d been locked up on big wards. I was there in 1989 and my first shopping trip, because I was moving on, was 2002 and that was the first time that I’d really seen the outside world, you know? And that was just to shop a little bit and back but here you can, if you want, instead of going shopping, you can go to the cinema and you can go to bingo. They do community trips for a few of us who’ve got community leave, you know? I hadn’t seen those things for years. I’d never sat in a bar and ate something, it just didn’t feel normal to me, but now you just feel you are normal and you are a human being, you know, you don’t feel like that at that kind of hospital. I’m glad that people are moving off, especially females, because some don’t need to be in that kind of place – I mean, I don’t need to be, I didn’t need to be in there, you know? I’m glad ... ... getting out, to a better place. It was no life there really.

Woman service user

In 2000, there were 39 medium secure services in England. Of these, almost all were mixed provision with only 14 NHS and 79 independent sector medium secure beds in dedicated women-only services\(^1\).

In January 2009, there were 27 dedicated women-only medium secure services (nine independent and 17 NHS) with a total of 51 wards and providing 543 beds (261 in the independent sector and 282 within NHS services)\(^2\). There was at least one service in each health region of the country; with six in the North-West and only one in the South-West. Of the 27 services, 12 had either a women-only rehabilitation or pre-discharge ward, of which seven provided a women-only low secure or step-down service. Five offered a women-only low secure service but no rehabilitation or pre-discharge ward. Four of the 27 services were women-only sites with five on mixed sites but no regular mixed activities. Seventeen were on sites where some activities were mixed.

This evaluation involved 50 women service users and over 60 professionals in looking at the way in which services have developed and their impact on women’s lives.

1.1 Background to the evaluation

The overall aim of this study was to evaluate established, new and emerging dedicated women’s medium secure mental health services that cater for women with complex needs. It was funded by the NHS Research & Development for Forensic Mental Health and approved by the South East Multi-site Research Ethics Committee. The evaluation was supported by an Advisory Group which included women service users.

The quality and safety of secure mental health provision for women has been the focus of research and campaigns\(^3\),\(^4\),\(^5\),\(^6\) and recent policy initiatives\(^7\). There are consistent and inter-related themes in this literature. First, it is repeatedly noted that women within mixed secure
services have been disadvantaged by their minority status and as a consequence they have received services that have been primarily developed with men in mind, are often unfairly affected by institutional responses to the behaviours of men, and are at risk of further psychological damage⁸,⁹,¹⁰.

Second, evidence has accumulated about the adverse effects of gender and other inequalities on the treatment and care of women in secure provision¹¹,¹²,¹³,¹⁴. This includes the operation of double standards of behaviour, pernicious forms of misogyny¹⁵,¹⁶ and limited access to work and training¹⁷.

Third, there is increased awareness of the risk to women of harassment and assault in mixed sex facilities¹⁸,¹⁹,²⁰ accompanied by the recognition that their therapeutic and safety needs are unlikely to be met in such contexts.

One consequence of these concerns is that local high and medium secure units frequently have been deemed unsuitable for ‘difficult’ women. Women-only wards and units have been pioneered in a range of provision including dedicated medium secure services for women in the independent sector, and despite the costs and the implications of out of area placement this involves it has become the emergent solution for many commissioners and providers²¹. There has also been a rapid expansion of NHS women only medium secure units. The number of beds has risen from just over 20 in 2000 to nearer 200 in 2006, an almost 10 fold increase. Nonetheless, Hassell and Bartlett ²² caution that this development is likely to have a negative impact on the continuity of care for individual women patients. Furthermore, as the annual costs of such a placement are typically in excess of £125,000, this curtails the development of community based services that offer both diversion from secure service and opportunities for appropriate discharge.

The recent development of ‘women’s services’ which is receiving policy support from the Department of Health²³,²⁴ has been largely a response to the perceived vulnerability – and to a lesser degree the minority status – of women in low and medium secure services. Piloting and then providing – through Inequality Agenda Ltd – a national training programme for staff working with women in secure services²⁵ has provided us with valuable insights into the demands and possibilities of change. It is encouraging to find within some services a real concern to meet the mental health needs of women patients and not to ignore or replicate the damage and deprivation of their earlier lives: we welcomed this opportunity to evaluate these changes more systematically.

Finally, support for the development of better mental health service for women from the Department of Health²⁶,²⁷ has helped to prioritise these developments, which also have important relevance for the criminal
justice system. A recent study of women on remand\textsuperscript{28} found that almost 60% met criteria for being diagnosed with a mental disorder, with 11% being acutely psychotic; though this was being poorly detected by standard prison health screening procedures on entry to prison. This and other evidence\textsuperscript{29,30} validates current efforts to divert women from the criminal justice system\textsuperscript{31}.

1.2 Background to women’s medium secure services

Women represent a small minority (about 15%) of the patient population within secure mental health settings, and yet they have been much more likely than men to be detained as civil patients, especially in high secure hospitals. Until recently almost all medium and low secure services have been provided in mixed-sex wards which were typically very male-dominated, with many women finding it difficult to cope in these environments. Consequently, in the past women have tended to spiral up the system to high secure care. During 1999, an assessment of all women patients in high secure hospitals showed that the majority did not require such a high level of security but would be more appropriately cared for in conditions of lesser security or community settings. (In the case of women patients in Broadmoor hospital, only 18% were assessed as requiring High Secure care; Source: HSPCB 31/12/1999). This position was clearly at odds with the standards set out in the new National Service Framework (NSF) for mental health published that year. Standard Five of the NSF states that service users requiring inpatient care should be cared for “in the least restrictive environment consistent with the need to protect them and the public”\textsuperscript{32}.

In 2000, the NHS Plan\textsuperscript{33} set a target to transfer at least 400 patients out of high secure hospitals with women deemed as a priority group. This target was reiterated in the Department of Health priorities outlined in Improvement, expansion and reform the next three years priorities and planning framework 2003-6, emphasising the need to ensure effective use of secure and forensic facilities. Subsequently the National Women’s Mental Health (MH) Strategy of 2002 and the Implementation Guidance in 2003 identified the need for integrated, dedicated women-only secure mental health services which provide gender-specific services addressing the specific mental health needs of women (e.g. histories of abuse, self-harm, and women as mothers). It includes a service specification and standards for women’s secure services, pre-empting the development of a national programme of reprovision of women’s secure services overseen and monitored by the National Oversight Group (NOG). The women’s MH strategy consultation document highlighted the need for research to determine whether there are advantages across a broad range of outcomes (including service user defined outcomes), in delivering mental health care in women only environments. The implementation guidance identifies the need for an independent evaluation of dedicated women’s
secure services as they represent new models of care. The independent evaluation will contribute to their continuing development, enable sharing of good practice, and provide measures of effectiveness of care within these new and emerging service models for secure care for women.

The evaluation will be of specific relevance to the Criminal Justice System (CJS) priorities and in particular to the Joint DH and Prison Service Strategy 34 (2001) for developing mental health services in prisons. This identifies performance indicators, including the “quicker and more effective transfer arrangements for the most severely ill prisoners to NHS facilities” and recommends increased collaboration with NHS staff in the management of those who are seriously mentally ill. The Women’s Offending Reduction Programme (WORP) has a particular focus on meeting the needs of women with mental health problems. The WORP action plan 35 includes action points for improving availability of Mental Health Diversion Schemes, equipped specifically to deal with female defendants; equal access for women offenders to improved gender specific mental health services including low and medium secure services; and in women’s prisons early assessment and identification of mental health problems and need to transfer to NHS facilities at the earliest point of sentence.

Women’s medium secure services form part of a national network of secure dedicated NHS services for women being developed as part of the reprovision of services to facilitate a programme of accelerated discharge of patients from high secure care where women patients have been identified as a priority. The reprovision programme is underpinned by the principles set out in Mainstreaming Gender and Women’s Mental Health: Implementation Guide and in particular, the service specification for women’s secure services described in section 7.2 (p.38-44).

1.3 The changing landscape: Recent policy, research and service developments

Since this evaluation commenced in 2006, there have been a number of important policy and service developments that have impacted on the provision of medium secure mental health services for women. A summary update on policy and service developments follows.

1.3.1 Women in the Criminal Justice System

There have been several key policy developments in relation to women in the Criminal Justice System. In response to increases in the female prison population the Home Office 36 launched its Women’s Offending Reduction Programme in 2004, focusing on improving community based services and interventions that are tailored for women and support greater use of community rather than short term prison sentences. Despite this, in 2006 the number of women in custody was still rising, with a 78% increase in...
the number of women remanded into custody over the previous ten years (a rise from 4221 to 7498)\textsuperscript{37}. Statistics also showed that most women were still being given immediate custodial offences for non-violent offences, with two-thirds of women sentenced during 2006 given terms of six months or less\textsuperscript{38}. The Department of Health’s\textsuperscript{39} “Women at Risk” report on the mental health of women in contact with the criminal justice system, published in 2006, recommended the development of better data collection regarding the needs of this vulnerable group of women to inform the planning and development of services to meet their needs when transferring from or leaving prison, as well as the development of court diversion schemes and prison in-reach services for women offenders with mental health needs. Also in 2006, and following the deaths of six women at Styal prison, Baroness Jean Corston\textsuperscript{40} was commissioned by the Home Office to undertake a review of Women with Particular Vulnerabilities in the Criminal Justice System. Her report was published in March 2007 and the Government’s response\textsuperscript{41}, in December 2007, accepted 40 of her 43 recommendations. The Government then produced its first National Service Framework for Female Offenders\textsuperscript{42} in May 2008.

However, one of Corston’s key recommendations, stating that “the Government should announce within six months a clear strategy to replace existing women’s prisons with geographically dispersed, small, multi-functional custodial centres within 10 years”, was not fully taken on board despite widespread support for this proposal (a public opinion poll commissioned by Smart Justice\textsuperscript{43} showed 86% of the public questioned supported the proposal). Following a pilot study an announcement was made that, whilst the Government accepted the principles upon which Corston recommended the development of small custodial units for women, it had identified significant issues suggesting standalone units of the size recommended (20 to 30 women) were neither feasible nor desirable. Implementation of the other recommendations is being regularly reported on, with a Ministerial statement in December 2008 setting out progress including additional resources to divert vulnerable women from custody, development of a cross-departmental Criminal Justice Women’s Strategy Unit, the publication by NOMS of an Offender Management Guide to Working with Women\textsuperscript{44} and Gender Specific Standards for Women’s Prisons\textsuperscript{45}. A review by Lord Bradley into the diversion of offenders with mental health needs or learning disabilities to appropriate mental health settings is due to report to the government in early 2009. Its recommendations are due to be taken forward in the Offender Health and Social Care Strategy, currently being developed by the Department of Health to be published in the summer of 2009.

Serious concerns regarding the welfare of women prisoners and other vulnerable offenders (including those with mental health needs), and the inadequateness of the response to their plight, continue to be raised through various independent reports. A report by INQUEST\textsuperscript{46} published in 2008 examined women’s deaths in custody between 1990 and 2007. It
revealed a “shameful and deplorable” picture of preventable tragedy, with many of the women dying being inappropriately placed in custody despite clear evidence of their requiring care in mental health settings, and issues raised from investigations into deaths in 1990 still being just as prevalent 17 years on. A report by the All-Party Parliamentary Group on Prison Health on the Mental Health Problem in UK HM Prisons described a dysfunctional system and recommended a fundamental shift in thinking at each stage of the individual’s pathway through mental health and criminal justice services. During 2008 two reports by the Sainsbury Centre for Mental Health and one from Policy Exchange all highlighted problems with inadequate funding and resources for prison mental health care in England. These included a lack of multidisciplinary expertise in prison In-Reach teams, and an average of just 11% of the prison healthcare budget being spent on mental health care despite the much higher prevalence of mental disorder there than in the community where 15% of health funding goes towards funding mental health services. In addition, some NHS regions spend significantly less than others, leading to a post-code lottery of mental healthcare in prisons.

1.3.2 Gender and Women’s Mental Health
Following the publication by the Department of Health (DH) of its national women’s mental health strategy, NIMHE (National Institute for Mental Health in England) established its national programme on gender equality and women’s mental health in order to support the Implementation Guidance: Mainstreaming Gender and Women’s Mental Health. This aimed to ensure the development of mental health systems able to deliver responsive and gender sensitive services to meet the specific and diverse needs of women. The work of the programme since 2006 has focused on improving women’s safety in inpatient settings as well as developing women only and gender sensitive day services, improving choice and access to psychological therapies, and developing better perinatal mental health services. Informed Gender Practice: Mental Health Acute Care that works for women was published in July 2008 to encourage practitioners working in acute mental health settings to develop gender sensitive practice with a focus on women’s physical and psychological safety. In addition, following a two year pilot project, the Mental Health Trust Collaboration Project worked with 16 Mental Health Trusts across England to improve the care and support provided to service users who have survived sexual and other abuse, following which a national policy was launched in June 2008. This included the provision of sexual abuse training to all Mental Health Trusts in England from November 2008 and the publication of supportive practice guidance in April 2009. Delivering equality for women (including race equality for women from BME communities) has also been a recent priority of the Gender and Women’s Mental Health national programme. To help prepare mental health providers for the implementation of equality legislation, it produced guidelines for Mental Health Trusts about the implementation of the Public Sector Gender Equality Duty which came into force in April 2007.
1.3.3 Safeguarding patients, safety and single-sex provision

In July 2006 the National Patient Safety Agency\textsuperscript{77} released its second Patient Safety Observatory Report stating that 122 ‘sexual safety’ incidents in mental health inpatient wards had been reported to them between November 2003 and September 2005. These included 19 alleged rapes, 13 cases of exposure, 18 cases of unwanted sexual advances and 26 cases of “invasive touching”. Following publication of the NPSA report, Community Care magazine used the Freedom of information Act to request information from Mental Health Trusts about sexual safety incidents\textsuperscript{58}. The 44 Trusts responding (out of the 70 approached) reported over 300 incidents during the three years between 2003 and 2006, of which 224 involved assaults on patients by other patients. The following year the Government published new guidance on “Safeguarding Patients”\textsuperscript{59} as its response to the recommendations of the Shipman, Ayling, Neale and Kerr/Haslam Inquiries, which covered boundary transgression issues in mental health services. This reviews the recommendations in the Kerr/Haslam and Ayling inquiries about the failure of health organisations to take seriously allegations of sexual assault on female patients.

Dent\textsuperscript{60} reported that sexual safety incidents are treated as part of mental health inpatient life with disbelief built into the system (as there is an attitude that patients cannot be believed because they are ill) and the lack of adequate training and experienced staff exacerbate poor levels of safety on mixed inpatient wards. In 2007, the Royal College of Psychiatrists\textsuperscript{61} produced guidelines on sexual boundary issues in psychiatric settings which included particular issues for secure units and the safety of women in these settings, stating that their sexual vulnerability must be recognised and addressed by the multidisciplinary team in individual care plans. The Mental Health Act Commission\textsuperscript{62} in their Biennial Report for their reporting period 2005-7 also raised serious concerns regarding women’s sexual safety in inpatient settings and expressed disappointment at the lack of progress in implementing the Government’s policy on the provision of single sex accommodation in all hospital wards.

In the debate about the implementation by the Government of the Labour Party Manifesto pledge to eradicate mixed sex wards, the Shadow Health Secretary released figures from a Freedom of Information Survey in January 2009\textsuperscript{63} which revealed that 2% of Mental Health Trusts were still using “nightingale wards” (large, dormitory-style rooms) to look after men and women; 8% still used curtains and 11% used partitions rather than solid walls to segregate patients in some areas; as many as 29% failed to provide segregated washing facilities for patients in some areas; and 24% did not provide segregated toilet facilities on all wards. The 55 Mental Health Trusts responding to the survey had received 135 complaints from patients about privacy and dignity issues in hospital during the year to September 2008. In response, the Government has announced its clear commitment to eradicate all mixed-sex hospital accommodation (in all
clinical areas apart from Accident and Emergency), and is publishing further guidance on its definition of single sex accommodation as well as setting up a £100m Privacy and Dignity Fund to help trust make improvements to hospital accommodation over the next six months. In 2010/11 it will introduce fines for NHS Trusts not complying with the requirement to provide inpatient care in single sex accommodation.

1.3.4 NHS Commissioning arrangements and Minimum Standards

In March 2006 the Government White Paper “Our Health, Our Care, Our Say” outlined plans for major structural changes and a ‘change management’ programme aimed at developing “World Class” commissioning in the NHS. Following this, in July 2006 the number of Strategic Health Authorities (SHAs) which are responsible for co-ordinating and managing Primary Care Trusts was reduced from 28 to just 10 with the aim of strengthening commissioning capacity. The Department of Health at the same time published “Health Reform in England: update and Commissioning Framework” which introduced the regionalisation of commissioning of low and medium secure mental health services. From April 2007 these services have been commissioned on behalf of Primary Care Trusts by Specialised Commissioning Groups set up by the ten newly formed Strategic Health Authorities, with PCT financial allocations being top-sliced to fund this specialised commissioning. Other developments affecting the commissioning of secure mental health services include the introduction of a new standard mental health contract in England which will place independent sector providers on a more level playing field with in-house NHS providers. These new contracts are due to be introduced on a voluntary basis in April 2009 and compulsorily from April 2010. They will be subject to regular reviews, with commissioners expected to review a list of quality indicators as part of contract monitoring. These quality indicators, for medium secure units, are likely to overlap with National Minimum Standards.

Standards for Medium Secure Services that were developed by the Royal College of Psychiatry Quality Network for Forensic Services have been adopted by the Department of Health as National Minimum Standards for adult medium secure services in England with the Department publishing Best practice Guidance based on these standards in July 2007. The RCPsych Quality Network has subsequently developed an additional set of Standards and Criteria to specifically address the needs of Women in Medium Secure Care. In 2009, only nine women’s medium secure services had become members of the Quality Network although joining will become a requirement in the future. The add-on standards for women’s services have yet to be adopted by the Department of Health as required quality standards for the Specialised Commissioning Groups to incorporate when developing their service specifications for women’s secure services.
1.3.5 Service developments for women requiring medium secure care

Concurrent with the evaluation process there has been a number of major service developments in secure mental health provision for women, including the closure of Broadmoor Hospital’s Women’s Service during 2007. This leaves just one National High Secure Service for women at Rampton Hospital, based in a new purpose-built facility which opened in December 2006 providing 50 beds across four wards including one for women with learning disabilities.

During 2007 and 2008, three Women’s Enhanced Medium Secure Services (WEMSS) have been opened, one each in the North West, East Midlands and London regions. Additionally, four High Support Community Residential projects are being developed to enable the rehabilitation and community resettlement of women leaving secure mental health services. Both of these new developments are pilot schemes funded by the Department of Health as part of the strategy for the Reprovision of Women’s Secure Services, and are aimed at improving care pathways for women in secure services. As well as these nationally commissioned developments a significant number of additional medium secure beds in both the NHS and Independent sector were opened during this period.

This reorganisation of women’s secure services has seen the rapid expansion of NHS women-only units with many NHS Commissioners aiming to return women placed in private out of area treatment service to in-house NHS provision in their home area, although private sector provision also continues to expand with further independent sector units/beds opening during 2007-08. In 2000, a survey of all medium secure units found just 14 NHS medium secure beds for women in single sex wards and 79 medium secure beds in single sex units in the independent sector. At that time most medium secure beds for women were provided within mixed sex ward accommodation, and these provided a further 249 women’s beds, making the total medium secure bed capacity for women to 343. However, by January 2009 a follow-up telephone survey to all providers of medium secure care for women in single gender units (see section 2) found the number of medium secure beds for women in single sex settings had increased to 543 across both sectors (NHS and Independent), with just a small number of women’s beds still provided in mixed sex wards, although these are now very much the exception rather than the rule.

1.4 The evaluation approach

Within the context of the literature, policy and practice and in order to achieve its aim, the evaluation had six objectives as follows:

- to examine the extent to which and how these services are delivering care, support and treatment which meet the specific needs of women
- to examine the extent to which and how these services are able to
maintain women’s safety and security in line with the service specification for dedicated secure services for women (detailed in Mainstreaming Gender and Women’s Mental Health: Implementation Guidance)

- to explore factors which help and hinder services in delivering appropriate care, support and treatment
- to make recommendations for future service development
- to enable women to participate in the process and express their views and needs
- to enable other key stakeholders to contribute to the development of women’s secure services

The evaluation did not set out to examine the extent to which women’s medium secure services were delivering differentiated care to meet the specific and individual needs of women. This would have required a more in-depth study of a small cohort of women service users. Further, it was not designed to examine the longer-term outcomes of the services provided to women. However, a follow-up study of women who have moved on from medium secure services would provide an insight into the impact of differentiated care on women’s futures.

Women-only secure services involved in the evaluation included:

- NHS self-contained women-only units where either there are no male wards on site or women do not mix with male patients from other wards.
- NHS self-contained women-only secure units where there is some level of mixing with male patients.
- Independent sector and “not for profit” services.

In addition to a survey of all women-only medium secure services in England (NHS and Independent), six case study services were invited to contribute in more depth to the evaluation. From these the evaluation learned about what helps or hinders in developing services for women and about how different contexts impact on provision.

The case studies were based on a number of different stages including:

1. **Two stage qualitative study of women patients’ perceptions and views**: an initial interview used Repertory Grid interviewing techniques and women service users were invited to talk about their experience of the service. The method provided an opportunity for women to determine the constructs and elements (roles of people and what they associate with them) which they considered important and contributed to their perceptions and views. Some women took part in a follow up interview.

2. **Rank ordering exercise**: a content analysis of the interviews with women was carried out to identify the most featured constructs and
then women as well as other stakeholders were asked to rank them in order of importance. A comparison has helped us appreciate the degree of shared understanding of the aspects of the service that women valued.

3. **Semi-structured interviews with other stakeholders:** with clinicians, support staff, advocates, service managers, multi-disciplinary team members and commissioners were conducted which explored their experience and views of delivering differentiated care and treatment of women patients.

4. **Documentary review:** a review of policies and protocols in order to understand the context.

5. **Documentary review and audit of CPA reviews:** from this the evaluation explored women’s involvement in care planning, gauging their progress towards discharge and recovery.

In total, 50 women and 65 staff and other professionals participated in individual discussions. Appendix 1 provides details of the evaluation approach and methods and reflects on their use in this context.

1.5 **Report structure**

This report is divided into a further seven sections.

- **Section 2** provides a descriptive background and a map of service provision across England as well as case study portraits.
- **Section 3** provides an overview of women’s journeys through medium secure services focusing on what helps or hinders them in getting where they hope to arrive; the philosophy and models of care in use and the implementation of policies that facilitate a route through.
- **Section 4** reflects on women’s day-to-day realities; their care pathways in, at and on from secure services with exploration of the early days, admissions and arrival; and how life works on the wards.
- **Section 5** discusses making it work for women patients and for staff whilst maintaining women’s safety.
- **Section 6** focuses on Care Pathways, Care Planning in theory and in practice as well as women’s discharge and moving on from medium secure services.
- **Section 7** is concerned with the working environment, ward staff and other professionals and the ways in which their experience has an impact on the service and the women within it.
- **Section 8** looks to the future of gender sensitive, dedicated women’s medium secure services drawing on what works well and areas for future development.

Good practice in the case study areas was identified through the range of data collection methods and examples are included throughout the report. It is important to note that all the services were at different stages – some
well established, others new; some involved in major expansions; some experiencing changes in leadership and management structures, and all delivering a service within a context of the effects of their independent, charitable and NHS status on funds and services.

2 Forensic Directory (2009) St Andrew’s Healthcare
19 Department of Health: Women’s Mental Health: into the mainstream, DH 2002
23 Department of Health (2002) op.cit.
24 Department of Health Implementation Guidance: Mainstreaming Gender and Women’s Mental Health, DH 2003
26 Department of Health (2002) op.cit.
27 Department of Health Implementation Guidance (2003) op.cit.
32 Department of Health (1999)
2: Mapping service provision across England

I don’t want to spend the rest of my life in here or in hospital. I’ve only been in two and now I’m moving forward, you know, forward instead of going backward. But it’s really normal compared to where I was. I’m glad that people can move off. I’m glad for getting to a better place.

Woman service user

What I get is a safe environment, I guess physically safe. I also feel quite happy emotionally that they haven’t tried to overdose me with medication. There have been times where I’ve been a bit down and I was worried, oh God! They’re going to put me on more medication and – they haven’t! I’ve had quite a lot of psychology and the nursing staff I’ve used to talk to as well.

Woman service user

This section of the report provides an overview of dedicated women’s medium secure services in England as well as detailed descriptions (based on a combination of services’ own documentation and additional information collected for the evaluation) of the six case study services selected for the evaluation.

During July 2006, our mapping exercise identified that in England there were 15 NHS Secure Services and eight independent hospitals providing medium secure care for women in single sex wards. These were women-only services or women-only units within mixed secure settings providing a total of 386 beds across 38 wards. This information was updated with a follow-up survey of women’s medium secure care providers. By January 2009, across England there were 18 NHS Trusts and nine independent hospitals providing medium secure care for women in single sex ward settings with a total of 543 medium secure beds for women with 51 single sex wards across the 27 hospital sites. There were 282 NHS; 41 independent not-for-profit; and 220 independent beds. In addition to these 543 beds, there were still a small number of medium secure beds for women in mixed-sex wards. Some were in medium secure services that only had mixed sex ward facilities for women. Others were in mixed-sex medium secure rehabilitation or pre-discharge wards on sites where there was also single sex admission or acute wards. However, these are not included here in total bed numbers.

The geographic spread shows the paucity of provision in some areas of the country. At the time of the evaluation, there was a minimum of one NHS women’s medium secure ward or unit in each of the ten English NHS Strategic Health Authority areas, with just one NHS service per SHA in the East Midlands, East of England, West Midlands, Yorkshire and Humber, South Central and the South West. However, there were four NHS medium secure services for women in the North West, including a specialist learning disability service, and as many as five NHS women’s services across the London SHA Region. There were four independent organisations providing medium secure services for women in England, with one of these being a registered charity and not-for-profit company (St Andrew’s Healthcare Group). The other three were private sector organisations, of which one (Partnerships in Care) dominates the market for independent secure service provision and was responsible for six of the nine independent women’s services.

All medium secure services are governed by the NHS Healthcare Commission Standards although from 1st April 2009, a new organisation called the Care Quality Commission (CQC) became responsible for regulating health and social care in England. Nine services have joined the Quality Network for Forensic Services which in 2008, and after consultation, published Standards and Criteria for Women in Medium Secure Services.
2.1 The overall picture

In September 2006 two questionnaires were sent to all providers of women’s medium secure services asking for information about all their women only sites and wards. The first concerned the service overall and was targeted towards service managers or Clinical Leads for women’s services. A second questionnaire (in some cases more than one) sought information about individual women’s wards. In response to this initial survey, data was received from 14 of the 20 providers (one opened in 2008), with 12 NHS Trusts and two of the four independent providers supplying information about their women’s services. In January 2009 and prior to completion of the evaluation, a follow-up survey was undertaken to update our data and mapping of services. Consequently further information was collected from all 27 women’s services providing medium secure care in single sex accommodation, to ensure the most up-to-date description of provision across England.

In 2009, of the 27 services, four described their provision as ‘self-contained women only with no male wards on site’, six as services on sites where there are male wards but where women patients do not usually mix with men patients; and 17 where there are also male wards on site and opportunities for women to attend some regular mixed-sex activities.

Twelve had only one women’s ward providing medium secure care. Ten services had 2 women’s medium secure wards, and five services had three or more wards offering medium secure care. Whilst 13 services had women only rehabilitation or pre-discharge or low dependency wards within their medium secure service the majority, 14 did not offer a separate ward for women who no longer required acute care but still requiring medium secure care. Three of the NHS services were pilot sites for the new Women’s Therapeutically Enhanced Medium Secure Service (WEMSS), and four services offered specialist medium secure care for women with learning disabilities (one NHS; three independent). As well as the specialist learning disabilities services, four others said they accepted women with some learning disabilities and usually only women with mild or moderate learning disabilities.

| Table 1: Current medium secure provision for women |
|-------------------------|--------|----------|--------|
| Sector                  | No. of sites | No. of wards | No. of beds |
| NHS Trusts 16 providers  | 18      | 31        | 282     |
| Independent 4 providers  | 9       | 20        | 261     |
| Totals                  | 27      | 51        | 543     |


One independent hospital provided a specialist unit with five beds for deaf women requiring medium secure care. Whilst all the services said they did accept women with a diagnosis of emotionally unstable personality disorder (including Borderline Personality and Impulsive Disorder*), two stipulated they would normally only do so if the woman also had a diagnosis of Mental Illness alongside their BPD diagnosis.

* From hereon referred to as BPD given the wider recognition of this diagnostic label especially
2.1.1 On the wards

From the first survey (2006), we received information about 21 women-only wards from the 14 responding services (one ward did not submit). This represented 208 beds in total. Ward sizes varied considerably from five to 16 beds. However, the smaller wards tended to be within services which had more than one ward, for example, three five-bed wards equal to 15 beds overall.

Most wards were full at the time of completing the questionnaire. Of the 21, 16 had women waiting for admission. A number of services noted that they rarely had vacancies and had made few of transfers or discharges from the unit.

The range of patient groups that these wards were able to cater for included:

Table 2: Patient groups catered for (n=21)

<table>
<thead>
<tr>
<th>Patient group</th>
<th>Independent wards (n=6)</th>
<th>NHS wards (n=15)</th>
<th>Total (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women diagnosed with mental illness</td>
<td>6</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Women with Complex Needs</td>
<td>5</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Women with challenging behavior</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Women diagnosed with Borderline Personality Disorder</td>
<td>5</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Women diagnosed with other Personality Disorder</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Women with learning disabilities</td>
<td>4</td>
<td>6*</td>
<td>10</td>
</tr>
<tr>
<td>Other: Autistic Spectrum Disorder</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

* Of these, three only took women with learning disabilities

There was little variation across the wards in terms of the patient groups they worked with. One provider had recently opened a service for deaf women and others were dedicated services for women with learning disabilities. Three-quarters of services catered for women diagnosed with either Borderline or Personality Disorder.

In January 2009 the follow-up survey of all 27 services providing medium secure care for women in single sex wards, found that the 51 wards ranged in size from only four beds (in one WEMSS unit) to as many as 16 beds (in an independent hospital). The average number of beds per ward was 11 overall, with an average of 13 beds for independent sector wards, but just nine beds for NHS wards. (The service specification for Women’s Secure Services in the Implementation Guidance for the National Women’s Mental Health Strategy and the new Standards for Women’s Medium Secure Services recommended a maximum of 12 beds per ward). Beds per site also tended to be more in the independent sector, with an average of 29 beds providing medium secure care for women per site, compared with an average of between 15 and 16 beds in NHS Trusts.
2.2 Case study services

The following descriptions were derived from information available in the public domain, documentation sought for the evaluation and additional material provided through interviews in some but not all cases.

2.2.1 Case study 1: Newton Lodge NHS
Newton Lodge (Yorkshire Centre for Forensic Psychiatry) is a 90-bed medium secure unit provided by the South West Yorkshire Mental Health NHS Trust and located in Wakefield on the Fieldhead Hospital site. It is commissioned by the Yorkshire and Humber Specialist Secure Commissioning Team and caters for adult men and women from the Yorkshire catchment area who require inpatient medium secure mental health services. It provides a service for women from the Humberside catchment area who have needs that cannot be appropriately met within the mixed-sex medium secure facility at the Humber Services in Hull. The geographical area covered by the unit is a mixture of rural and very sparsely populated areas such as the Yorkshire Moors and Dales, and urban districts including the city of Leeds and its surrounding conurbation. The Women’s Service, which opened in 2000, is based on Gaskell ward, a single-sex acute admissions ward with 10 beds and an Extra Care Area.

The medium secure rehabilitation or pre-discharge ward (Priestley) is mixed-sex with up to six (of 22) beds designated for women providing a care pathway for women on Gaskell ward who need to access a medium secure rehabilitation ward prior to moving on to low secure or community facilities in their home district. Women on Priestley are still able to access support and therapeutic input from the Gaskell ward team. The Women’s Service also provides a prison in-reach service to HMP New Hall, working with women across the prison who are referred for mental health support as well as those in the Prison Healthcare unit. Newton Lodge is also commissioned to provide gate-keeping assessments for men and women in community or prison settings who are referred for medium secure care within the responsibility of the Primary Care Trusts across the Yorkshire Forensic Catchment Group.

2.2.2 Case study 2: the Edenfield Centre NHS
The Edenfield Centre is a 118 bed medium secure unit provided by the recently formed Greater Manchester West Mental Health NHS Foundation Trust and first opened on the Prestwich Hospital site in 1986. Commissioned by the North West Specialist Commissioning Team, it caters for adult men and women from the Greater Manchester area requiring inpatient medium secure mental health services. It also provides an outpatient service via its community forensic mental health team. Greater Manchester, in the North West of England, is made up of ten metropolitan boroughs and has a large and ‘culturally diverse’ population exceeding 2.5 million. The Centre provides gate-keeping assessments for men and women in community or prison settings who are referred for medium

“We developed a forensic strategy for women across Yorkshire so the idea of recovery was very fundamental to that because we were looking at having a network of services across Yorkshire that would enable women to move through the services because we found that women weren’t getting stuck at high secure, but the women we had were getting stuck at medium secure, and often in the independent sector, and the strategy was about creating this network and an ability to create a seamless pathway for the women.”

“I suppose the philosophy of care with women is about helping them recover, its about being conscious of their past experiences and how important they were in things being as they are at

London Metropolitan University
secure care within the responsibility of the Primary Care Trusts across Greater Manchester.

Women are a minority within the in-patient population, currently occupying about a sixth of the beds. They were cared for on mixed sex wards but, as a response to local and national guidance, the unit opened its first women-only ward with five beds in 1998. A further seven-bed women’s ward opened in 2003 as a response to the closure of beds in high-security hospitals with many patients assessed not to require this level of security and with the ‘Accelerated Discharge Programme’ aiming to return women and men from high secure care to regional/medium secure services in their area of origin.

During this process it became evident that many women required a higher level of procedural and relational security than was usually available within medium secure settings. As a result, a national programme was developed by the Department of Health to establish purpose built facilities offering ‘Therapeutically Enhanced Medium Secure Services for Women’ TEMSS(W), with the Edenfield Centre being selected as one of three pilot sites in England.

The development of this service, which opened in July 2007, allowed for the re-provision of the existing 12 women’s beds plus an additional six ‘enhanced’ beds in a new purpose built facility (i.e. 18 beds in total). The inpatient women’s service therefore now comprises three wards providing four ‘therapeutically-enhanced’ beds; nine beds for women who are acutely unwell including two beds for women with complex needs who are stepping-down from but with the support of the TEMSS(W); and five beds for women whose mental health is currently more stable, providing a less restrictive environment than is available on the acute/admissions ward.

### 2.2.3 Case study 3: Guild Lodge NHS

Guild Lodge, a service provided by Lancashire Care NHS Foundation Trust was opened in 1999 and is commissioned by the North West Specialist Commissioning Team catering for adult men and women from Lancashire and South Cumbria requiring inpatient low or medium secure services. It also provides step-down accommodation in rehabilitation cottages just outside the secure perimeter and a community forensic mental health team. Guild Lodge is commissioned to provide gate-keeping assessments for men and women in community or prison settings referred for low and medium secure care that are the responsibility of the Primary Care Trusts across Lancashire and South Cumbria.

Women represent only about a fifth of the patient population on site and were historically cared for in mixed sex wards. As the women’s service at Guild Lodge developed, a ward opened specifically for women from the different mixed wards. Several years ago when the opportunity came to open a second ward for women, a decision was made to split the two...
according to the clinical needs of the patient group; with Elmbridge established as an eight-bedded ward for women with psychosis and/or cognitive needs and Marshaw as an eight-bedded ward catering for women with relationship and attachment issues. Both wards are commissioned to provide a service for women requiring either low or medium secure care. There is also a four-bedded women’s step-down facility in the cottages outside the secure perimeter.

2.2.4 Case study 4: Fromeside NHS

Fromeside, near Bristol, was a new 80-bed medium secure unit and is the largest development of its type in the UK, offering forensic services to a large part of the South West including rural and urban conurbations of Bristol and Swindon in particular. It has a 12 bed self-contained unit for women. The service, commissioned by the Avon and Wiltshire Mental Health Partnership NHS Trust and opened in December 2005, provides a medium secure environment for men and women between the ages of 18 and 65. Patients are admitted from the courts having been involved with the criminal justice system, from high secure hospitals or from general psychiatric hospitals because they require care within a medium secure environment. Some women have been admitted from prison including from Eastwood Park, a local women’s prison.

Fromeside has eight wards of which seven care for men at different stages in their recovery and in 2005 it opened the new self-contained service for women. Fromeside provides a range of facilities including a café and the Malago Therapies Centre which includes workshops, a recreation hall, arts psychotherapy rooms including a music therapy workshop and a drama therapy studio, and a therapies garden.

The women’s service was afforded the opportunity to take two years to plan the service before opening. This allowed for the early appointment of staff, time to consult with women already in medium secure settings, and to visit other services. The annually reviewed Service Specification states that the Women’s Service aims to:

- Provide a gender sensitive in-patient service for women who require medium security in the South West of England.
- Provide a quaternary level referral and assessment service for women from the South West.
- Assist the forensic case managers in the management and planning of care pathways for women from the South West in medium and high secure NHS facilities, out of area and independent sector placements.
- Provide a liaison and advice service to the criminal justice system, local tertiary forensic services and providers of WEMSS and High Secure Services.

Teign Ward, as the women-only service, has developed a policy for male staff working on the ward and a philosophy and aims of care as part of its
operational policy. The service has a strong commitment to reflective practice through the process of daily multi-disciplinary team handovers, weekly meetings which offer opportunities for reflective practice and through supervision. There are monthly psychoanalytic case presentations for staff to discuss how they manage their own feelings. There are four team leaders. There are no locked doors within the ward and service user involvement is considered key to the effectiveness of the service. This includes employment of a service user involvement worker; a close working relationship with WISH and MIND advocates; appointment of service user representatives; weekly community meetings and women’s feedback into CPA meetings. There is a monthly service user steering group and facilities management meeting. Community Meetings on Teign Ward also form an important aspect of how ‘business’ gets done. The service has benefited from having time to work with women and build the staff team in a way that will lead to sustainable approaches and services. Teign Ward has been acknowledged as developing initiatives of broader use in medium secure services and regularly advises planning in the men’s service at Fromeside.

2.2.5 Case study 5: the Dene, Partnerships in Care, Independent

The Dene, Partnerships in Care, is one of five medium secure services they provide for women. However, the Dene is the only PIC medium secure service that caters exclusively for women and it recently extended its provision in 2008 from 50 beds for women with mental illness to 80 to include a Learning Disability service and enhancement to a specialist Trauma and Complex PTSD service. Ward size has increased from 12/13 to 16 which has had more recent staffing implications. The service aims for a 70/30 ratio but are achieving approximately 50+ women to 40+ men in their ward staff. Psychologists, OTs and social workers have usually been women.

The Dene takes women from all over UK, Channel Islands and the Isle of Man. There are limited secure services for women in Wales and Scotland and these women tend to be referred to the Dene.

The Dene aims to involve women in 25 hours of activities per week and has a range of facilities for them to use including a sports hall, tennis court, gymnasium and communal recreation areas. Creative activities are available within a purpose built art room and workshop, and women have use of two practice kitchens. The service also employs a nutritionist and a dietician to work with women in relation to weight and fitness. There is a library which enables women to participate in a basic skills programme with the education team. The psycho-educational programme covers trauma, flashbacks, self-harm, and anger management.

PiC has a number of specialist forums including one for people with Learning Disabilities, a Women’s Liaison Group, and a Personality Disorder group. These forums provide an essential part of service development and

“Across the male service, all the teams work across seven wards and that makes it really hard to all be singing from the same hymn sheet, really hard. It’s a privilege to have a dedicated team.”

“We’ve reorganised the Clinical Governance system trying to make sure front-line staff understand what this is and making sure everyone felt involved. Things fit together better now. The independent sector’s advantage if that they can redirect its focus to areas of perceived need.”

“Our whole ethos is around women who come here who have had very major problems, very complicated lives and a
staff from the Dene are active representatives. The Dene has implemented a care pathways for women policy, developed by PiC.

PiC recently opened a nearby women-only low secure step down facility, Pelham Woods, with 21 beds. This has positively impacted on opportunities for women from the Dene although the number of beds is limited by comparison to the 80 bed medium secure service.

2.2.6 Case study 6: St. Andrew’s Hospital, Independent

St. Andrew’s is a large independent hospital located in Northampton (and also a registered charity) with a total of 512 beds covering medium and low secure services, as well as open and brain injury services for adults including elderly people and adolescents. Until summer 2007, there were 25 beds in two medium secure wards for women with 14 beds in General Psychiatry and 11 beds for women with Learning Disabilities compared to 55 beds for men. Women from both wards then moved to the new purpose built unit for women’s secure services, Smyth House. The service has expanded its total numbers from 25 to 41 and is comprised of three units each with access to separate secure outside courtyards.

The Stowe Unit (Mental Health) is the most supervised environment and accommodates service users considered to be at immediate risk of self-harming and/or physically aggressive behaviours. It has 13 bedrooms, an extra care suite and a seclusion room each of which has en-suite facilities. The Seacole Unit (Mental Health) accommodates service users regarded as presenting lower risk of self-harming and/or physically aggressive behaviours. It has 15 bedrooms, and a seclusion room each of which has en-suite facilities and lockable storage. The Sitwell Unit (Learning Disability) will accommodate women who initially require medium security due to their severe challenging behaviour and then continue to care for those who have progressed in their treatment and rehabilitation to discharge. The Unit has 13 bedrooms, an extra care suite and a seclusion room.

The Women’s Service philosophy of treatment is theoretically based on contemporary social learning theory, and in practice is based on the recognition of the importance of multi-disciplinary assessment and treatment. Social learning theory emphasises the need to combine medical and social treatments in a complementary manner, to mitigate the effects of any illness, and to help promote more adaptive attitudes, skills and behaviour. The long term aim of treatment is recovery, rehabilitation and accommodation in an appropriate environment, with the least restrictions.

2.3 Commissioning procedures

As described in 1.3.4, funding for secure services has undergone restructuring and services are now commissioned on behalf of Primary Care Trusts by Specialised Commissioning Groups set up by the ten newly
formed Strategic Health Authorities. The relationship between NHS services and the Specialised Commissioning Groups was relatively straightforward and often geographically determined, i.e. funding would be provided for women who were from the area. For independent services, different types of agreement had to be negotiated. In one case study area, the regional commissioning team agreed a service level agreement for the mixed-sex hospital as a whole. They purchased a block rather than individual beds including some in the women’s service. The advantage of this was that it ensured the referral and admissions processes were not adversely affected by difficulties over funding.

A different model operated in another case study service where spot-purchasing was the norm. This and other independent services were often under commercial pressures to admit women but in the knowledge that the process of admission was sometimes too rushed and involved considerable ‘paperwork’. They were sometimes unclear about funding sources which interfered with effecting a smooth referral process. However, a perceived advantage of this model was that services could respond with more flexibility to areas of need and provide services to women where there were gaps in other provision.

- There was considerable variation across women’s medium secure services in terms of provision.
- Independent sector services tended to provide a higher number of beds for women. However, they also had more than the recommended number per ward/unit.
- The case study services, selected on the basis of organisational structure and location, illustrate some of the different ways in which the women’s mental health policy agenda has been implemented.

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72 DOH (2003) op.cit.
73 Tucker, S. & Ince, C. (2008) op.cit
3. Women’s journeys through medium secure services: Finding synergies between philosophies, policies and practice

Good staff will have time for you and talk about your problems and they will listen, be proactive and they will help you if you are struggling and perhaps if they are not aware that you are struggling, they will help you as well. They take an interest in your care and try and do things if you say, like if I say I want to do the OT groups then I would have liked someone to have helped me with that rather than me having to go knocking on doors and saying I want to do this. So somebody to help and get your programme the way you want it.

Woman service user

In an ideal world, women’s medium secure services would operate with a synergy between philosophies of care, operational policies and practice based on an in-depth understanding of women’s, carers’ and staff views of what the service should look like to support women’s recovery. Based on the findings from the evaluation, this synergy was exactly what services were trying to achieve. At the same time, they were working within the confines of limited resources, different and sometimes competing views of what was needed and what works; and a normative attitude which reflected the gender divide that is pervasive in society more broadly. All of these had an impact on how services developed, were successful in their endeavors and how they were perceived by external audiences. This section examines first what women, and the staff who work with them, believed was essential to creating an environment that enabled women to benefit from the service and journey through it, which for some would lead to leaving the secure system. It then moves to describe the philosophies of care in place within the case study areas and the extent to which they reflected what women believed was important in their care. Finally, it describes the policies in use and their implementation, assessing how far and in what ways they underpin the services’ ability to achieve their aims and objectives.

3.1 Factors affecting women’s routes to recovery

Women who participated in the evaluation were invited to take part in an exercise which asked them to identify a set of elements, i.e. people (which could include themselves) involved in or enabling their care. A series of Triads (sets of three elements) were presented to elicit bi-polar personal constructs, i.e. how the women discriminated between their experiences of, and relationships with, different elements and women were also asked to rank all the elements (people) against all the constructs. Both qualitative and quantitative analysis of grid data were carried out to arrive at the most frequently referenced factors and women’s commentary on how they viewed the contribution of people and factors to their recovery. Some women commented that they found this an interesting and useful exercise where they reflected in new ways on their situation and the care they received. Interestingly, the analysis did not identify particular differences between case study sites or between women with different characteristics.
So, what was most important to women?

- **Relationship with staff:**
  Women wanted a care team to display human attributes, e.g. sense of humour, ability to understand them as individuals, show empathy, and to share commonalities.

- **Trust:**
  Women said that only if they believed staff really cared about them, and were not ‘just doing a job’, could they trust them. They needed to know that staff really listened and could validate their feelings rather than judge or trivialise them.

- **Positive expectations:**
  Women wanted staff to believe they will get better (recover) and reassure, encourage and provide positive feedback on their progress.

- **Empowering approach:**
  Women looked to others to help them understand their own illness or behaviour and take responsibility for managing this themselves.

- **Reducing isolation:**
  Women wanted to maintain connections with life outside the unit and be enabled to keep contact with family.

- **Good daily support:**
  Women identified a need for continuous access to emotional, social and practical support as well as regular activities to keep them occupied or take their mind off things so that they could cope with life on the ward.

- **Relational Security:**
  Women described the importance of services promoting an atmosphere of trust, strong leadership and consistency of team approach with good therapeutic relationships, including with male staff as positive role models.

- **Holistic Approach:**
  Women sought people who offered understanding of and response to the social context of their illness or behaviour, e.g. abuse and socio-economic factors.

- **Emotional needs:**
  Women believed in the importance of services which ensured that they were not just managing needs but facilitating the process of change.

- **Range of Interventions:**
  Women wanted robust and structured programmes of appropriate therapeutic and social activities.

While the language sometimes differed, there was consensus among women and staff about the most important attributes of a women’s medium secure service. Women who took part in a second interview and all staff and others providing the service were asked to rank order ten statements from the women’s perspective. The results of the rank ordering exercise are shown below in table 3. There was a high degree of
correlation between the women’s and professionals’ rank orders (Spearman r 0.85 p<0.01).

**Table 3: Rank Ordering of Key Construct Themes**

<table>
<thead>
<tr>
<th>What was most important for women’s safety and recovery?</th>
<th>Women’s aggregated rank order</th>
<th>Professionals’ aggregated rank order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand me as an individual rather than just seeing me as someone with a particular diagnosis or index offence</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Able to TRUST and tell them everything, as believe they genuinely care about women/service users</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Caring approach and provides the emotional support needed to get through each day</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Help understand and take responsibility for managing own mental health and behaviour</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>One of my team is usually available when need someone to talk to, they really listen, understand and accept feelings</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Help to maintain connections with life outside the unit, reducing sense of isolation and supporting contact with family/friends</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Have faith, believe can get better and encourages along the way</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Have a laugh with, and talk about things we have in common, not just communicating as professionals/patients</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Day to day practical and social support needed to cope with life here on the ward</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Access to daily activities that enjoy so don’t get bored, and takes mind off things</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

A Spearman rank order correlation coefficient yielded a result of 0.85 which indicated the women’s and professionals’ rank orders were significantly correlated to a high level (p<0.01).

The statements used in this rank order exercise were determined by a content analysis of personal constructs from the women’s repertory grid interviews, from which key themes across all grids were identified.

What emerged was agreement that these services are much more than just about keeping women safe. They also needed to focus on:

“I think what’s important for women is that they need to get the message that their emotions aren’t wrong or inappropriate, or can’t be contained or managed by the service and the onus is
In addition, both women service users and staff identified a variety of factors which impacted on women’s potential for recovery including the following;

- **Understanding women as individuals** rather than just seeing them as someone with a particular diagnosis or index offence
- **Being available** when women needed someone to talk to who listens and validates their feelings and
- **Working towards recovery**

**Multi-disciplinary and ward teams needed to hold values** in keeping with gender-sensitive service philosophies and positive attitudes towards working with women creating a culture that is supportive to women and validates their emotions. A small number of staff and in particular among those based at mixed-provision sites and who had no choice about which wards they worked on, said they were initially sceptical about the concept of gender-sensitive models and single-sex secure services. However, in all the case study areas, most staff described their understanding of the models in place and their commitment to the provision of dedicated women’s secure services. Recruitment was noted as key in ensuring that prospective team members signed up to existing philosophies and demonstrated that, even in the absence of experience, they held a positive attitude towards working with women.

**Staff needed to listen** to women in the context of one-to-one therapeutic relationships and understand their needs within a holistic life context. All services used a ‘named’ or ‘primary’ nurse structure whereby women had ongoing access to a qualified nurse and developed a relationship with someone who knew about their life. Usually a second qualified staff member was assigned to each woman who was the back-up when the first named was unavailable. Levels of choice women were given varied. However, some noted that, although they did not choose who to have, they were able to refer to team leaders and/or the ward manager if they felt the relationship was productive or positive for them. For staff, this was an important aspect of how they worked with women. Some were frustrated by lack of time to give individual attention due to their other duties. Others were concerned that the nature or content of these relationships was not always clear and that they did not always have access to appropriate supervision to enable them to explore their concerns further.

**Therapeutic relationships** needed to facilitate a process of internal change and not create on-going dependency on mental health professionals. While women and staff valued the provision of high levels of emotional support, they recognized that this alone would not

"It’s about recognising the women’s emotional needs and responding to them but also enabling them to understand and manage themselves rather than meeting some of the women’s needs without helping them to recover. It’s about a process of internal change."

"We developed a forensic strategy for women across the region so the idea of recovery was very fundamental to that because we were looking at having a network of services across Yorkshire that would enable women to move through the services because we found that women weren’t getting stuck at high secure, but the women we had were getting stuck at medium secure, and often in the independent sector, and the strategy was about creating this network and an ability to create a seamless pathway for the women.”

"They’ll sit with me for hours sometimes, when you’re
enable women to take increasing responsibility for their mental health and engage in a process of change leading, it was hoped, to recovery. In addition to team nursing, some services had introduced groups which focused on self-reflection, awareness raising and developing strategies for self-management of needs as part of the weekly programme of events. The latter included learning to recognise signs of relapse and developing appropriate coping mechanisms. One service had developed an Associate Practitioner role where a member of staff provided clinical interventions to women focused on their understanding and self-management of mental health issues. These included self-injury, hearing voices, self-esteem and anxiety management, within the context of a gradually established therapeutic relationship while working in a support role in the women’s service.

- **“Seamless” pathways for women were also identified as important for their recovery.** For one service, there was only limited access to gender-specific routes out, with some women transferred to a mixed sex rehabilitation ward in the same service. Not all PCT areas in this region had women or men-only low secure services. This women’s service, including some of the women service users, had worked with their Specialist Commissioning Team to successfully bid to the Department of Health for funding for a High Support Residential Service for women transferring out of secure mental health facilities. It opened in early 2009 and, it is hoped, provides a gender-specific care pathway for women to return to a community setting either directly or via rehabilitation or low secure settings as appropriate for the individual.

- **Structured ‘therapeutic’ days as well as informal activities were essential to women whilst confined to the wards.** Women described the monotony of weekends and the importance of being busy. All the case study services provided some weekday formal and informal activities and several offered a full programme to women. Formal activities ranged from individual psychology, OT and education to group work focusing on varied issues. Some services had involved women in consideration of what should be on offer. Less formally, services offered hairdressing, opportunities to cook for themselves and others and occasional social events including themed take-away meals. Some staff commented that even the informal activities had a therapeutic potential as they increased self-esteem and confidence as well as preparing women for moving on from medium secure.

- **Markers of progress** were important as means of reflecting back to women what had changed during their time at the medium secure service. In addition to the required monitoring of a woman’s progress through ongoing discussions with women, with the MDT and through the CPA process, some services had introduced innovative methods
which could both motivate women and, depending on their progress, provide tangible ways of measuring change. One case study service had developed a ‘status’ system and an incentive programme. The status system enabled women to earn privileges and lose them too. The highest level was four in one ward which included holding a room key, unsupervised activity, e.g. use of the computer or gym and swimming pool. Level four meant consideration for a move to a different ward and rehab. The level women were placed on reflected the progress they were making in relation to self harm or aggressive behaviour. Its purpose was to keep women safe and enable them to reduce risk to themselves or others. The incentive programme paid women to attend essential sessions daily over a 12 week period up to a maximum of £1.50 per day.

Due to the individuality of each woman’s repertory grid interview, with both the elements and personal constructs being freely elicited, it was not possible to undertake an electronic analysis of aggregated grid data. However, a manual review of how the women rated each construct was undertaken by looking at the mean scores in each grid. From this it was established what women rated most positively, in terms of what helps to ensure their safety and their progress toward recovery with the top three themes being:

1) Relational Security
2) Communicating positive expectations
3) Good daily support

In terms of who the women identified as elements in their grid interviews, i.e. who were the individuals that they felt had an important impact on their care and safety, a member of the nursing team on the ward was identified at least once by all the women interviewed, with the Responsible Clinician (was RMO) or psychiatrist being identified as an element in nearly all of the grid interviews. Table 4 gives details of the role/relationship of the individuals included as elements in each of the grid interviews.

A review of how well each of the elements was rated against the constructs in the women’s grid showed that the Primary Nurses were most highly rated of the professionals involved in their care, whilst “other patients” were rated as having the most negative impact, with many women commenting on the detrimental effect of disruptive behaviours from other patients on their ward. It was notable that nearly three quarters of women service users included a family member or friend from outside the unit. Maintaining contact was a key factor to enable some women return to their home area.
Table 4: Elements, i.e. people, included in Repertory Grids

<table>
<thead>
<tr>
<th>Element</th>
<th>No. of times included at least once in grid</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any nurse or ward staff</td>
<td>42</td>
<td>100</td>
</tr>
<tr>
<td>Psychiatrist/Responsible Clinician</td>
<td>35</td>
<td>83</td>
</tr>
<tr>
<td>Myself (Prompted)</td>
<td>31</td>
<td>74</td>
</tr>
<tr>
<td>Family or friends</td>
<td>30</td>
<td>71</td>
</tr>
<tr>
<td>Primary/named nurse</td>
<td>24</td>
<td>57</td>
</tr>
<tr>
<td>Psychologist</td>
<td>19</td>
<td>45</td>
</tr>
<tr>
<td>Social worker</td>
<td>18</td>
<td>43</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>18</td>
<td>43</td>
</tr>
<tr>
<td>Other patients on ward</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Ward managers</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Others</td>
<td>12</td>
<td>29</td>
</tr>
</tbody>
</table>

It is interesting to note that women, albeit frequently prompted, saw that they were also important in how they could benefit or not from the service they received.

3.2 Philosophies and models of care: in theory and in practice

The survey of all services revealed that, while there may not have been specific policies in place, most had a philosophy of care which supported their work with women. Some noted that this included frameworks for meeting the diversity of need supported by strong ward boundaries and crucially, effective user involvement processes. In all but one of the case study areas the concept of relational security (discussed further in section 4 of the report) underpinned service philosophies.

There were some shared aspects to the philosophies of care adopted by the case study services and there were as many areas of difference. Here we briefly describe these philosophies in each case study area before turning to the reasons which underpin their use, how far and in what ways they enable services to function and, interestingly, why they differ from one service to another.

In one service, a philosophy of care based on gender sensitive and psychodynamic approaches with an ethos of empowerment, independence and recovery, has been in place for some years. Recently during the setting up of a new TEMSS(W) service, a more detailed evidence-based ‘model of care’ has been developed based on Attachment Theory integrated with Mentalisation (as developed by Bateman and Fonagy\(^{74}\)) and drawing on Alanen’s\(^{75}\) Integrated Needs-Adapted approaches for women with psychosis. Although initially developed for a new women’s “enhanced” service, the model had...
started to inform practice throughout the women’s service. It aimed to create a therapeutic culture informed by awareness of the impact of early trauma with a formulation-based holistic approach (i.e. attempting to understand the women’s emotional, behavioral, interpersonal or mental health difficulties from a biological, psychological and social perspective). The approach relies heavily on relational work between the staff team and the women. Through a focus on Mentalisation-based treatments, the staff team aimed to help women to understand and manage their own mental health difficulties that involved working with women in a process of enquiry which acknowledged that women themselves were the experts on their own story and nurturing their capacity for change.

**Attachment Theory** provided the basis of a model of care for a second service albeit formulated as part of a different approach. Although based within a mixed secure service, the women’s service developed its own model of care and related policies some of which were later explored in relation to the men’s service. This service offered support within a high dependency unit and a rehabilitation unit, both of which needed to be able to make use of the model of care. Here it focused on attachment being understood as part of a model of recovery. Finding ways for women to feel safe and take positive risks was an important part of how staff worked with women within very clear boundaries. The service recognised that women needed to be able to develop and maintain relationships before they move forward to recovery. The model was seen as a helpful framework to refer back to and training was provided for all staff. A series of study sessions to talk about the model of care as well as facilitated reflective practice have supported staff in developing their understanding and implementation of Attachment Theory in situ. The **Recovery Model** is an approach that focuses on a woman’s potential for recovery and is seen as a personal journey. Its function is to “…[enable] people with mental health problems to maintain or rebuild valuable and satisfying lives within and beyond the limits imposed by their difficulties”.

The women’s service has a dedicated OT who works with women on developing their skills and confidence. The OT department in this mixed secure service worked with Kielhofner’s **Model of Human Occupation**. This model is based on three elements of volition, habituation and performance capacity and was seen to be very helpful in a secure service for holistic OT assessments and developing appropriate occupation.

One service worked within a **philosophy of collaboration**. This was at an operational level and focused on women’s involvement in their

“She is really good, she advises you, it’s like she gets into your life and reads your mind and everything she says to me is correct. She makes me look at my mistakes, my illness and different things like that in a different perspective that I didn’t see before”. Woman service user

“Kielhofner looks at environments where some environments can ‘afford’ people, in his language, or ‘repress’ people in their occupational performance and that’s really important in a secure unit.”

“That’s really interesting as we haven’t asked the women, we’ve asked the staff what do you think of the model of care. They say it’s different here and give practical examples but I think it’s about having a therapeutic milieu.”

“There are models and they are implemented to different degrees in different parts of the service. There’s
Collaboration within the staff team where individuals were able to work in a self-reflective manner was seen to have a positive impact on how staff then worked with women. The service had undergone considerable change at senior staff levels and through expansion of the service. With major developments, the service had introduced a more streamlined structure and a commitment to staff training in DBT to underpin its philosophy. As a women-only service, albeit part of a larger organisation, there has been some flexibility in determining the philosophical direction for the future. The unit provides a range of specialist services and has found that through making appropriate assessments and placement within a specialist ward, staff were better able to understand and work with women’s needs in relation to, for example, a form of mental illness or learning disability. This had helped move away from descriptions of behavior to exploring the factors which underpinned it in a therapeutic environment. A therapeutic community model had been adopted with recognition that events affected the whole service and thus needed to be discussed across the community inclusive of women and staff.

In another service, the team reported that a model of care which provided a gender sensitive approach had been developed and adopted across the women’s service although there were some operational differences at ward level reflecting the differing clinical needs of the patient groups. As a starting point, the service had adopted the Commissioning Team’s Standards of Care for Women’s Secure Services, with some members of the team having been involved in the development of these regional standards. They had also looked at WISH (Women In Secure Hospitals) Standards and Recommendations for key attributes for a gender sensitive service, and incorporated as many of these that they could into their model. An away day, involving Commissioners, MDT members, ward staff and women service users, was organised to contribute to the development of their model of care. They looked at Trauma, Attachment and Recovery models and discussed how to integrate them into how they work with women, and what would work best on each ward area; with recovery principles being particularly important for some women and trauma and attachment models being particularly pertinent to meeting the needs of others. Efforts had been made not to replicate the traditional division between Personality Disorder/Mental Illness wards that had been set up in other services, but instead to focus on women’s recovery. Rather than seeing them in terms of diagnosis, they attempted to deconstruct what women’s clinical and risk needs were within a more holistic context, and then to incorporate gender influences within their individual case formulations.
For one women’s service, there were no separate operational policies or a written model of care but they operated on the basis of Unit or Trust-wide policies. The philosophy of care on the women’s ward was **gender sensitive and holistic** taking account of women’s backgrounds and life experiences. Various models and approaches had been reviewed by the team and influenced their individual practice with the women, including **psycho-social approaches and the Tidal Model** (http://www.tidal-model.com), which emphasizes the importance of the recovery process starting from day one or when the patient is at their lowest ebb and is centered around them reclaiming their own story as a way of gaining understanding of the causes of their mental distress and taking back control of their lives. But, whilst there is no approved “model of care” document for the ward its philosophy of care is led and driven by the clinical leads who aimed to embed it in the culture of the Women’s Service and the way in which the team thought and responded to women’s needs on a day to day basis. It encouraged a ‘positive’ attitude toward working with women in a secure setting. The ethos was based on trying to provide a “human” response to women’s emotional distress and putting the women’s needs as paramount rather than trying to fit the women into a particular set of procedures or ways of working.

In the sixth case study area, contemporary social learning theory provided an overall framework and was argued to emphasise the importance of combining ‘medical and social treatments in a complementary manner, to mitigate the effects of any illness, and to help promote more adaptive attitudes, skills and behaviour’. As a treatment approach **RAID (Reinforce Appropriate, Implode Destructive)** was adopted across the entire medium secure service. RAID is based on a philosophy of how to view and work with extreme behaviour argued to enable staff to intervene positively and effectively to minimise its occurrence. It is not a single approach but based in many including behavioural theory. There is one training provider in the UK (http://www.apt.ac/raid.html). Staff were all trained to encourage positive behaviour, to record ‘green’ behaviours, acknowledging a woman’s progress as well as ‘red’ or negative behaviour. In addition and although this service made use of standardised care planning and documentation, for example, it was also clear about working within a **gender specific model of care**. Thus, the RAID approach also took into account women’s backgrounds, types of exploitation and subsequent vulnerability, child care issues and exploration of women’s roles as daughters, mothers, partners and how these roles impact on their quality of life. Staff were risk aware and working to make sure women received appropriate levels of

**“Within this gender specific service we have no specific model but what we have done is use the principles of psycho-social interventions in agreement with the national standards and the gender policy and as supported by NICE. The outcome has been tremendous! If you come into our ward, the atmosphere is constantly normalised, incident levels have gone down and you find there is more openness and interaction and the right attitude in care. It has ultimately led to reduction in use of the Extra Care Area.”**

**“We are trying to give positive feedback but also to make clear what is not acceptable behaviour. For example, if a woman puts her feet on the table, challenge this in a gentle way and not just shout ‘get your feet off the table!’; Suggest to her this isn’t the done thing and give her an opportunity to respond appropriately without it becoming an issue.”**
monitoring and support. Good relationships were seen as one means of making sure staff were aware if something was wrong and thus recognise that something needed to be done.

The philosophies described above were usually articulated by those in senior clinical positions within the case study areas: consultant psychiatrists, heads of psychology and senior nursing staff including ward managers. In one area, however, and on the basis of an audit, the service identified that staff were keen to work with a model but needed training to help them understand the complexity of theory and its use in practice. In a number of areas, it was not always clear what had led to adopting a particular approach although contributory factors were said to include:

- Senior staff with experience of a specific model would often influence service development and thus the choice of model
- Time provided for new service development to explore different approaches and their potential use
- Evidence-base for an approach used successfully with women with complex needs
- Existing services reviewing philosophy and policy in the context of bidding for new services, e.g. the WEMSS
- Existing organizational approaches that the service was required to adopt, e.g. where it was part of a large structure that already had a model of care in place.

In some cases, staff referred to developing the model through their practice. In one area, working with attachment theory become important once women had arrived into the new service. It was clear that working towards recovery was essential but that women needed to be able to work on relationship building in order to work on recovery.

During the course of the evaluation, many staff and most women interviewed found it difficult to articulate that a specific model or philosophy of care had been adopted in their service. However, they frequently referred to taking a positive attitude and the importance of shared values, shared approaches and shared goals but these were not necessarily connected to a theoretical approach.

In one case study service, concern was expressed by some professionals that if staff responded to women’s emotional distress by simply telling them to think positively this could be extremely invalidating. Here it was also reported that on occasion there was a reluctance by some workers to properly acknowledge that a woman’s emotional distress had led to dangerous behaviours in the past yet it was essential that this connection was understood and addressed as part of the woman’s recovery process.
The terminology differed but what emerged as important in all services was ensuring that senior members of staff had or were planning to put in place a clear framework that allowed staff and women to operate effectively. The framework provided an overview of the direction of the service within which operational policies could be developed and implemented. A coherent and thought-through model or philosophy of care was essential and where this was not the case, staff and women described more tension, confusion and a higher number of difficult incidents. Staff were also less likely to receive regular support and supervision.

3.3 Implementation of policies to facilitate a route through

In the initial survey and final follow-up of services, we asked about the range of policies in place. Dedicated women’s services were often left juggling demands in terms of the range and content of policies to put in place. On the one hand, there was agreement that policies needed to reflect the purpose and philosophy of the service as laid out in Mainstreaming Gender and Women’s Mental Health Implementation Guidance. On the other hand, some services were constrained by the requirements of their ‘parent’ organization.

In some case study areas, the Women’s Service had developed a full policy for its new service which covered all aspects of practice. The following table illustrates the range of policies and the extent to which they are in place within individual services. Those which have developed or been redesigned recently were more likely to have all of these either as individual or as part of an overarching service operational policy.

Table 5: Policies in place 2006 (n=13, 1=not known)

<table>
<thead>
<tr>
<th>Policy</th>
<th>In place</th>
<th>Not in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of aggression/distress</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Child visiting</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Management of self harm</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Equalities and diversity</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Sexuality and relationships</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Anti-bullying or harassment</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Implementation of Relational Security</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

The following is an example of a service policy which notes its ‘ethos is committed to examples of good practice emanating from research into the experiences and needs of women service users in secure settings. These place particular emphasis on the need to provide physical environments, activities and professional services in a manner that is gender-sensitive and the need to take particular account of the fact that many women service users will have had past experiences involving abuse or other trauma. Of particular consideration are:

- National Service Framework for Mental Health 1999
- Philosophy of care (WISH 1999)
- Equality and Diversity Policy
- Women’s Mental Health: Into the mainstream (DOH,
Few additional policies were identified apart from one service which had a ‘male staff working with women’ policy. However, some services noted that they were in the process of developing gender specific policies in particular.

At the outset of the evaluation, less than half of services responding to the survey had a policy on Relational Security although one noted that relational security was ‘understood and reflected in the ward’s staffing profile’. Where there was a policy in place, two services commented on the importance of this to the way in which they were able to work with women. Where services were women only (or on sites with men but no mixing between them), the development of women-specific policies was considered most relevant. Interestingly, one service said all its policies were under review as none were gender-specific. This seemed to be a common situation and few services said they had all seven of the identified policies in place. Policies which are likely to be at the heart of women’s secure services tended to be least likely to be in place – sexuality and relationships as well as relational security. Those without frequently noted that these policies were in draft or in discussion within their service.

Since then, and over a period of two years, most women’s medium secure services now have these and other relevant policies. Indeed, there has been considerable change over time which has been influenced by a number of key factors:

- the implementation process of Mainstreaming Gender which has required considerable time to turn the guidance into reality
- the publication of Best Practice Guidance: Specification for Adult Medium Secure Services (DH 2007)
- the publication of Implementation Criteria for Recommended Specification: Adult Medium Secure Units (Quality Network for Forensic Mental Health 2008)

Whilst not all services are members of the Forensic Quality Network, the publication of standards which emphasise relational security has had an impact. In addition, the Implementation Criteria contains a substantial section on women’s services.

Providers had different views of what policies best represented the efforts of their women’s secure service. Ensuring local development of policies for women’s services based on consultation with women themselves had been very useful.

The questionnaires suggested that there are clear reasons for the extent to which services have appropriate policies in place. Services described the factors which enabled implementation as well as those that hindered it. Three key factors which helped were frequently identified across the services including the importance of strong leadership, ensuring staff
awareness of policies and the involvement of staff in local policy development. Implementation was further supported by having the following in place:

- Experienced staff teams
- Consistency of approach (by multi-disciplinary and nursing teams)
- Regular review of policies and procedures
- Resources for implementation

Factors which hindered implementation were most usually where the above were not in place. However, services noted other issues which acted as barriers in their settings. These included:

- Lack of appropriate staff; use of bank/agency staff and high levels of new and inexperienced staff
- Lack of time for staff to read and absorb policies
- Individual staff who lack awareness of the issues in relation to women’s mental health
- Lack of understanding in large mixed MSUs

Women interviewed also suggested that even if they did not want the detail of policies, they experienced their impact and sometimes saw them as ‘the rules’. They too wanted consistency and consultation. In one case study area, women described how policies changed depending on which staff were on duty. An example they gave was about smoking and garden access once their building became no-smoking, some staff allowed continuous access and others who did not despite agreements at the community meeting and a service policy.

Concerns raised by services were consistent and it was clearly a resourcing as well as staff retention issue for many. This was also raised in relation to training (see section 7) where levels of gender specific training appeared low often as result of staff turnover.

3.4 The importance of single sex policy and provision

Located at the centre of the DH Women’s Mental Health policy was the importance of offering women safe places to work towards their recovery. This required that women, for whom it was appropriate, had access to dedicated women-only services that would meet their needs. The evaluation findings suggested that there was broad agreement about the importance of single sex policy and provision but the form this took differed as did women’s and staff attitudes towards them. However, it was not always clear that the concept of differentiated care was understood as more than single sex provision.

In one case study area, it was reported that when single sex provision was

“They are not in a separate service! They live on same gender wards and that is how we perceive it. I suppose my philosophy is that we don’t have a women’s service and a men’s service we have a forensic service for men and women and we have pathways for men and for women and we certainly in our service try to have staff working solely with men or solely with women because I think there are more things that are common than there are differences.”

“Being on a women only ward is very much different, it is more settled and it’s more pleasant, it really is more pleasant. The girls get on really well we all help each other in various ways from doing each other’s laundry to making brews for each other.”

Woman service user

“You need interaction with men. Some people have fears of being around men anyway and the way of getting over those fears is to have male workers, being able to gain trust in male supporter.”

Woman service user

“In some ways I don’t want unescorted ground leave but I know some women wouldn’t mind. I don’t
first introduced at the unit, it was on the basis of promoting women’s safety and awareness of their vulnerability within mixed-sex wards. However, over the years and as the women’s service developed, it became clearer to the clinical team that women’s needs were different and, as a minority group within forensic services, their needs could not be specifically targeted when they were cared for alongside men. Whilst single sex provision was still seen as a pre-requisite for women’s safety, it was also recognized as essential in order to provide appropriate gender specific care.

At another service, all the women interviewed said they preferred being on a women-only ward, stating it felt safer. Two of the women though said that whilst they liked being on a women only ward, they did like to have the opportunity to mix with men in off-ward areas and during some activities. Two women spoke about previously being cared for on mixed-sex wards. One reported she had felt threatened by the presence of male patients and their behaviour on the ward, saying she would not feel safe if male patients had access to sleeping or living areas on her current ward. The other also said she had felt intimidated when on a mixed sex ward.

Women’s attitudes were sometimes determined by their own experiences of abuse and relationship to men in other circumstances. However, more broadly, many women said they were not concerned by limited contact, e.g. through service-user groups, but they would not seek out to go beyond an occasional hello in a corridor to men from the men’s service. In one service, returning from community leave was identified as a potential problem as women had to walk through the grounds to get to their unit. They were issued with mobile phones to call the unit for an escort although they had not been allowed phones hitherto.

In mixed-sex services which included a women-only unit, staff identified a number of issues which, in their view, made it more difficult to deliver an effective service. These included:

- **Lack of critical mass:** two case study areas provided one ward each of 12 women in large mixed units. This had led to being forced to take women with a range of needs and diagnoses who might not be treated together if placed in a larger women-only unit.

- **Service scepticism:** whilst changing with time, services with a higher proportion of men tended not to recognize that some women, given their histories of abuse, needed to be provided for in women-only services which took a gendered approach to the provision of care.

- **Disproportionate resource allocation:** in addition to holding different attitudes which could be very blaming of women, men’s units in mixed services were reported as having access to fewer resources which had led to criticisms of dedicated services for women.

At the same time, there was recognition that women’s services had the
advantage of dedicated and highly visible staff teams that women saw frequently in the sitting room and other areas of the unit, as one person interviewed said:

“I was talking to an OT about things for women. We’ve tried to talk about having a male-specific service agenda starting to introduce the idea that there are specific areas to think about. (In the women’s service) we’ve got a record of birthdays and anniversaries. The OT was saying the male service was different, for example, they don’t even know which of the men are fathers.”

While services were in agreement that women-only was more appropriate with male staff to provide positive role models, it was not always easy to find male nurses who wanted to work with women. Most services had agreements that male staff did not go to women’s bedrooms or onto a corridor where there are bedrooms; they did not give injections or sanitary products and in some cases, did not do night-time observations. Some men were concerned that women might accuse them of forms of sexual abuse. Interestingly in this study, few of the male staff interviewed had wanted to work in a dedicated women’s service. Their choices were more usually informed by location and position. (See also section 7 on working in a women’s service.)

- Women and professionals involved in their care were clear, regardless of terminology, about the importance of key factors and in particular relational security which underpinned what services should work towards. However, the survey showed that policies about relational security were only in place in half of services.
- Essential to service provision was the development of a coherent and thought-through model or philosophy of care. Where this was not the case, staff and women described more tension, confusion and a higher number of difficult incidents. Staff were also less likely to receive regular support and supervision.
- The case study services demonstrated the difficulty at times of turning philosophy and policy into every day practice for a variety of reasons. However, core to this process was an understanding that working in the service and being able to reflect on theory needed to be integrated.
- Some women’s services were constrained by their location as a relatively small part of mixed provision.
- Policy implementation was hindered by lack of staff; time; awareness and, in larger mixed medium secure services, understanding.

4. In whose hands: how are women safe and secure?

The consultants hold our lives in their hands so whatever they say goes – the top dog. They make the decision about whether we’re ready for discharge. I tell mine everything about past, present, future.

Woman service user

At my last (mixed) hospital, they didn’t protect me from sex offenders and I got sexually abused. They said I was psychotic and injected me. Here the doctor said I was hypersensitive emotionally and shouldn’t have been treated that way. The doctors here are a solid block for me. They nurture me and make me feel confident to walk on my own and to explore myself. They give me wisdom about my illness and help me become sturdy with explaining the way I am. They really care which is very unusual.

Woman service user

The philosophies of care and policies described in section 3 were underpinned by consideration of how to maintain women’s safety. This has been defined as physical, procedural and relational, each of which in practice carries definitions dependent on levels of understanding and diversity of context. The evaluation examined the range of interpretations of safety and security from the perspectives of women service users through to commissioners of services in order to make sense of whose safety and what security were being referred to. This section explores more specifically how far and in what ways the essential concept of relational security and practice has been adopted by women’s secure services.

4.1 Definitions of security

Those involved in the provision of services for women were asked about their understanding of the concept of relational security and the ways in which they believed the concept was or was not core to service delivery. Women patients were also asked if this was meaningful to them and if so, how did they see its role in service provision. Standard definitions of security in use covered the following:

Physical security
Physical security referred to the design and maintenance of buildings, fittings and the site of the unit including, for example, the height of the perimeter fence, gate entry and key management of the service. The 49 standards for medium secure services were applied across single and mixed-sex services.

Procedural security
Procedural security referred to the policies developed and procedures implemented to ensure the smooth-running of the service ranging from the use of seclusion, observation procedures through to the control of mail and use of telephones for example.

“People initially think it’s just about quantity of staff and it is partly about quantity of staff but I think crucially it’s about quality of staff and the quality of the relationships that they can have with patients. It’s about using those relationships as a way of managing and maintaining behaviours and that is without having to resort to other strategies or structures or observations or whatever, so for me it’s really about the quality and the kind of skills the person has in terms of the understanding they have. The women’s service very much focuses on reflective practice thinking about what we do.”
**Relational security**

Relational security lies at the heart of the National Women’s Mental Health (MH) Strategy (DH 2002) and the Implementation Guidance (DH 2003) for gender-specific services addressing the specific mental health needs of women (e.g. with histories of abuse and/or self-harm). Relational security has been embedded in the standards for all medium secure services. In the context of women’s services. It encapsulates the importance of high staff-to-patient ratios, the amount of time spent in face-to-face contact with women and a balance between intrusiveness and openness; working towards high levels of trust between patients and professionals. ‘Mainstreaming Gender and Women’s Mental Health’ states that structures for the provision of secure inpatient services require a range of provision:

“to create an integrated system of secure inpatient care for women. Women’s needs for security are predominantly for relational and procedural security and therefore making the distinction between existing (physical) medium and low secure care, is probably unnecessary.”

There was some variation across the case study areas, staff groups and among women themselves. For example, in one area, all staff interviewed provided a definition of relational security even though they identified some concerns about how it happened in practice. In another area, staff interviewed had no clear ideas about relational security. However, some here described their practice in ways consistent with the concept.

### 4.2 The experience of security: what did women say?

It was rare that any of the women we met used the language associated with security as described above. However, many did describe factors which broadly fit within the concept of relational security and believed that this ‘different’ way of working had helped them to stay safe including:

- **being able to talk to staff** who they knew well and trusted. One woman spoke about the atmosphere on her unit, and the fact it was accepting of all women whether well or very unwell – the staff “accept you as you are”.
- **being on a women-only ward** had been very important to many in keeping them safe, although as one woman noted, since she has been more settled and transferred to the mixed-sex pre-discharge ward, being on a mixed ward has worked well for her.
- **being able to address specific issues** in a safe way. One woman who has a history of self harming said she had completed a course with the Clinical Nurse Specialist for self harm and it had benefited her,
particularly the focus on relapse prevention. After completing the course she had had a review with the psychologist who had summarized the most important points for her into one leaflet, which she felt would help to keep herself safe in the future.

- **being able to just be with staff** was important to some women who appreciated that higher staff ratios meant there were opportunities for staff to be on the unit. One woman described the importance of staff who could sit with her, observing her in a more relaxed way and that she felt able to talk or not while reassured by their presence.
- **being able to form and sustain good peer relationships** with other women played a significant part in how safe they felt. One woman described how her friends ‘shopped’ her, telling staff that she was at risk by vomiting her medication. Staff encouraged her peers to intervene in the first instance while they provided back-up which proved not to be necessary. She said she appreciated that her friends had ‘cared’.

Most of the women who were interviewed said they felt the level of procedures and restrictions in place was appropriate, recognizing they were there to keep them safe, and they said these had been explained adequately. Women held this view about levels of physical security as well and said they understood the need for this even though it was overly restrictive in some instances and confusing in others.

One woman felt however there were too many restrictions and rules, and that they were just told what they could or could not do without any explanation as to why. An example of this was where women were sometimes told they could only go outside to smoke at certain times and sometimes there were no restrictions to when they went.

There were instances in which women described experiences where they had not felt sufficiently safe in the service including:

- a very few women who talked about bullying and how it was dealt with
- new women arriving at the ward or unit
- high staff turnover resulting in women feeling less able to find someone they knew and trusted to talk to.

### 4.3 What did staff say about security?

Key staff in senior positions were more likely to provide a definition of types of security and their place within their setting. In one case study area, the term relational security had not been adopted but the concepts and practices had been as part of their philosophy of care. Staff interviewed said they were not familiar with the term but outlined a model and practice premised on understanding that women needed to

“*My belief is that there are many women who have had years and years and years of individual psychology and you know what? They have not processed any of it because they have never been safe and I don’t believe that when people feel unsafe they are able to work in-depth at all. What we try and achieve is safety first with an emphasis early on in the psycho-social treatment programme on building skills be that around managing anxiety or dealing with feelings or interpersonal relationships.*”

“*There is some very positive practice but I think staff are not always consistent and this doesn’t promote relational security when staff don’t all maintain the*
feel safe in the service and in relationships in order to work on their own recovery.

Case example:

Operational polices for the women’s wards in one case study area included the implementation of relational security and stressed its importance within the women’s service in achieving safety through establishing “good rapport and an effective therapeutic alliance between patient and staff”. Written policies also emphasized the importance of staff having thorough knowledge of their service user’s individual case, enabling them to detect and act on changes in mental state promptly, and policies recognized the importance of staff awareness of their own responses to service user distress or anger, aiming to establish a culture of reflective practice.

There was also unit-wide guidance available on relational security which emphasized the importance of maintaining professional boundaries whilst also developing close working relationships with service users and providing empathy.

The model of care being developed within the women’s service based on Attachment Theory provided awareness of issues like re-enactment of trauma, the importance of interpersonal relationships, and the effects of dysfunctional attachment that may be experienced by women with histories of abuse.

Interviews with staff from the various disciplines indicated that there was good awareness of the particular importance of relational security when working within the women’s service, with all staff being able to give descriptions of what the term relational security meant to them. The main problem identified by some staff, in terms of the implementation of relational security on the women’s wards, was that of inconsistency in the way some staff applied procedures and individual care plans.

One member of the multi-disciplinary team emphasized the importance of understanding the offence and to not deny that the women the service works with have often committed very serious offences. He felt that sometimes women’s violent actions were only explained (and perhaps excused) by the context of them surviving abuse, although it was also the case that many of the men service users at the unit were also survivors of childhood abuse although this was not used to try and explain or excuse their violent offences in the same way.

The women service users who met the evaluation team all reported they generally felt safe on the unit. One woman reported that although she felt safer on a women-only ward, she found disruptive behavior by some of the other women and the consequent staff interventions (i.e. use of restraint) upsetting. Another woman reported she had been attacked by another patient on a couple of occasions although the ward staff had dealt with those incidents promptly and appropriately. One woman said

same rules or work to the same policies and procedures.”

“It’s easy to have a go at nurses – we’ve got some brilliant ones. On the women’s service it’s really important that they’re people who do have skills in relationship building and have a degree of intelligence. When it’s not there it’s stark. Patients point it out and say ‘I don’t want that person on shift, don’t ask me to go and tell someone what my problems are when they’re not someone I can trust and they don’t listen to me’. That’s the biggest issue for me.”

“I think relational security is highly important because again looking at the histories of the women that we tend to have here you are going to have problems in terms of interpersonal relating, a lot of reenacting and a lot of early childhood abuse and I suppose dysfunctional attachments and I think it important that staff are trained in recognising those and are also supported and have supervision around that.”

“Numbers of staff is an issue and patients will always say they want more staff. Nurses will always say they want more staff. My experience is it’s the inverted U curve where you get to a certain staff to patient ratio and then staff regardless of discipline start
she felt that when the ward was short staffed it did not feel quite so safe.

One of the women who used to self harm frequently when she first came into the unit explained how support from her care team and help with developing appropriate coping strategies had enabled her to stop any self harming for over six months now and that due to this help she now felt safer.

Key features which enabled relational security to be embedded in service provision included:

- **High levels of staff retention**
- Provision of regular support and supervision for staff on the wards
- Provision of unit-wide guidance which emphasised the importance of maintaining professional boundaries while developing close working relationships with women
- **Involving ward staff** in clinical interventions
- **Zonal observations** which allowed staff to spend time with women and pick up early signs of risk behaviours or changes in a woman’s mental state
- Provision of risk assessment and care planning which supported women to develop safe and appropriate relationships
- Ensuring local level discussions in teams
- Support for the development of positive peer relationships among women

However, there were factors which were seen to hinder the process:

- The concept and language of relational security was not always meaningful.
- There were some concerns about the practical implications of relational security which included low staffing levels and few opportunities for supporting staff in how they worked with women.
- **Physical and procedural security** were seen to obscure the importance of relational security, for example, where some question the need for perimeter fences at all, others were frustrated at having to comply with generic standards of physical security deemed unnecessary in women’s provision. In one service, a new build incorporated a child visiting suite with separate entry for families and children. However, they have been required to address this by closing this entrance.
- Trust lies at the centre of this approach but was perceived as being complex to create and requiring understanding and willingness on the part of staff as well as women service users
- Continuity across the service was important but some women suggested that _staff had favourites_ and thus treated women differently.

“**I think again there is some very positive practice, but I think staff are not always consistent, and this doesn’t promote relational security, when not all staff maintain the same rules and work to the same policies and procedures, but I think there are some very good therapeutic relationships between individual members of staff and women they work with but the inconsistency is a big problem.”**

“The patients are very important as well as sometimes they are the best people to judge when another person is not well. You can just tell because sometimes it’s like looking in the mirror, you can see your emotions in them.”

**Woman service user**

“They are not major things but to be signed off as medium secure now you have to be like male medium security. Into the mainstream wanted that not to be the case, to be different for women. So things that aren’t causing problems at all in terms of women are going to have a lot of money thrown at them to alter them.”
- Individual approaches and attitudes had in a small number of situations prevented staff from fully implementing the relational security model. Some professionals were perceived as ‘old-school’ and reliant on treatment by medication. Others were seen as still finding it difficult to move away from viewing women as attention seeking, for example, to understanding a woman’s life experience and therefore context for her behaviour.

- The use of patronizing or infantalising language concerned some women and the professionals working with them. This included referring to women service users as ‘the girls’ on wards where most women were over 30. In services where there was ongoing training and CPD related to gender issues, language was rarely identified as an issue.

- Changes in staff and high levels of turnover prevented the development of meaningful relationships in some instances.

“...I don’t like the newly qualified ones very much - I don’t talk to them, they’re the same age as my son, and I’m not going to go to him with my problems, so I’m not going to go to some 24 year old, and pour my heart out. I find them patronising as well, sometimes - you know - like it’s curfew time, girls and bleurgh, don’t call me a girl and don’t tell me it’s curfew time. I did have a spat with a couple of them - one was calling me sweetie, and another one was calling me lovey. And I said can you stop the staff from calling me that, because I find it patronising and I don’t like it. So they’ve stopped it.”

Woman service user

- The concept and practice of relational security were not universal. In some cases, services had adopted the philosophy but not the terminology. In others, a policy was in place but some staff were unclear about what this meant in practice.

- Women described what they valued about the service in terms consistent with the ideas underpinning relational security.

- Some were frustrated by the level of physical security but in particular, inconsistency of security policy implementation was a cause of complaint.
5. Day-to-day realities: arrival into and staying at medium secure services

I think other women patients are very important because sometimes they are the best people to judge when another is not well. There have been instances on the ward where the patients have observed and been saying ‘that person’s going to self-harm’; you can just tell because sometimes it’s like looking in the mirror and you can see your emotions in them. You try and explain to the nursing staff and they’re like, ‘well, we don’t have any signs’ so that makes it difficult for you. Sometimes I think it helps people that we notice something and can go and talk to them as we seem to pick things up easier. That’s where the patients come in.

Woman service user

The day-to-day life of women patients in medium secure services and their as well as staff perceptions of routes to recovery were shaped by a variety of factors. These included the interior as well as exterior physical environment; the rules and regulations in operation at the time; the range of activities on offer or obligatory and, importantly the overall ambience of the unit. Each impacted differently either because of differences in service ethos, structure and space or because of the ways in which individual women responded to them in the context of their own situation. This section examines these different responses and identifies areas of apparent shared effective practice for a dedicated women’s service.

5.1 Early days: admissions and arrival

Women’s services operated a range of admission procedures from an eight-hour turn around being promoted by an independent provider to processes which could take many months to conclude. One service described their weekly admissions and transfer panel where discussion was based on a structured pre-admission assessment process template with inclusion and exclusion criteria and consideration of whether the woman could fit into the service as it stands. Services noted the need to achieve a balance which did not keep women waiting too long yet gave them time to adjust to a possible move. With the growth in the number of women coming via the Criminal Justice system, time was not always available but ideally should have been provided. Further constraints on the ideal policy resulted from the necessary but sometimes convoluted arrival at agreement of how a placement would be paid for.

The women who participated in the evaluation rarely talked about formal admissions policies. However, they frequently described the experience of admission and then arrival at the medium secure service. For many, moving to medium secure represented an improvement in their circumstances, a sign of hope that they were on ‘the way out’ and an opportunity to live within a more congenial and often more attractive environment.

Some women were instrumental in the choice of service and most...
wanted to be placed close to family, friends or where they came from. Others specifically wanted to be away from a location where they were known. Not all were so fortunate in terms of choice and although services for women were working to provide appropriate placements, constraints of funding and local availability determined and indeed limited choice. The Dene in West Sussex offered services to women from any area and frequently had women from Scotland and Wales as well as other less well-served areas of the UK.

A small number of women expressed concern about their admission. This was more likely to be in relation to appropriateness of the placement rather than the process. Staff also noted that for some women moving from prison or a high secure hospital and arrival at a medium secure service could trigger mixed feelings.

Some women missed the stricter regimes of high secure settings and others were concerned that by moving from prison to a secure mental health service, they were wrongly identified as having mental illness and worse, had no idea of how long they would stay. A pre-defined prison sentence was preferable. For one woman, however, the move represented a positive change and she noted ‘how clean it all was, how comfortable and how gentle everyone was’ on arrival.

Standard admission criteria for women’s dedicated medium secure services usually included the following:

- adult women of working age (18-65 years) from specified geographic areas who will benefit from admission to a women’s secure service and be able to integrate safely into the environment and the patient population
- detained under the Mental Health Act 1983 (MHA) or Criminal Procedure Act 1991 (CPA) with a primary diagnosis of mental illness
- the service will recognise the complex psychopathology within the legal category of psychopathic disorder as defined under the MHA
- assessment may be offered for women with borderline learning disability
- women with severe mental impairment are excluded as are women with major acquired or organic brain damage.

Assessment policies which supported decision-making were important and in particular where initial assessments examined the way in which a woman could benefit from environments where relational as well as procedural and physical security were adhered to.

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**my shoulders, that the girls were going to be all right because you worry about things like that**

Woman service user

“They wanted me to be closer to my family, so they moved me. I didn’t really get asked, they just did it. It was presumed to be the best for me and as I wasn’t that well, would I really have been able to say anything not to move? Where I was did say to me that if I didn’t want to go, I could have stayed there but the ball was rolling.”

Woman service user

“I think it works fairly well. If women are having difficulties with other placements, it’s important that they’re not left in a situation where they’re not getting the service they need for a long time. The pre-admission assessment is responsive to patients’ needs and if there is a need for psychological or OT assessment they will go out too in advance. We’ve been able to give the patient lots of information and they’ve felt relatively well-informed when they come.”

“We’ve had women from Broadmoor where we’ve been lots of times to develop care plans so that a woman is very clear about what she needs to achieve to step-down and visits here whereby they’ve already got something to do, the OT knows what they’re interested in. We also go to the CPA before they get here so care plans can be made..."
Case example:
In terms of referrals from prison, although the clinical team was able to respond by arranging an assessment visit within an appropriate time frame, usually the recommended two-week period, due to insufficient beds to meet the demand for medium secure for women from the area, women were often either waiting within the prison setting for a prolonged period for a bed to become available or referred to the commissioning team to find a bed in the private sector. One clinician who regularly assessed women in prison reported that, because he was aware that due to the long waiting times for female beds at the unit, if he felt the woman needed to transfer from prison to a more therapeutic setting rather than wait the ‘arbitrary’ three month period for a bed to become available at the service, knowing that it was highly unlikely to happen, he took a more proactive approach and referred the woman through to the independent sector without delay.

Although on occasion women were referred directly from the courts, due to the small number of beds in the women’s service, and with several women usually on the waiting list, it was rare that the service admitted a woman directly from court. However, if she was assessed as urgently requiring a medium secure mental health setting, the case was referred to the Specialised Secure Commissioning Team to find an appropriate placement in the independent sector, which usually required her being placed out of area. For women who received a Restricted Hospital Order and who required supervision from the community forensic team once they were eventually discharged into the community, the aim will normally be to bring them back to the unit as soon as a bed becomes available. This was because the clinicians who acted as Responsible Medical Officer for the women in the community believed it was necessary for them to have worked with a woman in the in-patient setting before taking on responsibility for them in the community. However, this led to delays in women being able to move along the care pathway at the appropriate time, for once women were placed in the independent sector and they already had access to a medium secure bed they may not have been given the same priority when a bed becomes available at the unit as a woman who was in a prison or community setting. This lead to blockages in the care pathway with out-of-area women sometimes having to wait lengthy periods of time to be returned to an NHS bed in their home area.

In the case study areas, staff involved in the admissions process and women identified a number of factors which helped the admissions process work well including:

- Speed of pre-admission assessments
- Consultation with the woman concerned about her needs
- Provision of information to the woman about the new service
- Keeping the woman in touch with the new service, e.g. sending pictures and arranging ongoing visits while waiting for a space
- Maintaining the woman’s outside connections, e.g. with children,

so it’s a gradual letting go and gradual introduction to us – unless it’s an emergency when we’ll bring a woman in very quickly.”

“We’re a bit different to a men’s service! When coming from prison, rather than coming via the vehicle air lock which is standard for the men’s service, what we prefer is that women just walk through the front door if at all possible, not in handcuffs, not in shackles because that’s just adding more trauma.”

“In some parts of the country an assessment takes place, we supply the reports and it goes to the Funding Panel and then they are not sure, then there may be gate-keeping by the local MSU and this could take several months. Sometimes the patient’s clinical needs seem to take a minor position in terms of the ranking of priorities.”

“This is perhaps worse in the sense that there are obviously insufficient beds and we don’t have the capacity to admit the number of women referred and that leads to the women spending longer periods of time in prison when they are deemed to require treatment in hospital. There are no guidelines in place as to how long a person can wait or
prior to the move and on arrival at the new service

- Continuity of staff, e.g. ensuring the woman’s primary nurse attended the discharge meeting from the previous placement and inviting previous placement staff to attend first CPA meeting at the new service.

A number of changes were identified as potential for improvement:

- Enhanced communication between commissioners and referrers to ensure agreement prior to movement which was seen to be especially important where referrals take place very quickly
- Reducing the patchiness of referral processes
- Reducing commercial pressures on some independent sector providers for rapid admissions before there has been sufficient opportunity to meet with the woman concerned and staff involved in her care.

From the women’s perspective, central to ensuring smooth admission and arrival for women were:

- Visits to the service and from staff to the individual woman in anticipation of transfer
- Clarity about what was happening and why in relation to transfers, explaining the need for appropriate provision and thus how decisions are made
- Sufficient time to ensure appropriateness of the admission for the woman concerned and in relation to the mix of women in the unit
- Provision of a policy or at a minimum, service expectations on arrival
- Time to absorb change on arrival before having to deal with official paperwork.

For professionals making decisions about referrals and admissions, an important factor was the balance of women already part of the unit. Consideration had to be given to how settled the unit was, possible disruption that might be created by a new service user and the staffing and support in place to give sufficient support to someone coming in.

5.2 Physical environments: what works for women and staff?

For women and the staff working with them, the physical environment of a women’s service was a key factor in how well the service was able to function. Four of the case study services were housed in relatively new buildings. Two opened during the course of the evaluation and in one case, women and staff here were asked to make comparisons between the old and new buildings.
Women identified the importance of design and layout of the unit and how it felt to be there. For example, one woman on arriving from an older style hospital to a new-build unit observed that it still smelt like a hospital and for her worse was the fear that it would be a less settled environment where women were far less well than she was used to. Immediate responses were influenced by previous experience. Some women found their most recent placement into new-build units too ‘sterile’. Many, however, experienced a more homely approach within clean and modern buildings. They said this was very important to them. They liked having their own rooms (often with en-suite bathrooms) and access to communal areas sometimes including a women’s gym, activity rooms, gardens and visiting areas for families and children.

Women’s input into design varied across services. However, with new build units they were less likely to have had any input into the architecture or basic decor. These units were all required to meet a number of physical security standards as well as ensure that they could provide a safe, ligature-proof environment. Although women were able to individualise their rooms with posters for example, some said they would have liked a more active role in at least the decoration of the interior shared spaces.

Women at one unit were clear that the shared space was just too small. The day room acted as sitting room, dining room, television room and garden access. This service had a number of other rooms for activities, meetings and one-to-one one sessions but the main area was limited in the number of people that could be accommodated at any one time. One new-build service was designed with open-plan day areas to three sides of the office/observation area. Other rooms led from the open plan area which was large enough to have several seating areas and a separate dining room.

A further important consideration was how to ensure that design enabled women to be ‘at home’ whilst staff were able to observe the activity within common areas as well as mix with women on the unit in a relatively relaxed way. Zonal observation of shared areas was thus the preferred option for services over intensive one-to-one observations which some women found intrusive. In addition, many women noted that one-to-one observations impacted on the unit more generally where activities, e.g. escorts for access, on/off ward activities, had to be limited due to the unavailability of staff.

One service was able to partition off areas for the provision of a higher level of support, others had dedicated and usually separate areas.

Key physical environmental considerations for women and staff included the provision of:

“I think letting patients lay around all day and sleeping in the day room could be changed. It’s not nice if you are sitting in the room and all you can hear is snoring.”

Woman service user
- Private rooms with en-suite bathrooms
- Lockable space in their rooms
- Zonal observation areas
- Women-only areas, e.g. bedroom corridors
- Permanent and not timed garden access
- Sufficient space in day rooms for all women to use
- High support/intensive nursing areas for women when acutely ill

Outdoor space in the form of gardens and/or access to hospital grounds was very important to many women at the units. At all the case study units, garden space was considered essential and was provided. However, in all cases the use of outdoor space raised some issues for women and staff alike including the following:

- Women said they preferred garden doors to be open at least all day rather than timed exits. In one service, they were concerned that different staff operated different rules for giving access.
- Staff in one service observed that regulations would require them to install immovable (and to them unattractive, difficult to use) furniture in their garden. Providing shelter from the rain was another issue.
- Where feasible and agreed, some women had leave to go out unescorted in hospital groups or further afield.

Of considerable concern in at least three case study areas was the impact of the standards for medium secure services. These imposed generic requirements, e.g. the height of perimeter fencing regardless of appropriateness in a woman’s service. In 2008, one women’s medium secure service was forced to become low secure as a result of inspection.

5.3 Interventions, treatments and therapies

5.3.1 The range
Women’s services agreed that it was essential to provide women with access to a range of activities and therapies. There was a high level of commitment in most services to finding ways of meeting women’s psychological needs as well offering opportunities to be involved in other ways which were intended to facilitate recovery.

Services participating in the original survey were asked about the interventions, treatments and therapies available to women. Table 6 shows the total number of wards providing the different treatments. It was interesting to note that despite most providing individual therapy and creative therapies, these were not being used by all women. In one year, only eight wards had more than 60% of women who attended individual therapy. They were less likely to have attended well-women sessions and complementary therapies featured in only two cases.

“You get inspected. This doesn’t fit with empowerment because we’ll be replacing the garden furniture. We’ve just been told to do this, well, we won’t say that but you know, it doesn’t promote empowerment does it?”

“(The standards for medium secure services) place far too much emphasis on physical security but that’s the world we live in. The person who inspects us is male and he’s very staunch in his views.”

“I had psychology for six years at the other place so coming here it’s the same thing but it’s more working to the future instead of backwards. There it was all backwards, the past. This is forward now, the future. It’s weird because I always thought therapy talked about the bad things but now we’re talking about the good things and what moves me on.”

Woman service user
Table 6: Interventions, treatments and therapies 2006 (n=21 wards)

<table>
<thead>
<tr>
<th>Interventions/treatments and therapies</th>
<th>Independent wards (n=6)</th>
<th>NHS wards (n=15)</th>
<th>Total (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual psychological therapy</td>
<td>6</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Creative therapies</td>
<td>6</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Well-women sessions &amp; screening</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Group therapy</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Dialectical Behaviour Therapy (DBT)</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Individual therapy based on DBT</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Harm-minimisation/reduction approach to self-injury</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
</table>

Whilst not all wards provided all the interventions we specified, 18 wards provided information about additional types of specialist therapy that they offered to women. These included:

- Psychotherapy for eating disorders/issues
- Smoking cessation
- Fire setting
- Substance misuse
- Mental health awareness
- Offending behaviour
- Healthy living
- Cognitive problem solving group
- Relationship group

This represented a wide range of different provision. Some wards said that they had introduced new developments very recently and were piloting their usefulness, e.g. a cognitive problem solving group.

Wards were offering a wide range of activities to patients. Whilst vocational training was infrequently offered, on-site education sessions and creative arts were provided and taken up by women. Highest levels of up-take were in relation to sports and exercise (16 wards said over 60% of women took part), community inclusion, e.g. leisure activities and shopping (14 wards said over 60%) and social events (15 wards said over 60%).

In the case study areas, services said that they provided structured timetables of individual and group activities. These were weekday only and some women said they would like more to be offered at weekends which became boring. In one service, women were asked to complete an
individual timetable weekly making choices about what they would attend the following week. These activities are discussed in more detail below.

5.3.2 Psychological therapies
All of the case study areas provided psychological therapy for individuals and in groups but arranged and delivered in a variety of ways. The philosophy of care which underpinned the service provided the basis for the range and content of provision. For example, in one area, women were encouraged to join a group for ‘dealing with feelings’ before they began to consider individual therapy. This was in recognition of women’s experience and the need to develop strategies before moving on to in-depth exploration of their past and actions. Any group or individual work was expected to be supported by staff on the ward although this was not always the case.

Case example:
There was widespread awareness among nursing staff of the importance of responding appropriately to the emotional needs of women service users. One nurse manager spoke of the “sponge-like” quality of women to absorb high levels of support and attention from staff, and warned that problems arise if this support is not available. Nursing support on the wards was organized with each woman having an allocated team of ward staff, with at least one member of her team always being on duty at any time. Women were encouraged to approach a member of their own team if they need emotional support or to talk for example about issues relating to their index offence, past experiences of abuse or for support around self injury. Someone familiar with their needs and care plan should always be on hand. Each woman also had an allocated primary nurse who provided regular one-to-one sessions which usually included specific work to help her understand and manage her own mental health needs, for example helping to recognize early signs of relapse or to develop alternative coping strategies to self-injury.

Women would normally have face to face contact with their psychiatrist (RMO) on at least a weekly basis, either within the weekly ward round or on a one-to-one basis. A Senior House Officer (SHO) was also available to provide medical input as required, including physical health issues, on a day to day basis. Most of the women who met the evaluation team spoke positively about their relationship with their psychiatrist. A number of women reported they believed medication played a key role in the management of their mental health needs, with some feeling it was one of the most important aspects of their treatment at the unit.

The psychology department provided a comprehensive assessment and individual formulation of each woman’s needs during the post-admission period and one-to-one psychology therapy sessions are offered when appropriate, often with a focus on index offence work. The formulation-based assessments undertaken by the psychologists were shared across the MDT so they could inform the work of the nursing and OT teams and support appropriate engagement with the women on the wards.

“My primary nurse was really good, he listened to me, listened to what I had to say, and he also seemed concerned about what was happening to me. I could also have a bit of a laugh with him... he helped me to understand about my illness, how to deal with it better.”
Woman service user

“Sometimes ward staff believe that psychology unsettles women, when women access psychology to work on difficult issues, they will come back onto the ward very unsettled as their session has brought up issues that have upset them, but this is part of the process, but the women will then pick up on the idea that the ward staff believe that perhaps psychology isn’t any good for them, and that
Some members of ward staff found it difficult to know how best to support women returning from psychology sessions when they had been working on distressing issues. Where it worked, it worked well. However, it was felt that sometimes ward staff undermined the work of the psychologist, by supporting or making suggestions that the women are better off not attending such sessions.

One woman interviewed reported that she had recently decided to discontinue her psychotherapy, saying that one of her care team on the ward felt it was not helping her to keep going back over the past. However, when asked about the role of her therapy in her recovery, it was clear the woman believed she would not have made the progress she had done if it had not been for the work with the psychotherapist.

In addition to meeting with a consultant psychiatrist and the Responsible Medical Officer (RMO and from 2009, Responsible Clinician), as part of the MDT, women were being seen by psychologists, psychotherapists and meeting with nursing staff who had received training in psychological therapies including DBT. What appeared to be important was finding ways for women to talk about traumatic experiences in their past and how they related to why they had been placed in a secure service, in ways that supported them. Formal activities provided one opportunity for expression.

**Case example:**
In this area, clinical psychologists were involved in women’s care from the moment they arrived. Initially, this would be through carrying out assessments to identify women’s clinical and ‘forensic’ needs with a focus on risk assessment. Having this at the outset enabled the service to monitor a woman’s progress through her care pathway and what had or had not been provided as part of this. At this stage, there was little individual work but women were encouraged to take part in groups and focus on understanding their own problems and developing skills. With a DBT approach on one ward, groups were designed to enable women to build skills in tolerating distress, social skills, emotional regulation and problem solving.

The service provides a CBT programme of groups as well as other group work, e.g. living well with schizophrenia, intended to support women in developing their own skills. The service was concerned about attendance but overriding this was whether women had gained something from the experience. Attendance at groups was linked to an incentive programme where women were ‘rewarded’ for taking part in the activities identified in their care plan. Participation was voluntary.

The provision of group work was encouraged but reflected that access to individual therapy may take a considerable period of time to organize due to demand across the service as a whole.

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undermines the process, and will agree with the ward staff and think well I won’t bother with this anymore, rather than the ward staff supporting the therapeutic process.”

“I’m doing CBT. It’s quite good – we’ve been talking about OCD behaviours and it’s good because no-one’s ever really sat down with me and said ‘What do you do? Why do you do this? A lot of the time, because it sounds silly what I do, I’m embarrassed to tell people but this time I’m telling her everything.”

Woman service user

“We have a very therapeutic programme for women to develop social skills or be able to learn problem-solving skills. I think everything has an impact on their mental health so it’s about looking at the broader picture rather than just, say, medication for schizophrenia.”
Women in medium secure services said that:

- They were able to exercise some choice about the type and time commitment to psychological therapies. Some women had come from services where they had been in therapy for years. They then found they could attend groups and undertake other activities as an alternative.
- They appreciated learning to take a more positive outlook and some saw that therapy was a way of moving forward.
- They could become confused by different staff views about the value of therapy and more continuity would have been helpful.

What was interesting was where the line was drawn in relation to what was or was not perceived as psychological therapy. Informal discussions about a variety of issues were viewed as being just as important to women as the formal provision of therapy.

In one area, the staff team believed that an appropriate range of therapeutic interventions and occupational therapy including creative therapies and leisure activities, were made available to women service users. Named nurses played an important part in individual women’s care. There were also Associate Practitioners based on the ward who were unqualified support workers and linked in very closely with psychology or OT staff. These had protected time to undertake specific pieces of therapeutic work with women including, for example, CBT work, self esteem and self perception, anxiety management, relapse prevention, women’s offending and risk management, e.g. fire-setting. As Associate Practitioners were ward-based, they were on the ward enough to be able to gradually build relationships with the women, especially with those who found it more difficult to engage with a psychologist where contact was more formal as they came to provide therapy sessions and then left.

5.3.3 Occupational therapy: beyond the stereotype
Occupational therapy (OT) has changed over the years and the case studies here demonstrated the ways in which this has happened in women’s medium secure services. While occupational therapists were primarily focused on working with women to develop skills that would facilitate their recovery and enable them to manage in lower-secure or community settings, not all services were able to give the role and function of OT the centrality it required. Resources affected some while

“We don’t sit around and make baskets! We produced a magazine and we produced a leaflet about self-harm and PTSD to be left in doctors’ surgeries and casualty departments so that they’ll have a better understanding of us.”
Woman service user
other services were perceived as being less open to the idea of gender-focused OT. Where it worked well, OT was an integrated function within the women’s service feeding into women’s psychological recovery and development of skills.

However, not all services were able to allocate an OT to women’s provision. In one case study area, whilst there was a dedicated psychologist for the women’s service there was only a “linked” occupational therapist. However, the appointment of a dedicated OT for the women’s service would have enhanced the development of gender specific groups and activities for the women at this unit. In turn, some staff argued this would improve access to activities for women who were not able to leave the ward or not able to, or chose not to, access mixed-sex activities.

In another area, many of the therapeutic and activity groups were not gender specific, as often there were not enough women to support the provision of women-only groups. Efforts were being made to provide some choices for women-only activities and creative therapies, and the OT service had allocated a women-only afternoon each week which provided social contact time for women. This OT department also ran a support group for women who self-injure, and the service as a whole had been developing practice guidelines to support safer self-injury as well as education and training resources for staff and service users.

Opportunities for women to increase their levels of independence and become involved in education, training and paid or unpaid work were promoted in all the case study areas. We interviewed women who:

- Worked within the secure service, e.g. in the café
- Attended a range of classes within the service including literacy, numeracy, IT and GCSE subjects
- Attended local colleges
- Undertook Open University degrees

There was some debate about how far a ‘teacher’ would be fully participant in discussions about individual women and their Care Plans. Some services employed a dedicated teacher while others contracted local agencies. However, neither model appeared to put education near to the centre of a woman’s plan and in one case, this had led to staff feeling that education was treated as a ‘poor relative’ despite its apparent successes and therapeutic potential.

5.3.4 Social work support: essential links outside the service
Social workers had very specific and for some, pivotal roles within women’s services. A principal area of work was to help women maintain contact with families and their children where appropriate and feasible.

“Women can express an interest in OT and we say has anyone got ideas and we’re open. But the key sessions are essentials. Some find it quite hard when they come. ‘You do get up in the morning, you do come and have breakfast and actually you can’t go to your bedroom’ unless on a higher status. Once they get used to that, it’s quite healthy to have a routine again because it’s also about how society out there works.”

“That’s something I would stand up and shout about! I’ve seen young ladies that have never taken exams before, have sat them for the first time and passed. Not long ago we had one who passed an exam and said ‘I never thought I could do this and now I’ve got a certificate!’.”

“We had one woman who had been labelled dangerous. We had to have several nurses, the children, the father and their social worker so the number of
From pre-admissions and arrival through to moving on, social workers provided women with support:

- Regaining and sustaining family contact where appropriate
- Supervision of child visits
- Family home visits
- Contributing to CPA and Tribunal reports
- Liaising with external agencies, e.g. CPNs and Social Services

Social workers experienced a very high demand on their time. They said they needed to be clear and boundaried about what they could offer to women as well as staff in the service. One social worker argued that it was important to involve ward staff in traditionally ‘social work’ issues, e.g. family visits, as a means of supporting women as well as building team relationships.

Social workers, in addition to other professionals, frequently had office space some distance removed from the ward which reduced their visibility and the access that women had to them. One suggested holding a regular ‘surgery’ where women could find a social worker on the unit and see them almost immediately.

5.3.6 Advocacy and involving women in their care

Of the 14 returned questionnaires in the 2006 survey, nine services said they had made advocacy available to women and one noted access to local Patient Advisory Liaison Service. Services were much less likely to offer a gender specific advocacy. At that time, WISH was making regular visits to three services which increased to six by 2009. In addition, and until 2009, WISH provided a service to four PiC women’s services.

Interestingly, few of the women interviewed had sought out the support of an advocate even though they often knew that an advocacy service was available. The lack of use may have been attributable to reports that advocates were spread very thin, services were under resourced and thus unable to provide an in-depth service to all women. At the same time, one advocate said that women service users were sometimes so busy, with activities and meetings with other staff, it was hard to make appointments with them.

Advocates were involved in issues including:
- supporting women after arrival
- supporting women in developing confidence
- providing practical information
- sorting practical problems, e.g. benefits issues
- supporting women in relation to their families
- ward environments and complaints about these adults in the room was absurd! We worked well together, social services backed out and we managed, with the mental health assessment and her real diagnosis, to rehab her out. Now she’s living with her partner and children. That’s where social work fits into medium secure with women.”

“My ideal scenario would be that there are some facilities where I could be more accessible, where I would have some space where I could see people, could eat and socialise with them.”
personal issues affecting women and their care plans

One of the key difficulties they experienced was the time limitation. For example, contracts services held with WISH were sometimes for as little as one day per month. Part-time roles also meant advocates could not be available to attend CPA meetings or support women at meetings with solicitors.

Advocacy services also raised concerns about the perceived lack of acknowledgment of the need for gender-specific advocacy; that in some circumstances how women are listened to, respected and not judged was, in itself, is a factor in their treatment, care and recovery; and that advocates had been seen in some circumstances as interfering in situations where staff saw themselves as the professionals and thus believed they knew best.

5.3.7 Physical health care

Most case study areas described a range of health promotion and illness prevention activities including discussion groups with women and sometimes annual health screening. What worked less well was women’s access to physical health care professionals as and when they needed them. Women described the variety of situations where they wanted to see doctors and preferably a female GP. Only one case study service offered this and along with one other, ensured access to a female practice nurse to see women in the unit. Women could usually request to see a doctor and sometimes staff would call one to the unit. How women accessed health care included:

- On unit appointments with a GP and/or practice nurse
- On site appointments
- Well-woman service
- Leave to see GPs and/or dentists outside the site
- Admission to Accident and Emergency departments

Provision varied widely across the case study areas. A few women described feeling that their physical health needs were not taken seriously enough. In one case, a woman described being denied access to a GP despite subsequently being diagnosed as very unwell.

An important consideration for staff was the relationship between self-harm, self-harm policies in the service and the way in which physical health care services could therefore be used. Restricted access was seen to have resulted from ward staff sometimes seeing a woman’s request for medical care in relation to her self-harm as seeking to be looked after in a hospital environment. It was not clear if this approach was perceived as happening in relation to other medical issues.

“We’ve got a female GP and practice nurse as a shared resource but we feel we actually need our own full-time physical healthcare nurse. Although a lot of the nurses are dual-qualified we want somebody who’s not counted in with the numbers, who is going to pick up on healthcare needs.”

“(The doctor) only comes once a week and everything is screened by the nurses before you get to see him. If you have a problem, you have to wait a week which is not good enough. And we don’t have access to a female GP. When the PCT was brought in and service users had their say, we were reassured that they would get a female doctor and they had female nurses. One woman had to have an internal recently and when it came to the crunch, she had to see a male doctor. For someone who’s had issues with men, it could be quite traumatic”

Woman service user
Physical health was also supported by health promotion sessions and the provision of activities. Case study services were concerned about the combination of some medications and poor diets and provided access to gyms, cycling and in some services, a swimming pool, classes and nutritional advice. Women at one service complained about the quality of food they were given and as a result, they often chose to buy sandwiches, crisps and other ‘fast’ foods from the café. Some women at this service and where able to do so, elected to cook for themselves, one of whom would also cook for others once a week. In another service, concern was shown by women and staff about women’s health. It was noted that approximately two thirds of women service users had a body mass index (BMI) of 30 or above and were classified as obese and many women were considered to be at risk of coronary heart disease.

5.3.5 Social life for women: community and being ‘ordinary’
It was artificial to draw a line between social and other activities as both women service users and staff described the vital role of a social life in women’s recovery and for some, progress towards discharge. Social activities varied depending on the unit and the level of security required for each woman.

However, women frequently talked about the importance of having opportunities to do what women anywhere might do including having a massage or a manicure. Some services provided this on site although it was patchy and for example, in one service where a local charity had come twice a month, they then ceased to provide the service. Others accessed hairdressers and massage off their ward but still on site. They had to be eligible for leave to make use of these.

A second and vital aspect of social life for most women who were entitled to community leave was to be able to go to a café, a meal out and the cinema. If the leave was unescorted, there were no problems. However, for women who required escorted community leave, staff were not always available and thus leave would be cancelled. Women were often disappointed.

A physical health care issue as well as a social one, some women on one ward reported that they had opportunities to increase/maintain their independence through self-catering, purchasing and preparing their own meals, and could access cookery sessions via the OT department if required.

5.4 Service user involvement: level and type

Women’s involvement in their care was an essential component of how services delivered a dedicated service. The following table shows the range of opportunities and how many services provided women with

"For some it’s extraordinary and what may be ordinary for me may not be ordinary for somebody else like handling money, ordering food or paying for something."

"For people’s birthdays we’d have a buffet. We’d get £10 per week and choose what we wanted to do like bingo or get a DVD but they stopped doing it. I think it’s because people weren’t bothering to go to the committee."

Woman service user
access to different ways of being involved.

Table 7: Service user involvement

<table>
<thead>
<tr>
<th>Range of involvement</th>
<th>Independent (n=2*)</th>
<th>NHS (n=11)</th>
<th>Total (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ council/user groups:</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>ward based</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients’ council/user groups:</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>across site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in Clinical Governance</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* no response from one service to this range of questions

The first survey of dedicated women’s services revealed that they were likely to have ward and site based user groups where women fed into broader discussions of service provision. The most usual model was for a weekly meeting the purpose of which ranged from dealing with practical concerns, e.g. repairs, to policies and at times concerns about interpersonal issues on the ward. Some services employed service user involvement workers to facilitate women’s participation.

Behind these activities lay the belief that for women to be empowered and active in their recovery, local involvement was one means by which this could be achieved. For some, there was an inherent contradiction between the concept of empowerment and being in an environment premised on control. Others recognized that they could be empowered through the mechanisms created to give them ways of contributing to their own care and the quality of provision they receive.

As a preliminary stage in the evaluation, we were invited to attend service user groups to discuss the project with women and receive their feedback on the proposed approach. These meetings suggested that there were different levels of interest in service user involvement and the groups had varied levels of energy and motivation.

At one service, the user group was run by the women themselves meeting weekly on their ward. A number of these women were also part of a regional service user involvement strategy group for forensic services and participated in regional involvement conferences as well as having participated in a Women’s Involvement project which informed the [successful] tender for a High Support Residential Service. There were also opportunities to contribute to Trust-based involvement projects with two of the women (who met with the evaluation team) attending regular user group meetings on the main hospital site. Another of the case study areas had a structure which included unit or ward weekly meetings which members of the MDT tried to attend. In addition, other staff, including the Facilities Manager, were invited in order to address practical issues, e.g. the quality of meals, directly with

“I don’t think this experience has empowered me. It’s probably done the opposite and taken away all of my control. I have chosen to make myself empowered. I could have just sat there and said ‘oh, everybody tells me what to do’ but I have got involved as I have always been quite a motivated person.”

Woman service user

“It gets us together to discuss any issues on the ward, people sleeping in the day room, the quality of life. A lot of the time I don’t think it has any impact at all.”

Woman service user

“There’s a patient rep who goes to the Clinical Team
the women. A representative from these meetings attended the women’s service user group facilitated by a member of staff. From this group, there were representatives on a hospital-wide group.

Did women feel that service user involvement was more than tokenistic and provided an effective means of interacting with the service? In one area, in addition to ward and service meetings, satisfaction surveys were used to elicit women’s views. Women had contributed to the design of the survey and suggested that this was a useful mechanism for user-feedback. They had been kept informed about the findings and one woman believed that the service had acted on the basis of these. From the interviews we carried out, these views ranged from thinking that they were listened to and the groups worked reasonably well to concern that user-involvement did not always result in action.

Women were encouraged to become actively involved but some were not motivated to do so. Sometimes this was attributed to not being well enough. Sometimes, women were perceived as just not caring about the broader aspects of service provision. In one area, a programme of social events ceased as the result of women not attending a sub-group meeting. This was reactivated as a result of discussion in the community meeting.

**Issues:**

- The physical environment was important to women and staff. Whilst new buildings were off-putting to some initially, most women appreciated efforts made to make the unit look and feel homely. Some would have liked more say in design and décor.
- Most services were concerned that women found ways of talking about their traumatic experiences despite contradictory views about the type of psychological therapy to provide and when it should be offered.
- Women and staff recognized the value of ‘informal’ activities. Women wanted to do what was ‘ordinary’. Some staff and other professionals saw this as having a therapeutic potential in the same way that more formal interventions were intended to have.
- Access to sufficient and appropriate physical healthcare was not always provided and women service users were particularly concerned that their needs were not being met in relation to seeing a GP or other doctors.

> meeting. I don’t think they work well. It’s an example of the dynamic in a secure unit plus the more mundane thing that wheels turn slowly in organisations. If you don’t get a ‘yes’ immediately, there’s a group that find it hard to tolerate waiting.”

> “I think that things are listened to but they are not always followed through. Unless you take things to a manager or one of the ward reps, you don’t really have a voice.”

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![London Metropolitan University Logo](https://example.com/logo.png)
6. My life: in my hands? Care Pathways, Care Planning and discharge

I’ve got to think that in the long run they only want what’s best for me but I need people on my team who I can trust. I do trust the staff, don’t get me wrong, but there’s some I wouldn’t talk to because of their attitude. The people on my team, I get on well with. I’d been thinking to change my care coordinator because I wasn’t happy with the care I was getting. It was brought up in the ward round that I didn’t get on with my care coordinator so it happened and I got someone I wanted.

Woman service user

‘An integrated care pathway (ICP)

- is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes
- ICPs are important because they help to reduce unnecessary variations in patient care and outcomes.
- They support the development of care partnerships and empower patients and their carers and
- ICPs can also be used as a tool to incorporate local and national guidelines into everyday practice, manage clinical risk and meet the requirements of clinical governance.\(^{78}\)

The Care Programme Approach (CPA) defines the overarching framework for the provision of mental health, including secure, services. Most recently reviewed in 2008, the CPA has four main elements as defined in ‘Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people’\(^{79}\) which states that there are four distinct aspects to the CPA:

**Assessment:**
- systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;

**A Care Plan:**
- the formation of a Care Plan which addresses the identified health and social care needs;

**A Key Worker:**
- the appointment of a Care Coordinator to keep in close touch with the patient and monitor care; and

**Regular Review:**
- regular review, and if need be, agreed changes to the Care Plan.

These four principles of assessment, Care Plan, Care Coordination and review are the cornerstones of the Care Programme Approach. Implicit in all of them is **involvement of the person using the service**, and, where appropriate, their carer.

Mainstreaming Gender in Women’s Mental Health\(^{80}\) states that:

- assessment should inform a formal Care Planning process under CPA;
- it should be **multi-disciplinary, holistic and comprehensive** including violence and abuse, self-harm, substance misuse, eating disorders, sexuality and gender sensitive assessment of risk;
- it will need to take place in a variety of settings including the community, family and residential homes, and distant secure placements including prisons, high secure hospitals and the independent sector; and
- links with local court/police diversion and liaison services should be explicitly agreed.
This section of the report examines Care Pathways and Care Planning as experienced by women and staff. Some of the case study services reported considerable improvement in the last few years moving from, for example, treatment and care plans that were not sufficiently needs-led to new CPA documentation and needs-based care plans.

The evaluation showed that while in theory women’s services had similar policies, in practice their implementation varied considerably. Indeed, within a single service, practice was sometimes dependent on the RMO/RCO involved in a woman’s care rather than as agreed across the service. Systematic use of documentation processes and computerised record keeping played a significant part in ensuring more rigorous and transparent procedures. Nevertheless, realistically the key factor in successful Care Planning lay in the relationships between a woman and her care coordinator and team.

6.1 Care Pathways

In section 3.1, we described how women and service providers wanted to work towards a ‘seamless’ pathway through and hopefully out of secure settings. The Care Pathway ideally acts as a road map for the individual. However, as the following three examples illustrate (not their real names), in reality the Pathway was neither seamless nor without some twists and turns en route. What is striking for these women is that it was the move to their current setting that activated the process.

Alice’s Care Pathway:
Now 24, Alice was just twenty when she committed her index offence. She had a history of physical and sexual abuse during her childhood and at the time of the offence she was using illicit drugs and drinking heavily, and all this had impacted severely on her mental health. She was initially remanded to prison where she spent about six months waiting for her trial to come up at the Crown Court. Whilst on remand she received no help for her drug and alcohol problem and her mental health deteriorated yet further, leading to her being transferred from prison to an independent medium secure hospital for assessment under the Mental Health Act. When her case came up in court she was given a restricted hospital order (Mental Health Act S.37/41) and returned to the same independent medium secure unit as, at the time, there were no beds available in the NHS medium secure women’s service in her area. She spent about two years in this independent hospital, during which time Alice felt there was little or no proper support available to help her get well or overcome her substance misuse problems. She feels it was not until about three and a half years after she committed her offence, when she was transferred to the unit where she is now (an NHS medium secure women’s service), that she was able to access the help she required to get her life back on track. After spending about a year on the unit, with the help of the psychologist and nurse therapists specialising in helping women who are surviving childhood trauma and abuse (including child sexual abuse) and with drug and/or alcohol problems, she is now ready to transfer to a low secure service nearer to her home area. She is looking forward to moving in two weeks time.
Barbara’s Care Pathway:
Barbara is in her early forties and has been diagnosed with schizophrenia since she was in her mid-twenties. Following her index offence, despite having a long history of mental illness and previous formal admissions to hospital, she was remanded into prison custody for ten months before her case went to trial. During this period on remand she received little in the way of care or treatment for her mental illness. When her case was eventually heard in the Crown Court she was given a restricted hospital order (MHA S.37/41) but, due to no beds being available in the local NHS Medium Secure Unit (MSU), she was sent out of area to an independent medium secure hospital for three months whilst waiting for an NHS medium secure bed to become available. Once admitted to the NHS secure unit she started to see a psychologist regularly to explore issues to do with her offence, and also learned a lot about her illness and how to manage it better and prevent relapse during one to one sessions with her named nurse. After about eight months on the admissions/acute ward she was transferred to a rehabilitation ward where she has been making good progress for the past three months. Her consultant has recently written to the Ministry of Justice Mental Health Unit to request leave for her to attend a course at the local college one day per week. She is hoping that it won’t be too long now before she moves to a hostel or supported accommodation in the community.

Caroline’s Care Pathway:
Caroline has learning disabilities and spent most of her childhood years in care. She is now in her early thirties but has been in hospital since she was a teenager. After her index offence she was initially remanded to prison, but was given a Hospital Order (MHA S.37/41) by the Crown Court and sent to a high security hospital where she spent nine years. About seven years ago she was transferred from high security care to a learning disability medium secure ward in an independent hospital. In this service, as well as medication, which is what Caroline believes helps her most, she has also been seeing a psychologist who has supported her to develop coping strategies around her self-injury. She also attends an anger management group run by the psychology department. She is looking forward to being transferred to the low secure service at the same hospital within the next few months, and from there it is planned she moves back to her home area to a new purpose-built unit which will provide continuing care for women with learning disabilities.

6.2 Involving women in the process

Most services responding to the survey said that all women attended CPA review meetings. However, in over half of these the invitation was extended to only part of this discussion. Staff said they tried to encourage women to be involved in the process as a whole which included:

“They don’t attend the meetings but they are allowed to come at the end. What happens at the moment is all the professionals sit and read
- Ensuring all women have a named nurse
- Involving women in planning for the CPA meeting
- Using self-assessment forms and/or contributions to written reports
- Offering opportunities for advocates, friends and family to attend the CPA meeting with the women concerned.

In addition, some services described specific initiatives to promote involvement. Examples of these included women being part of developing a pro-forma to be used for their feedback to the CPA meeting; active service user groups; and in one case, calling the plan a ‘recovery plan’ with women able to direct the content. Most services said they encouraged women to submit their own reports to the CPA meeting.

In the case study areas, Care Planning tended to use an individual case formulation approach informed by gender and other diversity issues. Multi-disciplinary teams made conscious efforts not to be diagnosis-led in the way they responded to women’s needs looking beyond a narrow medical within the context of a wider social model, thus avoiding replication of traditional divisions between mental illness and personality disorder. The Plans either contained all areas to be covered or separate Plans were prepared for different aspects of a woman’s situation, e.g. one for planning home visits and another for eating disorders.

**Case example:**
At this service, full CPA reviews were scheduled on a three-monthly basis with the women invited to attend, although sometimes they were only asked to come in at the end of the meeting, once the reports had been discussed and decisions made. One women said “[I am] not involved in the discussion, but called in at the end to be told what was decided”. There were integrated CPA reports with separate sections completed by different members of the multi-disciplinary team, e.g. medical, nursing, OT, psychology, social work, and also a form completed by the women giving their views on their current mental health, their treatment and their goals for the next three months and a year ahead. The primary nursing report also included a section about service user views and/or requests. The Occupational Therapy reports were based on an interview with the service user, reviewing their Care Plan and their goals. However, women told us they did not always get the opportunity to see the integrated reports prior to their review meeting which had impacted negatively on their ability to be properly involved in any discussions or indeed challenge any of the content of the reports, which they felt did not always reflect their perspective. One woman said she did not attend reviews although she was invited, as she felt there would be no point. As a sentenced prisoner on a Restricted Order, any major decisions about her future were made outside of the CPA process with the Ministry of Justice having to give approval for access and transfers.

**the reports and have discussions and then the women are invited so they aren’t really involved to my mind. I try and work as much as I can by sharing my understanding with the women and putting together a picture of why I think things have gone wrong for them with them. I don’t think that this is done enough and I think it’s a real failure that we don’t include the women from the very outset. There is no ownership of their recovery, there’s no involvement in this is what I need to do, or I understand what I need to do or I completely agree with what I need to do, they have it imposed on them.”**

**“The women aren’t as involved as they could be - in terms of decisions that are made by the Clinical Team just tend to be within the medical model, it does kind of impact a lot and still remains with us despite attempts to make it more mixed and psychological.”**

**“Care Planning with the women I would say we are getting there. We probably do more on the women’s service than we do on the male service. I would say that is partly because the**
In between the three-monthly reviews, the Clinical Team met on a weekly basis to review each woman’s Care Plan and progress. These meetings were for care team members only with women not attending or invited to take part. However, the women were aware of when their Clinical Team was meeting and were encouraged to put any requests, for example for changes to supervision levels, access or visits, to the meeting via their primary nurse, who gave them feedback about any discussions or decisions made regarding their Care Plan.

A number of staff echoed a service user’s view that more could be done to involve the women from the outset in the CPA review process so their views and experiences could better inform decisions about their Care Plan. Some staff also felt decisions made within the CPA process needed to be informed by a more holistic perspective including social and psychological formulations of women’s needs which take into account the woman’s life experiences rather than so much emphasis being placed on medical diagnoses in determining appropriate goals and treatment plans.

There was evidence that the CPA process did take into account women’s past experiences of abuse, with appropriate treatment interventions made available and generally staff appeared to have good awareness of how such experiences might impact on a woman’s mental health and her relationships and attachments to others including members of her care team. However, a minority of staff felt there was not enough awareness of how vulnerable women impacted on each other on the ward. They believed women could often be re-traumatized by the distress or aggressive behaviours of other “frightened or frightening” women on the ward, and that Care Plans should take better account of what staff interventions are required to support peer relationships and interaction on the ward.

Case example:
One of the case study areas brought together in one document its policies as they pertained to the whole women’s service. Within this, the section on Care Planning provided a detailed and clear description of how the process should take place (including approach, associated activities and examples of content) and how it related to the CPA and risk assessments for individual women.

All women were allocated a care coordinator on arrival at the unit as well as a named associate nurse and two further named staff (often Health Care Assistants (HCAs)) to ensure that in the absence of the care coordinator, there was always someone to turn to who had a specific interest in them. Representatives from external agencies as appropriate would be agreed at this point. An initial Care Plan was drawn up focusing on areas from mental health needs to budgeting and day-to-day self care. The Care Plan was seen to be an all encompassing document which noted the different and important aspects of the woman’s experience at the unit. Staff said that Care Plans took into account women’s often difficult histories in order to help determine the types of activities and interventions which would be agreed. For example, a woman who had been sexually abused by a male

women expect/demand it and you couldn’t get away with not doing it which I think is great that they set those standards for us to follow and also because we recognise that we need that. We need their involvement and co-operation.”

“I think we are quite good at the CPA framework and organisation and consistency and making sure that we don’t miss out attention to different aspects of care and treatment and that there is good communication. A lot of that is due to our good computer system, but yes I think it’s quite good really. We have a full multidisciplinary team with some very skilled professionals and I think it is an open culture here generally speaking and I don’t think there is a fear of people speaking up or voicing concerns.”

“Sometimes people can misconstrue what you say. You can say something and three different people hear three different things and then it gets written in your notes and it’s not correct or it’s not what you intended it to be. I feel it’s the younger less-experienced staff that take it the wrong way and they’ll happily start writing loads of stuff that’s not true or is incorrect.”

Woman service user
therapist in another service was allocated a male therapist at the new service. The Care Planning process helped to identify the issue and to ensure that this woman was reallocated to a female therapist.

Care programme update meetings took place either weekly or at least every two weeks and staff said women had an opportunity to input there. After an initial CPA meeting at three months, subsequent meetings were held on a six-monthly basis. A patient self-report provided an opportunity for women to reflect on their progress and aspirations and they were able to read staff reports in advance of the CPA meetings. Women were encouraged to attend the whole meeting and to bring advocates (where available as they did not always have time), family or friends.

Women interviewed at this service had a clear sense of the Care Planning process and the role of the care coordinator. However, they held different views about how well the process worked for them. For example, one woman described in detail all the people involved in her team, their roles and how, when she felt changes were needed, she was able to articulate this successfully. Conversely, a second woman expressed concern that members of her team recorded information about her in ways that were either open to interpretation or would be misleading to others involved in the CPA and Care Planning. She knew she could read the documents, notes and reports but this would only be after vetting by staff thus making it, in her view, a pointless exercise. This woman attended the CPA meeting and remained concerned that, thanks to the reports, misunderstanding persisted yet she did not want to have to keep explaining herself.

Many of the women here wanted more frequent contact with their RMO as part of their Care Planning and review.

Another of the case study areas had introduced a system whereby women provided written feedback to weekly ward rounds and a key concern for women from several case study services was that the process of staff recording of observations and reflections in their formal documentation was open to interpretation. Not all the women who raised this had looked at the reports themselves. However, during CPA meetings, some had challenged the content of these reports. Aware of these concerns, one service had worked with staff on their reporting and writing skills to ensure a non-judgmental and accurate approach when adding to case notes, Care Plans and thus reports for the CPA.

Views varied across the staff/multi-disciplinary teams about the current level of involvement of women and indeed the extent to which such involvement should be encouraged. In one service, women said they either had no Care Plan or if they did, had not been involved in its development. There was a high level of inconsistency here that some women attributed to individual staff and whether or not they did the Plan.

"Women are very involved in their care plans. Some don’t agree if they feel things are too prescriptive but we can work round that and change. Often it’s about changing the terminology, ‘I don’t like the way you’ve written that, I’m never aggressive. Just because I shout …’ and it’s okay. So it’s thinking about how we use language and just being a bit more flexible.”
Interestingly, while some staff argued that women should have an increased level of input to the CPA process, most women themselves said they were happy with their level of involvement in the CPA process and all appeared to have an awareness of how the CPA review process worked and who acted as their Care Coordinator. The women also reported they felt their views were taken into account and that, where appropriate, their needs relating to issues such as past abuse, self-harm and family contact were taken into account within their Care Plans.

6.3 The CPA Meetings

The CPA meetings usually drew together the professionals involved in the delivery of care for an individual woman. These included in-service staff, sometimes service commissioners, external agencies, e.g. from a women’s local area, and representation from the Ministry of Justice where appropriate. The purpose of the meetings was to review progress and plan for a woman’s future based on their and the woman’s own reports.

Women’s experience of and attitudes to the CPA meetings varied across and sometimes within services. The interviews with women suggested that some were more motivated to believe that the CPA meeting could address their concerns and enable their progress.

The practice of attendance also varied and a small number of women said very clearly that they did not want to be there throughout. They preferred the discussion to take place amongst professionals who would then relay their decisions and women could comment on them. Others wanted the choice of how they participated and the flexibility to attend the whole meeting one time but not another. Staff, even in the same service, had different views on this too.

Whilst some professionals felt women were adequately involved, many argued that decisions were made without the proper involvement of the woman concerned. They reported that often women would only be invited into their CPA review after the professionals had already discussed their case and made decisions, in order to be told about what had already been decided. Some staff felt it would be preferable for women to be invited into CPA reviews at the start of their meeting so they could put their views and requests for any changes to the Care Plan and then leave. The multi-disciplinary team could then have a frank discussion, without the women being present, but at least it would be informed by the women’s views. The women could be then told about the decisions made after the meeting.

Women sometimes had access to an advocate from WISH or Mind, for example, to support them during their CPA review meeting. In one case

“They said I was getting a bit high but I was trying to put my point across. You need time to explain but it’s a rushed approach as they’re waiting for the next person.”

Woman service user

“I think in the main, we do involve individual women. I think it is simply impossible to do it in the same way that you could in a non-secure service, I don’t think that is an ideal that one should even strive for personally. Women are welcome and encouraged to attend but from my own experience I am not comfortable with talking about the women’s care and treatment completely frankly with the MD team whilst the woman is there listening to it, or all of it.”

“The one thing I have been disappointed with is that women do not attend the whole of the meeting, they are invited in only half way through and towards the end almost just to hear the final summing up where decisions are explained rather than a consensus being arrived at.”
study area, the advocate had started to help women prepare a written sheet for their meeting listing the issues they wanted to discuss and any requests they wished to make. Three of the women interviewed about their experiences of and involvement in the CPA process were supported by a WISH advocate to prepare for and during review meetings, with these women all saying this support was helpful and important to them. Of the two women not accessing advocacy support one felt she did not need any support to put her own views forward and the other was supported by a family member. Advocates themselves noted that they could not always attend each woman’s CPA meeting given their limited resources.

6.4 CPA documents

As part of the evaluation, we reviewed CPA documents for 20 women across four case study services. Albeit a very small number, the reports revealed the following;

- In all four sites, integrated CPA reporting had been implemented, with different members of MDT entering their reports directly on to one form on the system.
- There was no clear evidence that the impact of gender was being considered in the case formulation as documented in the report. This was found in less than a quarter of cases, although there was some evidence in a further seven and no evidence in nearly half (nine).
- In just six cases were women’s experiences of abuse addressed in the Care Plan, but while specific therapeutic interventions were planned for the women, scant reference was made to how their experiences may impact on interpersonal relationships and trust in the unit (including with staff) and how this should be supported. The potential for further victimisation or retraumatisation was rarely addressed. There was some evidence that Care Planning took this into account but not across all services and for all women where this had been identified as an issue.
- Recording user views in the actual report varied across case study areas. In one, this was always carried out but across three areas, this was the case in just five of 11 reports.

Clearly there was considerable variation across the case study areas and sometimes within one service. This lack of consistency was reflected by women some of whom said that they did not know who their Care Coordinator was nor did they feel they had been sufficiently consulted about the content of their Care Planning.

6.5 Risk assessment

“I haven’t had anyone sit me down and write a care plan since I’ve been on this ward and I have been here two months. My understanding is that they are supposed to sit down with you and draw it up. I don’t like my primary nurse who dilly-dallies around. I’ve asked him to draw me up a care plan but he doesn’t.”

Woman service user
Risk assessments provided an essential underpinning to women’s safety and to the safety of staff. Linked to the CPA, we asked if women were involved in their risk assessment process. One service said they were not and only one said that it depended on their capability at the time. Women were also much less likely to be asked to sign the completed risk assessment documents. Services were also unlikely to have any gender specific risk assessment procedures. Of the five responding to the survey that did, one said this was with specific reference to unescorted ground leave and the risks of mixing with male patients.

A few women were concerned that, through lack of consultation, their behaviour was misrepresented in case files and risk assessments.

Only two services had a forensic community team for women which looked at risk in the context of moving on from secure services. In one case, this was the clinical team which carried a community caseload. In the other, the team was composed of psychiatry, psychology, nursing and social work plus a support worker. They said they worked with a range of services including courts, prisons, adult mental health units, CAMHS units and learning disability services.

Six services (four NHS and two independent) offered a risk assessed community inclusion programme to women. These were described as:

- Individual programmes of access to the community
- Programmes completed by MDT
- Assessment of risk when going to day services, social services and other agencies
- Women’s mental health development group is involved
- Programme of community leave, work experience and opportunities

Some services took a risk assessment and management approach sensitive to working with women who were survivors of violence or abuse. In one case study area, staff described if a woman escalated or became distressed there was a willingness to step back and not to go in and put hands on but to recognize the re-enactment of trauma. It was felt that sometimes this women’s service was criticized by the wider service due to a lack of understanding of this aspect of the model, and staff working in other parts of the site sometimes thought they just let the women get away with too much rather than seeing it as a clear part of a model of care and implementing more appropriate ways to manage risks in that situation.

6.6 Moving on: the final steps

This evaluation has highlighted ways in which the expansion of dedicated medium secure provision for women has significantly improved the situation of many and increased women’s chances of leading lives which
allowed them to make more of, if not fulfill, their potential. The increase in bed spaces has resulted in moving most women from high secure settings and provided an alternative to custodial sentences for some. At the same time, putting into practice the philosophy which underpins policies for women has identified a significant issue in terms of throughput and achieving an agreed care pathway. Many services had little access to either low secure or community-based independent living options which were appropriate for this group of women. While some women continued to need medium secure care, many others did not. Where do they go next?

Here we describe what was available as well as examine the barriers to move-on which prevented some women from taking that final step to independence.

The first survey for this evaluation revealed that that services rarely had vacancies and noted low numbers of transfers or discharges. Overall during a one year period and across all wards, 49 of 188 women were transferred or discharged as follows:

| Discharged to community setting | 10 |
| Transferred to lower secure     | 20 |
| Transferred to another MSU      | 16 |
| Transferred back to prison      | 2  |

Of 21 wards, nine made no transfers or discharges of which three wards for women with learning disabilities said that patient movement was almost nil. Average lengths of stay varied considerably from four months to several years although, as noted by one service, this ranged from six months to 12 years on one ward. Length of stay did not appear to be related to discharge.

Women service users and professionals agreed that a major barrier to women’s recovery and discharge was the lack of appropriate move-on services. In January 2009, only 12 of the 27 services provided a rehabilitation ward and just over half (14) had access to low secure services. The opening of four pilot community therapeutic residential services for women with complex needs adds a further range of provision.

One of the case study areas had established a step-down facility for women leaving medium secure care and the community forensic team to support women moving into the community who require ongoing supervision from a specialist forensic service. There was also evidence of the team working with wider community services to help increase their understanding of gender sensitive provision so they are better able to support women leaving the service.

“The work I’ve done and they say ‘don’t run before you can walk’ and ‘how long is a piece of string’. I’ve just come a long way, I’m at the end of the tunnel now and it’s true though, there is light, there is light!”

Woman service user

“I talk to the psychiatrist about my overnight leaves and how it went. She said I should get a conditional discharge. I’m hoping the Home Office will come to my CPA. They were meant to come but they didn’t turn up so hopefully they’ll come this time. (Where going to) the staff stay at the house, they’re very supportive as well and nice, really nice.”

Woman service user

“I think sometimes waiting for things can be the most frustrating thing, they can be very slow to do things or get anywhere... like from prison I had to go over to an independent hospital because I was waiting for a bed here...[now I am] ready to go on to supported living accommodation but it’s going to take months and months......Yeah they will say you are ready for this but you have got to wait months and months.”

Woman service user

“No, I don’t think it works well, but I don’t think it works well anywhere
Case example:
Internally there was a care pathway for women at this unit, with women admitted to one ward being referred to a second (often described as a “pre-discharge” ward) once their mental health was more settled, and women in the “Enhanced” service could be referred on to a ward which had two beds specifically designated as “step-down” places for the TEMSS service.

However, as well as blockages in the Care Pathway in terms of women accessing a bed at this service at the time it was required, many of the professional stakeholders reported concerns about delays in discharge for women patients. These were due to a shortage of appropriate placements of lesser security or in the community, or, in the case of women requiring community placements, the current funding arrangements meant there was a disincentive for placements to be arranged as funding responsibilities move from the NHS to Local Authorities. Although there may often be delays in finding appropriate placements, once a community placement was secured, women benefited from the support of the Community Forensic Team who provided supervision and support for women who were discharged into the community and back-up and advice to their community-based service providers across the locality.

It was reported that whilst there was, in principle, an agreement that funding would be available for the provision of a step-down facility for women on the hospital site but outside of the secure perimeter, as had recently been provided for the men patients, no date was known for when this would be built/opened. Of the six women inpatients interviewed four were waiting for appropriate move-on placements to be identified or for a bed to become available.

Services with a single ward frequently experienced greater frustration at the absence of move on accommodation. Women at different stages in their recovery meant that those ready to step down were required to live with women who were much less well at the time. Staff in one service described how the lack of low secure or other step-down accommodation meant women had to be well enough to go straight into the community. In order to effect successful move-on, they had negotiated with commissioners for women to have trial periods thus requiring payment for two beds during this time. The rationale was to ensure women received sufficient support from the women’s service and should the move not be successful, they had somewhere to return to.

At the time of the evaluation, it was unclear what impact the national move to the use of individual budgets in relation to discharge planning and routes back into the community would have for this group of women.

because of the funding arrangements, because the people who are going to fund them when they are out are not the same people who fund them when they are in so there is actually a financial incentive to delay, procrastinate as much as they can because that is a cost saving.”
While women service users did not always want to attend the whole CPA meeting, they did want to believe that they had made a significant contribution through their own and others’ reports.

Staff and women service users reported inconsistencies of approach to care plans and input to CPAs which had resulted in some women challenging the content of reporting to care teams and at review meetings.

It was not clear that the impact of gender was being considered consistently in care planning, review or with care coordinators.

Women service users and professionals agreed that there was a lack of suitable move-on accommodation. Access to rehabilitation wards or low secure services was limited. This had resulted in a bottle-neck situation until such time as appropriate provision could be provided.

Further research will be helpful in understanding the impact of individual budgets and their contribution to moving the needs of this group of women into mainstream provision.

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80 Department of Health (2003) op.cit.
7. Day-to-day for staff: working in a women’s medium secure service

It’s not helpful if we’ve got a member of staff who arrives for a 12 hour shift and when they’re one hour into it says ‘only another 11 hours to go!’. That’s not helpful but I suppose they have personal issues as well. We need more stability of staff, more permanents because we’ve lost a lot of staff and we’re back in a position where we’ve got a lot of agency staff. It unsettles us, makes us feel unsafe. There’s less opportunity to talk to anybody if you need to and sometimes it unsettles the ward to an extent where there can be quite a bit of self harm happening. Other than that, I would say it was perfect here!

Woman service user

Women’s experience of medium secure services was shaped by the unit staff and other professionals who they came into contact with. Considerable thought had been given to establishing organisational structures which supported an efficient and effective service whilst ensuring that the philosophy of care as well as the promotion of relational security were part of the reality of women’s experience. Women service users interviewed for the evaluation described how important it was that the professionals, including qualified and unqualified staff, they worked with understood what life was like from their perspective. Several women said they felt staff treated them in ways they found unsympathetic and attributed this to the fact that, whatever happened, staff left at the end of their shift or working day but they have to stay on. Among the professionals and staff groups participating here, many described their commitment to dedicated women’s services and their desire to contribute to developing and maintaining good practice which would led to women achieving their aspirations and full recovery for some. These same individuals also described the barriers they faced in achieving organizational and personal aims which in turn impacted on the women.

Mainstreaming Gender and Women's Mental Health states in the specification that services must pay attention to the composition of the workforce; the provision of multi-disciplinary management; training and support for staff and for research to be carried out. This section examines the 'working' environments, factors which enabled staff to deliver effective services, and improvements needed to ensure that provision meets its contractual agreements.

7.1 Staffing and staffing structures

In addition to setting up a “multi-disciplinary/multi-agency management team to help create gender sensitive organisational culture, policies and practice”, the specification expected services to develop a range of specific characteristics. The evaluation findings suggested that it was proving difficult for many services to meet all of these particular expectations.

1. Multi-disciplinary/multi-agency management teams:

The role of the management team extended to all aspects of a woman’s care and care pathway. In the case study areas, this was recognized as central to how well the women’s service functioned. The teams were usually multidisciplinary (MDTs) and internal to the service with representatives of external agencies feeding into the CPA
process. MDTs met on a regular and frequent basis with RMOs seeing women weekly or fortnightly. Some staff involved in the MDT were unable to attend all meetings due to other commitments. This could impact on communication about individual women and the service as a whole.

Women service users were usually aware that there was a team management approach to the provision of care and who the relevant members of the team were. However, frequently they mentioned the ‘distance’ between themselves and senior members of the team including the consultant psychiatrists. Some women and staff also described how, despite its best intentions, a team approach did not change the reality of secure services where ultimately the women themselves did not have the power to effect change.

Case example:
In one service, the MDT and staff group had changed some of their working practices as a result of experience in their early days. There was recognition that it was difficult to ensure effective communication from the MDT to the staff group as a whole. One way of ameliorating this was to have senior and qualified nurses attending the weekly ward rounds. They also introduced written summary feedback sheets for each woman from the ward round which all staff had access to.

Like many other women’s services, the physical layout of this unit was designed to provide greater communication between staff and women service users. The office space was completely visible to the women on the main ward which meant that they could observe, although not hear, what was happening. Some staff described being conscious of how they interacted in that space and that it was an opportunity to model how people relate in the professional group.

Members of the MDT said they visited the ward frequently and aimed to maintain high visibility. However, a disadvantage for them was that their own office space was some distance away and on the floor above, thus potentially reinforcing a strict hierarchy to the women and nursing staff. It meant that members of the MDT had to make a conscious effort to go to the ward.

2. A dedicated, appropriately skilled staff group with capacity for cross cover and the development of specialist skills:
Operational policies for the case study areas showed that they all sought to put in place the team envisaged for women’s services. However, in mixed services, the practice for recruiting and/or deploying staff within the service as a whole varied. In one area, nursing staff were allocated through a central system and this might have included allocation to the women’s service. In another, nursing staff from within or outside could apply for posts within the women’s

“This is the reality. You have no choice about whether you are locked up or not, that’s not your decision, it’s society’s decision via the courts or Mental Health Act which makes empowerment a challenge. Everyone would regard empowerment as an important thing. How readily you can empower someone who is ultimately powerless is challenging.”

“I think people initially think it’s just about quantity of staff and it is partly about quantity of staff but I think crucially it’s about quality of staff and the quality of the relationships that they can have with patients. It’s about using those
service as a separate employment opportunity. MDT positions were usually advertised for the women’s service in question rather than drawing on a hospital pool of professionals.

In one area, they developed an Associate Practitioner role that provided various clinical interventions to women and focused on supporting their understanding and self-management of mental health issues, including a self-injury support group; hearing voices; self esteem; and anxiety management, within the context of a therapeutic relationship built gradually whilst working in a support role on the women’s wards.

Capacity was an issue in two of the case study areas.

**Case example:**
The usual staffing complement was six staff during the day, of whom two were qualified. In the past, it had been three qualified staff on each shift, but this was reduced due to the Cost Improvement Programme. Some staff believed this had a negative impact on the level of service provided to the women. Whilst it was felt by both staff and women alike that having six staff members on duty was adequate for the most part, it was reported that it was not unusual for staff to be called away to work elsewhere due to staff sickness or shortages on other wards in this mixed unit. It was also said to be the case that it was often male staff members that were asked to cover on other wards, thus impacting on the gender balance of the women’s service team. The gender mix was generally aimed to be at a 3:7 ratio male to female, and it was recognized that it is valuable for some women to have access to good male role models among the staff team.

At night time four staff were on duty, two of whom would be qualified and at least two will be female as this was seen to be important to protect women’s privacy and dignity during the night-time shift.

Whilst overall staffing levels on this ward did not appear to be a concern, one of the women who had transferred to a second ward in the same service felt the number of staff was too low. There were usually just four staff on duty during the day for up to 22 service users. a “massive” drop from the staff input available to the women whilst they were on the previous ward. She explained the situation had been made worse recently because an elderly male patient who needed a high level of care due to his physical frailty generally monopolized two members of the staff. If someone then needed escorted leave that left just one staff member to respond to the needs of the other 20 service users on the ward. She felt this sometimes compromised both safety and the quality of care available on the ward.

Situations where there were regular staff shortages impacted on the day to day care provided. In one service, a ward with a rehabilitative focus meant that most of the women required a significant amount of relationships as a way of managing and maintaining behaviours and that is without having to resort to other strategies or structures or observations or whatever, so for me it’s really about the quality and the kind of skills the person has in terms of the understanding they have. The women’s service very much focuses on reflective practice thinking about what we do.”

“In terms of relational security, numbers of staff are an issue and patients will say they always want more staff. Nurses will always say they want more staff. My experience is it’s the inverted U curve where you get to a certain number and all staff regardless of discipline start congregating. I would rather see more OTs and Technical Instructors that can take people out to do activities.

“We did go through a phase with lots of patients on one to one observations. It’s important that members of staff who are there, are there regularly and know the patients pretty well rather than huge numbers of bank or agency staff. But it may be too tight and some who want ground leave may not be able to take it and you can’t achieve targets in terms of patient activities.”
leave off the ward to help facilitate their rehabilitation and the demand for escorts was high. Here there was a new ward with no access to outside space without leaving the ward area, so when escorts were unavailable, going out for walks or fresh air was restricted. Whilst typically there were two or three members of staff on duty when there were only two, leave opportunities for women requiring escorts were effectively prevented (this was because one qualified nurse must remain on the ward to hold the medication keys and another to hold the security keys). As a result, having the women cooped up on the ward for most of the day led to frustrations being expressed verbally and had a knock on effect on all the women.

3. A stable staff group which will help consistency in practice and the development of therapeutic relationships:
Women service users and the professionals involved in their care gave a clear message that a stable staff group was essential for them all for the following reasons:

- Frequent staff changes were unsettling for women
- Non-permanent staff were sometimes perceived as investing less in the service as they would not be staying
- The development of relational security was more realistic with a stable staff group
- Opportunities for staff development were improved where the staff group was permanent and individuals stayed for some time in post.

One service said that although encouraging men to work in the unit had been difficult, nursing staff usually stayed for about two years. This was contrasted in other services where nursing groups were reliant on agency staff and there was a much higher turnover. The ethos of the service and the provision of support were key factors affecting recruitment and retention. (See also 7.3 below.)

Case example:
In this service, there was no dedicated staff team specifically for the women’s service, although nurses and support worker staff were allocated to specific wards and whilst there was some internal movement for short notice sickness, the ward teams were fairly stable and established. Other members of the multi-disciplinary team, such as OT staff, worked across men and women’s wards (although there was an OT who worked across the three women’s areas and the women’s service has a fairly stable input from the department). There were Consultant Psychiatrists (RMOs) allocated to the women’s service but they also worked on the men’s wards. RMOs worked across both medium and low secure services so they could follow service users as they moved from medium to low secure care.

“I think again there is some very positive practice, but I think staff are not always consistent, and this doesn’t promote relational security, when not all staff maintain the same rules and work to the same policies and procedures, but I think there are some very good therapeutic relationships between individual members of staff and women they work with but the inconsistency is a big problem.”
The majority of the ward staff were female, although the team said there were some very good male staff members working in the women’s service that positively chose to work with women and who provided good male role models for the women.

Whilst, on the whole, the ward teams were fairly stable, due to uncertainty about the future of one of the women’s wards they have lost some of their junior staff nurses and there were vacancies on the ward. The senior nursing team and support workers though were fairly established and provided continuity in relationships with the women.

4. An appropriate gender mix of staff:

All the case study services agreed with the guidance and were working towards achieving a 7:3 female to male gender ratio across the wards and multi-disciplinary teams, as well as a broad skill and knowledge mix. However, this had been with varying success:

- One service which achieved this ratio had also until recently only employed men in ward manager roles
- Two services said that until very recently, ward managers were always men and in one area, many of the staff were male
- Professionals in a range of roles (social workers, psychologists, OTs) were more likely to be women
- One service still had nursing groups with a higher proportion of men and attributed this to the reluctance of female staff to working with women as they would feel more vulnerable.

Case example:

The staff recruitment and retention policies across this women’s service aimed to recruit a dedicated team to work with the women, with nursing job descriptions specific to the women’s service reflecting its philosophy of care. A gender ratio of 7:3 female to male was aimed for and a broad skill mix. The service favoured staff who actively chose to work with women. Individuals were needed who could create a non-judgmental therapeutic environment, work appropriately with women by providing active listening, empathy, warmth and compassion.

The acute admissions and treatment ward typically had five staff on duty during the day including at least two qualified nurses, although the number varied according to what was happening on the ward, for instance if a woman is being cared for in the intensive nursing suite or in seclusion, additional staff were available. It was reported by staff that generally the 7:3 gender ratio was achieved and they felt that many of the women had very good relationships with male staff. The presence of male staff was seen to add a different kind of dynamic and have a positive “defusing” effect within the emotionally highly-charged ward environment. As an acute ward, women tended to spend more time there so the demand for escorts was not usually high. As the ward layout was designed to facilitate zonal observation, the need for one-to-one nursing was reduced. Feedback indicated staffing levels...
on the ward were generally adequate with resources being appropriately allocated, although it was felt it was inevitable that there will always be exceptional days when, due to untoward incidents on the ward and/or a high demand for escorts for court appearances for example, staff resources were temporarily overstretched.

7.2 Recruitment and retention of staff

The recruitment of appropriate ward staff was considered to be very important in all the case study services. Where team structures were dependent on smaller numbers of qualified staff, e.g. two qualified staff per ward per shift, and high numbers of health care assistants and support workers, considerable thought needed to be given to who would be most suitable. The HCAs and support staff were an essential resource to women’s services and were usually the staff to spend most time with women in the units.

Services said they were usually looking for ward staff who:

- were motivated to work with women
- were sensitive to issues which affect women and women’s experiences
- have the capacity to work with the model of care in operation

In mixed-sex provision, staff and service managers agreed that new staff should be recruited specifically to work within the women’s service. In one service, they were able to do so and these posts had their own job descriptions which reflected the philosophy of care. In another area, the person specification stated that the service wished to appoint staff who had an active interest in and desire to work with women service users, and the induction and on-going in-service training included women’s mental health issues and gender specific practice. However, this was not always the case and one provider was moving towards a centralised employment process which would not necessarily address the needs of the women’s service. A concern here was that applicants would choose to work in the men’s service.

Agency or bank staff provided a back up source of staff and services tried to ensure a regular pool of people to choose from to ensure some level of continuity.

The retention of staff was of equal importance and services identified a number of initiatives to encourage staff to stay including:

- Committed and positive teamwork:
  Ensuring the involvement of staff in meetings and discussions was as important in some services as involving women themselves. However,
this was not always apparent and some support staff did not feel sufficiently included.

- **Provision of training, support and supervision:**
  One case study service had employed three Clinical Development staff each with different specialist skills to support ward managers and provide practice development in relation to clinical skills and knowledge. They also offered bursaries which offered unqualified staff the opportunity to train as mental health nurses. These staff committed to return to work for the service post-training.

- **Staff who are empowered in their work:**
  Dedicated teams who worked in a reflective way were seen to be better able to retain staff. One service provided a group analyst monthly to meet with staff, in service counselling and access for HCAs to the women’s service psychologist as opportunities for staff to address distress and gain in confidence.

### 7.3 Training, support and supervision

The importance of training including gender awareness as well the provision of formal supervision and other support were considered by staff at all levels to be key to the effective delivery of services to women. However, the reality was that in addition to many examples of good practice, services experienced ongoing barriers which in particular prevented qualified and unqualified staff from accessing formal and informal support.

**Case example:**
This service provided a wide range of training and support specifically for the nursing teams whose staff worked most closely with women. In addition to a service-wide induction, staff at the women’s service attended training specific to the women’s service. Inequality Agenda provided gender-awareness training at the outset of the service. However, it was difficult to offer this on an ongoing basis. The women’s service training was still gender sensitive, usually focused on the model of care. Since the service opened, when staff attended training was dependent on when they started and the periods during which the training was offered. Some staff noted that this was particularly useful to clarify the model of care and queries about working with women in a dedicated service.

The service offered two-weekly training sessions provided by a colleague from a specific discipline within the team. These sessions have covered:

- The model of care
- Working with women with children
- Prison cultures
- CBT

Managerial supervision was required for all ward staff in this service. Team
leaders supervised qualified staff who, once experienced, in turn might have been a mentor to HCAs. Clinical supervision was provided approximately monthly on an individual basis to discuss specific issues as well a group with an external psychologist for all staff.

Staff were also encouraged to make use of informal support from colleagues, in handovers as a peer group and specifically through access to the service psychologist.

Effective support was helped by committed senior members of the MDT who ensured that training and supervision were available and rigorously used. However, other factors often hindered take up including situations where there was no protected time for attending training or supervision which led to sometimes relying on the good will of ward staff to come in early or stay on after finishing their shift. Other factors included:

- Lack of understanding about what was or should have been available and knowing how to access this
- Demands on senior ward staff preventing them from providing regular supervision or mentoring
- Staff shortages on shifts
- Lack of resources for specialist training, e.g. gender awareness

Nevertheless, there was no question about the value derived from different inputs and that they directly impacted on women’s care.

### 7.3.1 Training

The specification states that ‘the service will need to be able to provide training to other organisations and professionals as well as appropriate training for its own staff group’. One case study area had a long lead-in development period prior to the opening of the service. Induction training including gender awareness was provided to the first cohort of staff recruited before any women were admitted to the unit. This was recognized as a luxury. However, the benefits were perceived as considerable including:

- Time to focus on the service and the team
- Opportunity to develop and embed a model of care
- Team building
- Intensive delivery of gender awareness training for all staff

The reality was that where women’s wards were redeveloped from existing services, e.g. in a mixed setting, it was not possible to have an ‘empty’ unit and thus the time for a dedicated induction.

Staff were all expected to attend general service inductions which would include training about health and safety, policies and practices and

“**We’re going to have difficulties this year because our training budget is fairly tight. Also because our staffing levels are not over-generous, releasing frontline staff is always a difficulty but we’re trying to make sure all front line staff have some training. We’ve been putting on CPD programmes but it has not been as systematic as it should have been.”**

“I think sometimes some staff get lost in the theory of it. So at handovers, if something’s happened, you try and think about that and try and work it out. We also have more formal structures in place, reflective practice once a week, a group analyst who comes once a month and we’re looking to make these much more attachment focused. But the biggest challenge is the drip, drip, drip, day to day.”
working within a secure setting. Differentiated care and its relevance was not necessarily part of specific training nor part of the women’s service induction. Of the 14 survey responses, one independent sector service had no staff who had received training specifically to help them work with women with mental health needs. However, across the other services, the proportion of staff who had received gender awareness training ranged from 10 to 100%. Some services noted their concern that training had been insufficient, and that staff turnover, or dissatisfaction with training received in one case, had impacted on the proportion of those trained.

Medium secure services for women provided gender awareness training in some form or other for new staff. This ranged from gender as part of a more general service (and in the independent sector, corporate) induction to specific gender training provided by, for example, Inequality Agenda. Where gender awareness training was provided, it was usually as:

- Three one-day courses for support workers, nurses, OTs and OT support, administration, catering and maintenance staff
- One and three day courses for nursing assistants, nurses, medical staff, psychologists and social workers

Services also provided training in their specific model of care, other psychological approaches and group skills facilitation.

### 7.4 The role and provision of supervision

The service specification recommends that staff support ‘should be integral to the organisation of services and include supervision, space for reflective practice and access to work-related confidential counselling and crisis support’.

All women’s medium secure services provided some training even if not always gender focused. The case study services described in detail their provision and some of the factors which helped or hindered in its take up. In addition, line management structures have been implemented to include the provision of formal supervision for all staff. Most wards had a single manager supported by team leaders/senior staff who in turn managed less experienced and unqualified staff.

On paper, there were clear guidelines about the provision of supervision. Qualified staff were usually expected to have monthly individual clinical supervision and with other staff, attend monthly group practice sessions. One service had developed a support mechanism for new staff as a supplement to formal managerial or clinical supervision which included allocation of a qualified staff mentor and an experienced HCA to shadow on the ward. However, in practice the reality in some services was haphazard and some ward staff reported rarely having supervision due to other priorities on the ward.

“It’s really up to us to be a bit proactive in organising the meetings for supervision because they can get forgotten about.”

“It can be very, very supportive as long as you let it be and with regard to continuing professional development, again it’s down to the individual to put yourself forward. I think the ones who are more proactive probably find they get more out of it.”
Unqualified support staff and HCAs were the most likely not to receive the supervision they had been told was forthcoming. In at least three of the case study areas, those interviewed described how, despite spending a great deal of time with women service users, they found it difficult to obtain and sometimes to ask for the support they needed.

Key concerns for services included:

- Increasing demands on qualified staff who were being pulled in too many directions and unable to give sufficient time to others
- Limited time available for ‘supervisees’ due to the demands of the ward and need to balance staff requirements with facilitation of women’s activities, e.g. escorted leave
- Recognition of the importance and value of support
- Lack of confidence among newly qualified/unqualified staff to seek out and ask for support

A further important consideration identified in one case study area was how to support ancillary staff, for example, housekeepers and other domestic employees to whom women service users might choose to disclose sensitive information. They noted:

“We did a brief research project about the fact that particularly women often chose unqualified members of staff to disclose [abuse] to or to talk to and it may not even be the support workers, it may be the domestics or the housekeepers and I think this has had to be something we have had to become very sensitive to and I think sometimes it is about not wanting a professional response and wanting a human response so again that’s something we have also tried to think about, what are their needs, what do you do if you are the housekeeper and you are cleaning on the ward and somebody comes and talks to you. What do you do with that information, where do you take it, do you feel you have the skills to respond to it. We have started to think about this in a wider format really.”

We identified very few areas where training was offered to these members of staff.

- Professionals across all areas valued a multi-disciplinary and multi-agency structure even though the latter was harder to achieve.
- Services wanted to work with dedicated, stable staff teams with an appropriate gender mix. However, given difficulties of recruitment and retention it was rare that this was achieved.
- There were considerable gaps between training and supervision policies in services and what happened in practice resulting in many staff receiving no gender awareness training. Supervision frequently took second place amongst a range of competing demands on senior ward staff.

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81 Department of Health (2004) Mainstreaming Gender and Women’s Mental Health DH
8. Building on experience: in even safer hands

I feel a lot is a lot of work from yourself, I mean its trial and error with your medication – I have had changes and side effects but it’s changed and I have a say in that, not too big a say but I can speak and there is the option to talk about it. I also feel that there is a strong working force here, that you can go to anyone of the staff who you trust and who you know will advise you well, who will listen and understand and who will help you. I have a great team, I can’t want for a better team who works with me. So I think it takes a lot from yourself, I think you have got to meet your medication half way and I think that’s important to maintain a strong mental well being.  

Woman service user

In 2000, the report Good Girls: surviving the secure system82 said ‘(women’s) stories revealed a shared belief that the dream of discharge could best be achieved by toeing the line rather than fully addressing the causes of their distress’. This evaluation has presented evidence which suggests that not only has the number of dedicated women’s medium secure services grown to better accommodate women with complex needs, many of these demonstrated that they were turning the corner and enabling women, with their help, to take back their dream into their own hands.

This section first identifies a number of key areas of good practice and what services themselves believed worked well in their context. It then considers the implications of the findings and what remains to be addressed by policy makers, service providers and staff, service users and researchers in the field. Third and finally, it reviews the current service specification which formed the framework for the development of dedicated women’s secure services.

8.1 Good practice in women’s services

The evaluation findings have demonstrated the variety of ways in which the service specification for women’s secure services has been or is being implemented. The six case study areas had all developed different approaches to philosophies of care. We could not find evidence from discussions with women and professionals or across changes in women’s situations, that the philosophy of care was necessarily the primary factor to determine how women perceived the impact of the service on their recovery.

More importantly, factors including the following appeared to provide the keys to successful implementation of the specification:

- A strong, transparent and embedded framework for staff and women service users underpinned by the concept of relational security and a clear understanding of the importance of boundaries
- An effective multi-disciplinary team which communicates across all staff groups and with women service users
- Gender-sensitive training and supervision for all including ancillary workers i.e., that it is required for the entire staff group
- Gender-specific care pathways that enable women to move through and out of medium secure services
- Planned programmes of activities including some fun.
In order to understand what works well and what may be deemed good practice in women’s medium secure provision, we asked services in the original survey to identify what they felt most proud about. We received an interesting array of responses from the team to the women patients. Key to many services were the following:

- Patient involvement and in particular through user groups
- The care women received which empowered them
- The strength of relational security
- Gender specific approaches implemented within a women-only service
- Committed staff teams and multi-disciplinary working
- Provision of therapy and other means of meeting women’s needs
- Specific and specialist areas of development, for example, for women with disabilities

### 8.1.1 Delivery of differential care to meet the specific needs of women

1. **Philosophies of care** for working with women were embedded within the daily practice of staff teams in most case study services based on gender sensitive practice, promoting a psycho-social approach taking account of the context of women’s mental distress and acknowledging the impact of trauma and abuse on women’s mental health.

2. **Staff recruitment policies** aimed to achieve a 7:3 female to male gender ratio, with male staff providing positive role models for women, although not all services had managed this yet. They also sought to appoint ward staff with an active interest in and desire to work with women, and in most areas, the induction and on-going in-service training includes women’s mental health issues and gender specific practice.

3. **Dedicated psychologists for women’s services** were able to undertake formulation-based assessments and treatment planning incorporating psychological and social perspectives which acknowledged the importance of the woman’s story and life experiences and while seeking collaboration with the woman, with her views and objectives being sought.

4. **Purpose-built facilities** as stand alone or attached to the main mixed-units usually offered structured programmes of therapeutic gender specific activities as well as women being able to access mixed-sex activity sessions when available and appropriate.

5. **The Assessment and Care Planning Approaches** in place suggested that some were formulation-based encompassing a biological, psychological and social perspective and acknowledged the woman as an expert in her own “story” providing a basis for women to feel they were involved in their care planning.

### 8.1.2 Maintaining women’s psychological and physical safety

1. **Relational security** was well provided for in most case study areas within regular professional practice by staff members on the wards and the strong therapeutic relationships they built with the women. In the main, ward staff were provided with some opportunities to develop reflective practice and were
supported to develop therapeutic relationships within appropriate professional boundaries through regular group and individual supervision.

2. **Extra Care, Intensive Nursing Suites or High Support Areas** on women’s wards allowed women who were acutely ill to be cared for away from the main ward area. These areas were used as a short term facility only. They provided women who were acutely distressed and at risk of harming themselves or others with a safe but comfortable environment without the need to isolate them completely, but where intensive nursing input and emotional support from staff was available to them.

3. **Clinical nurse and other specialists** were employed within some women’s services providing risk assessment, care planning, support and therapeutic and educational interventions for women who, e.g. self injure, as well as advice and support to members of the care team involved in their care.

4. **The gender sensitive practice** developed on wards supported staff to work towards de-escalation using means other than control and restraint techniques for managing women’s behaviour and it was reported that the use of control and restraint techniques had become less frequent.

5. **The physical layout of the women’s wards** were more likely to have been designed to allow zonal observation within the main day areas as an alternative to intensive one-to-one observations, which women often found intrusive.

6. **Team nursing approaches** were developed across most women’s wards so there was always a member of each woman’s team on duty who was familiar with her care plan and individual formulation.

### 8.1.3 Facilitating recovery for women, rehabilitation and resettlement

1. **Seamless care pathways** Having identified the need for a gender-specific route out of medium secure care for many of their women service users, some services have worked with regional teams and commissioners to develop a seamless care pathway for women. Several wards worked with *internal care pathways* for women with markers for progress. One service began the process pre-admission Another described its access to a Community Forensic Team for women who required this support once discharged from the inpatient service.

2. **The therapeutic treatment approaches** on some women’s wards meant that women were supported to develop knowledge and awareness of their own mental health needs. This was facilitated by the women being given the opportunity to explore their life stories and experiences in their own time and within the context of a trusting therapeutic relationship, to reach a shared understanding of how this impacted on their mental well-being.

3. **Women service user involvement** in service planning and development had enabled some women to take on responsibility for facilitating user group meetings and being representatives at external user networks and meetings.

4. **Social and vocational opportunities** In one service, women had access to a voluntary organization commissioned to provide education and work-related training and social opportunities including, for instance, office work, desktop publishing, participation in the running of a social club/café for service
users and advice about external training and career opportunities. Women were also contributing to
decision making about ward and other activities in some areas.

5. **Provision of family/child visiting suites** appropriate for children were seen as a considerable
improvement on previous facilities.

### 8.1.4 Structural and organisational factors

1. **Multi-disciplinary teams** brought key staff and women service users together in decision-making
processes. Staff across case study areas appreciated the value of this model of working.

2. **Streamlining administration** wherever possible from referral to discharge helped to ensure a smooth
pathway into and through a service. This included new computerized systems for recording information
and completing CPA documentation. One service worked with staff on how they wrote reports to
reduce judgmental language and improve the overall balance of their reporting.

3. **Monitoring activity** was required in all services to provide data to commissioners and/or parent
organisations. Several had introduced additional ways of capturing service delivery, e.g. through
satisfaction surveys in one case designed with women service users, staff training needs analysis and
take up of training and support, as a means of service development. Two case study services were
developing research to determine meaningful ways of measuring outcomes.

### 8.2 What needs to be addressed for the future?

The Equal Opportunities Commission\(^\text{83}\) said ‘**Most women still have very different life experiences from
most men ... because women’s lives are different from men’s they need different things from public services.
Meeting their needs often means changing the content of services and how they are delivered**.’

The evaluation identified many ways in which services had addressed the specific needs of women and
indeed, found that some providers had been invited to advise men’s services on their philosophy of care
and specifically relational security. However, professionals and women service users identified significant
gaps and areas where there was room for development and improvement. Services participating in the
survey were invited to comment on areas for change. These tended to reflect some of their previously
raised concerns about factors which hindered policy implementation and focused on the following:

- Ensuring staff are permanent
- Facilitating an attitude change among generic staff and management
- Ensuring that the environment meets the physical and relational security needs of women
- Increasing training and ensuring that gender awareness training was provided for all staff

On the basis of the case studies and review of documentation, we have listed a range of areas which policy
makers and service providers may wish to consider for future development. These are addressed below.
### 8.2.1 Processes

#### Models of care:
- A written policy for relational security needs to underpin service provision as an aid to consistency of practice and essential to protect women at risk of suicide or self harm as well as aggressive behaviour.
- Models of care (whether single or based on a range of philosophical precepts) need to be supported by policy and operational practice documentation which articulate the approach and its use in the service for all staff. Some services have versions for women service users outlining how they work in the unit. These documents additionally provide a basis for service review and help ensure a consistent approach across the ward and multi-disciplinary teams.

#### Referrals and admissions:
- In general, women need to be able to access a bed in their own geographical area unless, as in some cases, a women has specialist needs, e.g. learning disabilities, autistic spectrum disorder and her needs cannot be met locally. In addition, if the circumstances of the women's offence means she needs to move away from her home area then it maybe preferable for her to be referred to OATS.
- However, women should be able to access treatment in their own area. In the interviews for this study, family members featured highly with over 70% of women including a family member or friend from outside the unit as important. In their personal constructs, support to maintain contact with family members was a key factor for women service users. At the same time, for women planning to return to their home location after being sent out of area, lack of contact with their home team and difficulties in deciding appropriate care pathways was likely to disadvantage them over women able to access a medium secure bed in their own locality.
- It also may be useful for levels of referrals and admissions and unmet demand for local women’s medium secure placements to be closely monitored and reviewed, to ensure women are not penalized by routinely being referred to out of area private sector providers, often at some considerable distance from their families, social networks and home area care teams.
- Women were still not being appropriately diverted from the Criminal Justice System, and they were often remanded to prison even when there was a clear history of mental illness. There was little in-reach into women’s prisons, and often delays in transfers to hospital settings. This area of referral processes needs strengthening in light of the Corston Report and the forthcoming Bradley review.
- Admission processes need to reflect the woman service user’s situation and balance this with the composition of the unit.
- *Time is needed for effective admissions* including opportunities for women to visit the unit and be visited by staff to initiate the care planning process.

#### Care plan development and implementation:
- The development of individual care plans needs to be consistent within individual services. Training for staff on the care plan approach with clearer guidance would help to ensure greater consistency and this guidance could be developed further through on-going reflective practice groups active in case study areas.
- The implementation of individual care plans needs to be consistent to avoid patchiness of provision, e.g. situations where rehabilitation for some women was compromised due to the lack of availability of staff.
- There is a need for gender sensitive risk assessments and for histories of abuse being adequately taken into account in the development of care plans.
**Practicalities**

- The recent guidance on CPA recommends that in future *service users are placed at the centre of the CPA process* and are fully involved in reviewing their own care plans and, for those who are able, they should be encouraged to take a lead role in review meetings including, for example, sending out invitations to the meeting jointly with their Care Coordinator and chairing meetings.

**Discharge planning:**

- It is hoped that where little exists, *increased step down facilities* continue to be developed as soon as possible to unblock existing bottle-necks in some services.
- It would also be helpful for *discharge planning to start from day one of admission*, with for example, home area care coordinators being asked to identify both possible future community placements for when a secure setting is no longer required by the woman, and for the responsibility for funding such future community placements to be agreed and planned for in advance.
- Home-area *care coordinators and care team members* could also be more actively involved in the CPA process during the women’s stay at the unit.

**Meeting diverse needs:**

- Where a single women’s ward forms part of the medium secure service (as in two case study areas), consideration needs to be given to *the use of communal space and providing for women who may wish to be in quieter areas* away from main ward areas.

**8.2.2 Practicalities**

**Environment:**

- Due to the new Standards for MSUs there is now a requirement for a 5.2 metre perimeter fence for all medium secure units, including women’s services even if this is not seen as appropriate. However, *environmental security is still important* and should be emphasised especially due to the risk of self harm.
- Policies need to be implemented which address how to deal with *environmental risk and its review*.
- Services not in purpose-built units need to consider *how best to provide zonal rather than one-to-one observations*.
- Wards need to keep at best to 10 and a *maximum of 12 beds*.

**Activities/OT:**

- Women’s services in mixed-sex units without *dedicated OTs* may wish to consider facilitating this to increase gender specific groups and activities for women and improve access to activities for women who are not able to leave the ward or are not able to, or choose not to, access mixed-sex activities.

**Service user involvement:**

- Women service users described the ways in which they contributed to service development. Some services had worked with users to develop satisfaction surveys, newsletters and events’ committees. All services need to *consider ways of encouraging women to participate* as part of their progress. They also need to ensure that *feedback is provided to avoid tokenism*.

**Staffing:**

- Services need to give consideration to recruitment and as far as possible *recruit staff specifically to the women’s service*. 
All services need to have job descriptions and person specifications which reflect their philosophies and gender-sensitive practice.

Training and supervision:
- Increased resources including time are needed by all services to ensure that training and supervision are always available and attended. Take up needs to be monitored by unit/ward managers to further ensure attendance.
- In some areas staff were not receiving appropriate gender training. Training on gender issues as they affect women on the ward and importantly in the community needs to be more consistently provided.
- Additional models for support need to be encouraged including (as already happens in some services) peer-support, mentoring and shadowing for new staff.

Primary care:
- Lack of access to primary health care services to meet the physical health care, public health and screening issues for women had been identified as a problem at some units.
- Standards and Criteria for Women in Medium Secure Care from the Quality Network for Forensic Mental Health Services requiring women’s medium secure services to provide access to a female GP and Practice Nurse, and to appropriate screening and well-women services.

8.2.3 Monitoring, evaluation and research

There are a number of potential future studies that would contribute to the development of women’s medium secure services.

Monitoring and evaluation:
- Ongoing monitoring, the development of outcome indicators of women’s recovery and service evaluation will ensure that services review their process from aspiration through to successful implementation and delivery of services according to the specification.
- The development of ongoing peer-review and reporting would contribute to determining how far and what ways services are achieving in relation to appropriate benchmarking.

Research:
- Based on the qualitative learning from this evaluation, a further study to determine and quantitatively measure degrees of women’s progress across and within services against previously determined indicators (see above).
- Research will be needed to explore the impact of individual budgets and their contribution towards moving the needs of women in medium secure services into mainstream provision.

8.3 Reviewing the Service Specification

The findings from the evaluation suggest that there are a number of ways in which the Service Specification could now be updated to reflect the learning from dedicated women’s medium secure services since the
Implementation Guidance was published. Here we have not addressed every part of the specification but identify a number of specific areas which would benefit from review.

- **Environmental security** provided by the built environment, wherever possible, rather than perimeter fences and specifically address maintaining an environment that reduces as far as possible the capacity for serious self-harm:

  *Due to the new Standards for MSUs, there is now a requirement for a 5.2 metre perimeter fence for all medium secure units, including women’s services. However, environmental security is still important and should be emphasized especially due to the risk of self harm.*

- **Access is also required to non-specialist, non-secure services** including acute inpatient and community settings (e.g. assertive outreach teams, high support community residential placements) that will accept women with challenging/offending/self-harming behaviours.

  *Care pathways for women were still problematic with few gender specific services available outside secure services, and services that accept patients being transferred/discharged from secure services were often male dominated. The Specification should include clearly identified gender specific care pathways for those women requiring women only settings.*

- **Forensic community teams:** These should be multi-disciplinary and include input from the following disciplines: psychiatry, psychology, psychotherapy, social work, occupational therapy and nursing. Sessional input from other services/disciplines such as substance misuse and eating disorders may be required. It may be appropriate to arrange secondments from learning disabilities/ rehabilitation/probation services to increase the range of experience, the likelihood of recruitment and the capacity for inter-agency liaison.

  *There was an issue for women in out of area treatment services (OATS) who require ongoing support of Community Forensic teams especially restricted patients who are likely to get conditional discharge supervised by Community Forensic Teams (CFTs), as they may be disadvantaged if local teams and responsible clinicians not involved in their current treatment/care planning.*

- **Outreach – consultation, liaison and crisis intervention**

  Support to: criminal justice system: probation service (including bail and probation hostels), courts and prisons; (Women still not being appropriately diverted from CIS, and usually remanded to prison even when clear history of mental illness, also inadequate in reach into women prisons, and delays in transfers to hospital settings.

  *This area needs strengthening in light of the Corston Report and forthcoming Bradley review.*

- **Private sector/out-of-area placements.**

  *Currently women in out of area placements are not always regularly visited by local area team and care coordinators. There is a need for the specification to make clear that women placed out of area need a care coordinator to be regularly involved in their CPA care planning and to identify future care pathway options at time of referral to out of area hospital, as well as agreeing funding with PCTs/LAs once women ready to move on.*

- **Assessment and care planning:**

  Assessment should inform a formal care planning process under CPA.

  *The importance of involving women in CPAs should be included in the specification in line with new guidance from CSIP on refocusing CPA. *Assessments should include routine exploration of histories of abuse, and care plans should take such experiences into account to ensure provision of appropriate
therapeutic interventions, informing relational approaches and to protect survivors of abuse from risk of re-enactment of abuse and re-traumatisation’ (as already referenced CSIP 2008 Refocusing CPA).

- **Treatment and continuing care**
  Teams should provide a therapeutic and non-institutionalised ethos which consistently incorporates a high level of relational security in all areas of the unit, e.g. ward activity areas and psychological therapy settings.
  *A written policy would ensure consistency of practice.*

- **Community follow-up** of all women discharged from secure care including those who do not require secure placement, but whose behaviours are too unusual/severe to be contained by local general mental health teams, and those with established forensic/offending problems and mental illness/personality disorder.
  *At the present time Community Forensic Teams are often only funded to work with conditionally discharged patients, and are not available in all areas.*

- **Operational policies and procedures**
  Policies and procedures should include the following:
  *Clarity regarding the operational management of an environment with a high level of relational security.*
  *A written policy will aid consistency of practice in this area and essential to protect women at risk of suicide self harm as well as aggressive behaviour.*

- **Staff support**
  This should be integral to the organisation of services and include supervision, space for reflective practice and access to work-related confidential counselling and crisis support.
  *The case studies showed often limited resources available to implement supervision policies. The specification needs strengthening to ensure adequate resources are made available for staff supervision and support in women’s services.*

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84 CSIP (2008) *Refocusing the Care Programme Approach*
Appendix 1: Evaluation methodology

1. **Overview of the evaluation:**
The evaluation was designed to ensure maximum participation from all key stakeholder groups through the study of both the development and delivery of secure services for women as well as the impact they have on women’s current and future lives. The design incorporated a multi-method approach making use of both quantitative and qualitative data collection methods to enable better understanding of the breadth of issues across services as well as offering in-depth and detailed exploration within a number of case study sites. Women patients were involved in determining the final design through participation in preliminary discussions as well as the use of repertory grid analysis which identified key issues as they perceived them. The design offered a number of ways to triangulate data as well as to further increase internal validity through evaluator-triangulation. Key components were the collection of information from all secure services for women about policies and practices in place; interviews with women patients and other stakeholders; and considering the ‘future’ for women in relation to recovery and rehabilitation. The methods of data collection and treatment allowed for analysis within and across data sets.

2. **Evaluation design:**
In planning the design of this evaluation, we wanted to ensure women service users were involved from the outset and played a role in defining “what works for them” in terms of service delivery. The evaluation was concerned with both process (the development and delivery of services) and outcomes (the difference these services make to women patients’ progress and recovery). The study set out to use a multi-method approach including:

1. Postal pro-forma cohort survey to all women-only medium secure services
2. Establishment of unit/evaluation team Liaison Groups (including representation from women)
3. Two stage qualitative study of women patients’ perceptions and views using Repertory Grid Interviewing Techniques
4. Semi-structured interview survey of other stakeholders
5. Rank ordering exercise to measure consensus between women patients’ perceptions of “what works for them” and those of service providers
6. Documentary review of policies and protocols
7. Documentary review and audit of CPA reviews of women patients to examine evidence of their involvement and gauge their progress towards discharge and recovery

While the evaluation adopted a case study approach enabling detailed data collection about the selected services, multi-methods allowed greater access to the breadth of information and learning available (across all sites). The evaluation was approved by the South East Multi-site Research Ethics Committee in 2006. The methods are described and reviewed below.

3. **Evaluation participants**
The evaluation aimed to reflect the holistic ethos which underpinned the reprovision of secure services for women by involving the full range of stakeholders in contributing to the study. The pro-forma survey was sent to managers of all services and we received completed questionnaires from 14 of (the then total number of) 20 providers (70%). At the end of the evaluation, we followed up all services with a telephone survey including seven new ones and received a 100% response.

We sought access and permission to conduct in-depth case studies with six units. The final selection was based on the information provided through the postal pro-forma survey of all units in England and guidance from the Evaluation Advisory Group, taking the following criteria into consideration:
- regional spread of units
- legal status of patients, i.e. civil patients via mental health system, or admitted via courts/prison
- ethnic group of women patients
- age of women patients
- unit catering for women with learning disabilities

Key stakeholder groups who participated in the case studies included:

**Women patients**: we involved 50 women in the evaluation representing 34% of women provided for by the case study services at the time and 13% of women patients across all women’s medium secure services in England. Characteristics of women participants are described below.

**Table 8: Characteristics of women service users participating (n=50)**

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<tr>
<th>Characteristic</th>
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<tr>
<td>Age ranges:</td>
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<tr>
<td>Under 25</td>
<td>8</td>
</tr>
<tr>
<td>25-34</td>
<td>14</td>
</tr>
<tr>
<td>35-44</td>
<td>11</td>
</tr>
<tr>
<td>45-54</td>
<td>6</td>
</tr>
<tr>
<td>55+</td>
<td>1</td>
</tr>
<tr>
<td>Not known</td>
<td>10</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>White BR</td>
<td>31</td>
</tr>
<tr>
<td>Black BR</td>
<td>3</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Not known</td>
<td>10</td>
</tr>
<tr>
<td>Length of stay:</td>
<td></td>
</tr>
<tr>
<td>under 6 months</td>
<td>9</td>
</tr>
<tr>
<td>6 months to 1 yr</td>
<td>10</td>
</tr>
<tr>
<td>1 – 2 years</td>
<td>13</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>3</td>
</tr>
<tr>
<td>5 – 10 years</td>
<td>5</td>
</tr>
<tr>
<td>Not known</td>
<td>10</td>
</tr>
</tbody>
</table>

**Staff of secure services**: Between eight and ten staff and other professionals were invited to participate from each site and we met with a total of 65 individuals. In some cases, we were able to meet as many people as were interested or could find time with up to 15 in one area. In others, logistics and cancellations made it more difficult to achieve more than eight people.

**Table 9: Roles of professionals participating**

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical directors; Clinical Lead/service manager; RMOs</td>
<td>14</td>
</tr>
<tr>
<td>Psychologists</td>
<td>8</td>
</tr>
<tr>
<td>Occupational Therapists; Teachers</td>
<td>6</td>
</tr>
<tr>
<td>Social workers</td>
<td>3</td>
</tr>
<tr>
<td>Ward/unit managers</td>
<td>8</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>10</td>
</tr>
<tr>
<td>HCAs/support workers</td>
<td>6</td>
</tr>
<tr>
<td>Advocates; service user involvement staff</td>
<td>4</td>
</tr>
<tr>
<td>Commissioners</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>
Two Modern Matrons and a Community Team Manager participated in a group discussion. We were particularly keen to involve staff working most closely on a day-to-day basis with women and over half of those interviewed were nurses, support staff and OTs.

4. Data Collection and stakeholder involvement

4.1 Postal pro-forma survey of all women-only secure services:
This survey was conducted across all women’s secure services in England to ascertain information on services’ facilities. The purpose of the survey was to ensure that the evaluation maximised the potential understanding about current service use and practices across the range and diversity of secure services for women. Detailed case study material was analysed within this wider context. The survey covered a variety of topics including:

- information about admission and discharge rates, case mix, legal status of patients, age, ethnic group, average length of stay
- range, frequency/intensity and take-up of treatment and activities provided
- provision and nature of gender awareness training for staff
- arrangements for women patients’ involvement in individual care planning as well as
- service planning and development
- availability of independent advocacy, including the involvement of WISH

The pro-forma also requested information about the range and content of policies in place, for example, for the management of self-harm, sexuality/relationships, and managing aggression. The postal survey further served to canvass services about their interest in and ability to participate as one of a number of case studies for the evaluation. In particular, it asked about arrangements for user involvement at the service and other relevant information required for selection of the service for the main study, e.g. length of time established, admission criteria, legal status and care-path of patients, women’s ethnic group, age and mental health classification.

On reflection:
The pro-forma served an important purpose in alerting services to the evaluation. However, in order to achieve a reasonable return, we began by identifying an appropriate staff member by telephone but still had to give considerable time following up where the questionnaire was within a service. In some cases and despite repeated calls and emails, we did not receive a response. A telephone survey might have been more successful in eliciting the data and increasing response.

4.2 Secure Service Liaison Groups:
We had hoped to establish a group for each unit to be included in the main study with service user representation, as well as members of multi-disciplinary teams, and service managers. The purpose of these groups was to contribute to the development of data collection instruments and evaluation procedures to ensure they are sensitive to environmental and cultural factors and provide an ‘access’ point and opportunities for information through-flow from the evaluation team to staff and women patients throughout the life of the study.

Where service user groups were operating, we were invited to discuss the evaluation with group members (or their representatives) as well as address any queries women raised.

On reflection:
The reality of the liaison groups was such that we worked with service/unit managers and group discussions tended to be ad hoc. What proved essential was to have a link person in each area who
could facilitate our access to both women service users and those working with them. Attending service user groups slowed the process of data collecting. However, they offered an opportunity to meet with women informally, discuss the evaluation with them and meant that on returning to conduct interviews, many were familiar with who we were. We provided written as well as verbal information at this and other points in the process as agreed with the MREC and service providers. In one case study area, women complained about the paper overload.

4.3 Eliciting the perceptions/views of women patients:
This aspect of the evaluation focused on what women found helpful in keeping them safe and supporting their recovery. Women patients were invited to participate in preliminary and follow-up in-depth interviews. The purpose of these interviews was to learn about secure services from the perspective of women patients. Where a service was new or recently established, this approach provided useful learning as part of process evaluation.

In the first instance, we used repertory grid interviews to elicit the views of women patients, a technique developed by psychologist George Kelly\textsuperscript{86} in the 1950s, as a means of studying an individual’s personal ‘constructs’ or perceptions and how they discriminated between different ‘elements’ in their environment enabling them to anticipate events and make sense of their experiences. The most recent edition of the Handbook of Repertory Grid Techniques\textsuperscript{87} first published in 1977, gives many examples of the different contexts in which the technique is now successfully used both in clinical and research fields and, for example, describes its value as a tool for exploring the personal constructs and evaluatory processes of people with learning disabilities, and gives examples of its use within forensic settings.

During the repertory grid interviews both the elements, i.e. those people that the woman viewed as important to her care at the unit, and the constructs, i.e. how the woman discriminates between different elements, were elicited from the women. Personal constructs were elicited by presenting triads of elements, usually people (chosen by a random method) and asking the woman to explain how two of these elements were similar, but different from the third.

The selection of women patients for interview included some consultation with the MDT to ensure vulnerability and security issues are considered. In the main, we included mostly women patients who had already had their first CPA review since admission to the unit so they had sufficient experience of the service being evaluated. However, we also issued an open invitation, asking women to indicate whether they had had a CPA review as it was helpful to include some patients who were new to the service and from whom we learned a great deal from initial and follow up interviews.

On reflection:
The repertory grid interviews offered a different way of involving women in shaping the evaluation as well as finding out about their experience of services. Direct questioning would not have provided the same insights and some women commented that the technique had given them different ways of looking at how they perceived people who were important in helping or hindering their recovery and finding connections between them. The interviews involved a ‘card game’ with coloured cards that were shuffled and represented in different triads to women. A small number of women found the process difficult and could not complete the whole process. However, most were engaged and with breaks, some women spent up to an hour and a half in discussion.

4.4 Semi-structured interviews with other stakeholders:
We believed that the involvement of other stakeholders was of vital importance to the evaluation in order to generate as full a picture as possible of how secure services for women function.
Participants in this aspect of the evaluation included clinicians, support staff, advocates, service managers, multi-disciplinary team members and service commissioners. These interviews focused on their views and experience of providing differentiated care and treatment to women patients (i.e. a gender specific/sensitive service) including provision of interventions to address the specific needs of women patients linked to their experience of gender and other inequalities (e.g. self-harm, sexual abuse histories, racism).

The interviews included questions about the involvement of women in their assessment and care planning, gender awareness training undertaken and the unit’s approach to relational security and how they view this is working. A core set of topics relevant to all stakeholders were developed with additional topics specific to the range of individuals/areas represented within the sample.

On reflection:
These interviews provided an essential source of data which contributed to the evaluation of services. Women’s experiences and view alone would not have sufficed as the organisational and agency issues were central to women’s potential recovery. They also provided an opportunity to reflect women service users’ views back to professionals as described in 4.5 below.

4.5 Measuring consensus between service users and other stakeholders:
In order to identify where there was consensus of views and perceptions, a content analysis was carried out of the personal constructs elicited from the repertory grid interviews with women patients. Their personal constructs were grouped to identify the key themes expressed by women. The 12 most featured construct types formed a list of the service attributes perceived to be most important to women patients. Women patients (at a follow-up interview), staff and other stakeholders involved in the semi-structured interviews, were asked to rank these from 1 to 10 in order of importance to them. Staff ranked the 10 constructs according to what they believed to be most important for women patients. A comparison of the rank ordering was used to illustrate the degree of shared understanding of aspects of the service that women value or find helpful.

4.6 Documentary review of policies, protocols and guidelines/facilities audit:
A checklist and audit document were intended for use to review relevant policies and procedures at each unit, e.g. relational security, as well as an audit checklist of the physical environment and the facilities at each unit. Case study services provided policy and procedure documents. However, in the event, we did not conduct a systematic audit of facilities and the environment.

On reflection:
This aspect of the evaluation was not as successful as we had envisaged and may have been over-ambitious. While the case study services made us welcome and provided a high level of assistance in facilitating access, an environmental audit was yet one more request. The interviews with women and professionals asked about the physical environment and the feedback was instructive.

4.7 Reviewing progress of women patients and discharge planning:
In addition to seeking women’s own views and in order to more fully understand their involvement in the care process, their progress was addressed by seeking the consent of those woman already participating in the study for the evaluation team to access to their CPA review and Discharge Planning documentation during the study period. A checklist and audit tool were designed incorporating the CPA monitoring and audit checklist and the SCMH/MHAC CPA audit document⁷⁸, along with appropriate gender specific requirements and measures of user involvement. This included the key recommendations for action on individual assessment and care planning made in section 5.1 of Mainstreaming Gender and Women’s Mental Health Implementation Guidance. The analysis of CPA review documentation was undertaken on site during the final visit.
On reflection:
This aspect of the evaluation required seeking women’s consent for a final time, the consent of the MDT and then finding opportunities to access paper and/or online files. Whilst interesting as an exercise, what it revealed was something about the women but more about the way in which case notes were kept and CPA reviews carried out. The data was not sufficiently robust to draw conclusions in this context.

5. Recruitment and access to information
There were a number of issues that needed to be addressed when developing appropriate routes into the evaluation for participants. It was vital that both women, staff/members of multi-disciplinary teams and other stakeholders were clear about how the evaluation was to be conducted and what it was hoped would emerge from it. The following ‘ground rules’ were employed in the planning and delivery of the evaluation.

- **Recognition that women patients in secure services are not a homogeneous group**, although they may share some common experiences and mental health needs. The evaluation may not provide women from all services in England with the opportunity to provide the detail of their experiences, however a broad cross section of women will be able to participate.
- **Awareness that many of the women patients have long-term mental health disabilities** and are vulnerable. Their interests and welfare need to be safeguarded throughout the process.
- **Recognition and respect for the responsibilities of clinical and other staff** in relation to women’s safety and welfare.
- **Provision of a written statement** for women patients, staff and others outlining the purpose and conduct of the evaluation including the issues to be addressed, information about the proposed strategy and with proposals for feeding back the findings. It will also be important to ensure that women fully understand that while their views will be listened to, there is no guarantee that they will be implemented.
- **Provision of written informed consent** demonstrating that women and staff understand the nature and purpose of their participation in the evaluation.
- **An explicit understanding of the confidentiality guidelines** that will regulate the evaluation, e.g. that women can express their views where staff are not present; that the findings will be confidential to the evaluators, that they will be provided to the National Oversight Group and others in an aggregated and anonymised form and that while quotation may be used to illustrate stakeholders views, no individual will be identifiable from any report.
- **Provision of an environment where all parties feel safe and comfortable**, where women can choose to withdraw at any time and that evaluators are able to offer appropriate responses and support to women who raise queries and concerns or become distressed.

In addition to these ‘ground rules’, it was important to demonstrate good practice in the following ways:

- by ensuring that women patients and staff/multi-disciplinary team members and other stakeholders see that this exercise can be conducted in an accessible way, where jargon is avoided and language or literacy do not act as barriers to participation
- by using methods which are flexible and reflexive allowing for full exploration of issues and concerns raised
- by being open to receiving information and views of women patients in particular through any written or verbal forms other than those proposed here.
6. Data analysis

The analysis of data collected for the evaluation reflected the multi-method approach described here.

Various specialist software programmes are now available for the analysis of the repertory grid data, many of which are available freely as shareware (e.g. INGRID, FLEXIGRID, WEBGRID, GRIDSTAT). Richard Bell\(^89\) also provides detailed guidance and instructions for undertaking both single and multiple grid analysis using a range of features and facilities available in SPSS such as cluster analysis. While we reviewed the various programme options available, we decided to use the shareware programme GRIDSTAT as it provided the most straightforward solution to data preparation and input and gave us a range of pre-programmed analysis options that met our requirements including analysis of variance (ANOVA) and cluster analysis. A content analysis of the personal construct data was undertaken by the research team, to compile a list of the 10 most frequent construct types/themes given by women patients for use in the rank ordering exercise, to measure the degree of shared understanding between staff and women patients about “what works” for the women.

The qualitative data generated from in-depth interviews with staff and other stakeholders as well as from the follow up interviews with women patients was stored as anonymised Word files and analysed using Framework\(^90\). Framework offers a means of conducting within and across case analysis. Through a process of identifying common themes and charting data within these themes, a robust and comprehensive analysis is provided.

\(^88\) Sainsbury Centre for Mental Health (2005) Briefing 29 “The Care Programme Approach – Back on Track” London, SCMH
\(^89\) Bell R. (1997) “Using SPSS to Analyse Repertory Grid Data” Melbourne, University of Melbourne
\(^90\) Ritchie, J & Lewis J (2004) *Qualitative Research Practice* Sage
7. Topic guides and research tools

Sizes of boxes for comments and font sizes have been reduced for reproduction reasons.

7.1 Pro-forma survey to dedicated women’s medium secure services

Evaluation of Women’s Secure Services:
Questionnaire for Providers of medium secure services with women-only wards

Background:
The National Programme on Forensic Mental Health R&D has commissioned this evaluation on behalf of the Department of Health’s National Oversight Group which oversees the secure mental health sector.

Reorganisation of secure mental health services is underway nationally in line with the NHS Plan¹. This includes a programme of accelerated discharge of patients from high secure hospitals with women deemed a priority. As part of the reprovision of services, a national network of secure dedicated NHS services for women is being established, with currently just under 200 beds nation-wide. Other mental health services for women being developed include women-only self-contained inpatient wards, crisis houses, and high support community residential services.

Mainstreaming Gender and Women’s Mental Health: Implementation Guidance² includes a specification for dedicated secure services for women, identifying the need for a gender sensitive approach. It also recommends an evaluation of these new dedicated secure services to assess whether they are delivering care, support and treatment that meet the specific needs of women, as well as maintaining women’s safety and security.

The evaluation has been designed to determine the extent to which the new women’s secure services are:

- Delivering differentiated care, support and treatment to meet the specific needs of women;
- Maintaining women’s psychological and physical safety;
- Facilitating the recovery process for women patients, including their rehabilitation and positive resettlement in the community with an appropriate level of support.

Women-only secure services to be evaluated include:

- NHS self-contained women-only units where either there are no male wards on site or women do not mix with male patients from other wards.
- NHS self-contained women-only secure units where there is some level of mixing with male patients, for example during off-ward activities and/or at the rehabilitation stage.
- Independent sector and “not for profit” services (these are mainly stand alone services).

Survey of all women-only medium secure services in England (NHS and Independent)
As the first stage of the evaluation, this questionnaire has been sent to all providers of medium secure care in women-only wards/settings.

Completing this questionnaire:

Part A: To be completed by Manager or Clinical Lead for women’s services
Part B: To be completed for each women-only ward by person responsible e.g. Ward Manager

References:

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QUESTIONNAIRE A: ABOUT THE SERVICE

You have been asked to complete this questionnaire because of your overall knowledge about secure provision to women. You are probably the Manager or Clinical Lead for women’s services.

Please contact us if you have any queries:
Georgie Parry-Crooke: Tel: 020 7133 5092 Email: g.parry-crooke@londonmet.ac.uk
Penny Stafford: Tel: 01904 421460 Email: penny@walkerhill.co.uk

A1. General Information about Service Provider:

<table>
<thead>
<tr>
<th>Hospital/Unit Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of NHS Trust:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Or

<table>
<thead>
<tr>
<th>Organisation Name if Independent provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name and position of Person completing this Questionnaire:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please provide your Contact telephone Number and email

A2. Are you a provider of Women’s Secure Services?

Please confirm that you provide a secure mental health service that is either only for women patients, or that has at least one women-only ward that can meet the security needs of women patients assessed as requiring medium secure care.

☐ Yes

☐ No (In this case this survey does not apply, and we do not need you to answer any further questions, but please return this questionnaire in the enclosed pre-paid envelope so we can amend our records).

A3. If yes: Is your women’s secure service:

☐ A self-contained women-only secure unit with no male wards on site.

☐ Self-contained women-only unit/ward(s) on a site where there are male wards but where women patients do not mix at all with men patients from other wards on site.

☐ Self-contained women-only unit/ward(s) on a site where there are male wards and where there is some level of mixing between women and men patients, for example during off-ward activities and/or at the rehabilitation stage.

A4. Policies and procedures for women’s secure unit/ward(s)

(i) Which of the following policies are in place within your women’s secure service(s)

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Any other policies you would like us to know about?

[Please attach a copy of your policies if possible]

(ii) Which policy/policies best represents the efforts of your women’s secure service? Why?

(iii) What do you think most helps the implementation of policies within your women’s secure service?

(iv) What do you think most hinders the implementation of policies within your women’s secure service?

A5. Service User Involvement and Advocacy:

(i) How does your service encourage or enable women patients to be involved the formal CPA (Care Planning Approach) process?

(ii) What proportion of CPA review meetings are attended by women patients?

   Please give or estimate %

(iii) Are women patients generally invited to attend the whole CPA review meeting, or just part of the meeting?

   Yes patients are generally invited to attend their full CPA review meeting.
Patients are generally only invited to attend part of their CPA review meeting

Patients are generally not invited to attend their CPA review meetings.

(iv) Are women patients encouraged to submit their own written report for their CPA review?
   - Yes
   - No

(v) Are women patients involved in their risk assessment process?
   - Yes, women patients are generally involved in their own risk assessment
   - No, women patients are not usually involved in their own risk assessment

(vi) Are women patients invited to sign their completed risk assessment documents?
   - Yes
   - No

(vii) Have you introduced any gender specific risk assessment procedures for your women’s secure service?
   - Yes
   - No

(viii) Are independent advocates available to support women with their CPA reviews?
   - Yes
   - No

(ix) Is independent gender specific advocacy available to your women patients?
    - Yes
    - No, but there is an independent advocacy service available for our patients
    - No, there is currently no independent advocacy service available for our patients

(x) Are patients’ councils, self-advocacy or user groups established for patients?
   - Yes, ward-based group(s) established
   - Yes, across site group(s) established
   - No, there are currently no user or self-advocacy groups at this hospital
Do women patients participate in Clinical Governance at your hospital?

- Yes
- No

Are arrangements in place for WISH (Women In Secure Hospitals) to make regular visits to your women’s secure ward(s)?

- Yes
- No

A6. Joint Working and External Links

(i) Do you provide a forensic community team for women?

- Yes
- No (skip to question (iii))

If Yes: Which disciplines are represented on the team (e.g. psychiatry, psychology, etc)

(ii) Is there regular liaison between the forensic community team and following local CJS and health services? (Please tick all that apply)

- Courts
- Court and/or police diversion schemes
- Prisons
- Probation service
- Adult mental health units
- CAMHS units
- Learning disability services

(iii) Is there a risk assessed community inclusion programme available to your women patients in medium secure care?

- Yes
- No

If Yes: Please give details
A7. **Provision of Gender Awareness and/or Gender specific training for staff:**

What percentage of the current staff group has received training to specifically help them work well with women with mental health needs?

Please give or estimate %

Please tell us about the training provided (e.g. date length of courses, topics covered, etc) and who attended (e.g. healthcare staff, MDT members etc), who was the training provider, etc?

A8. **Number of women-only secure wards?**

How many women-only wards offering medium secure care are there at your unit/hospital?

Write In Number

A9. **Thinking of the service you currently offer to women requiring medium secure care:**

What do you feel most proud of?

What would you most like to change?

A10. **Participation in Case Studies for National Evaluation Programme**

We will be carrying out detailed case studies over the next 18 months of at least six women-only medium secure services as part of this national evaluation commissioned by the NHS National R&D Programme for Forensic Mental Health. These will involve researchers making a number of visits to service sites, to interview members of multi-disciplinary teams, ward staff and women patients, to review policies and procedures, and with patients’ consent, to review CPA documentation. (Full Research Ethics Committee Approval has been obtained for this study.)

Would your service like to be considered for inclusion in the case study phase of this evaluation programme?

☐ Yes

☐ Not sure (please provide further information )

☐ No

THANK YOU VERY MUCH FOR YOUR GENEROUS TIME AND EFFORT COMPLETING THIS QUESTIONNAIRE
NOW PLEASE COMPLETE (OR ARRANGE FOR THE RELEVANT WARD MANAGER OR OTHER PERSON TO COMPLETE) A PART B QUESTIONNAIRE FOR EACH OF THESE WOMEN’S WARDS

PLEASE RETURN:
   Part A Questionnaire
   Part B Questionnaire (completed for each ward)
   Copies of relevant policies and other materials

TO:

Hospital / Secure Unit Name: 

QUESTIONNAIRE B: ABOUT YOUR WARD

You have been asked to complete this questionnaire because of your knowledge about a ward providing secure care to women on this site. You probably manage this ward

Please contact us if you have any queries:
Georgie Parry-Crooke: Tel: 020 7133 5092 Email: g.parry-crooke@londonmet.ac.uk
Penny Stafford: Tel: 01904 421460 Email: penny@walkerhill.co.uk

B1. Ward Details
   (i) Ward name: 

   (ii) Number of beds: 

   (iii) Number of beds currently occupied: 

   (iv) If there is a waiting list how many women are waiting for a bed: 

   (v) Date Established: 

       (If not known please write in approximately how long the ward has been operating as a women-only secure service)

   (vi) What patient group does your ward cater for? (Please tick all that apply)

      [ ] Women diagnosed with mental illness
      [ ] Women diagnosed with Personality Disorder
      [ ] Women with learning disabilities
      [ ] Women with Complex Needs (e.g. more than one diagnosis)

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Women with challenging behaviour

Women diagnosed with Borderline Personality Disorder

Other (write in) ____________________________

(vii) Does the ward have the following?

☐ Seclusion room

☐ Quiet/low stimulus area/room

☐ Women-only secure outside space

☐ Crisis suite(s) i.e. bedroom, Day and bathroom area that are separate, or can be separated off

☐ Child/family visiting area

☐ Ward lay-out suitable for zonal observation

☐ Ward environment designed to minimise the capacity for serious self harm

(viii) What percentage of ward staff time was spent keeping women “under observation” in the last month?

Please give or estimate % □□□□

B2. DETAILS OF ADMISSIONS OVER PAST 12 MONTHS

(i) Over the past 12 months (or since opening if ward established for less than a year) how many patients have been admitted to this ward (including transfers from other units/wards)

Write in number: □□□□

(ii) Please give a breakdown of admissions over past 12 months by legal status:

Number on a Civil Order under Mental Health Act (i.e. Section, 2 or 3): □□□□

Number on Court Order (i.e. section 35,36,37,38 - including those with Restriction orders): □□□□

Number of Prison Transfers (i.e. section 47, 48 - including those with Restriction orders): □□□□
(iii) Did you admit any women being transferred from a high security hospital during the past 12 months?

If Yes: Write in number: 

(iv) How many of the patients you admitted to the ward during the past 12 months were subject to restriction orders (i.e. s41 or s49) under the Mental Health Act?

Write in number:

(v) Please give a breakdown of admissions to your ward during the past 12 months by age group: (Write in number)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 or under:</td>
<td></td>
</tr>
<tr>
<td>21 up to 25 years:</td>
<td></td>
</tr>
<tr>
<td>26 up to 45 years:</td>
<td></td>
</tr>
<tr>
<td>46 up to 60 years:</td>
<td></td>
</tr>
<tr>
<td>61 and over:</td>
<td></td>
</tr>
</tbody>
</table>

(vi) Please give a breakdown of admissions to your ward during the past 12 months by ethnic group: (Write in number)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White:</td>
<td></td>
</tr>
<tr>
<td>Black (African/Caribbean):</td>
<td></td>
</tr>
<tr>
<td>Black Asian:</td>
<td></td>
</tr>
<tr>
<td>Mixed Ethnic group:</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
</tr>
<tr>
<td>Other ethnic group:</td>
<td></td>
</tr>
</tbody>
</table>

(vii) How many patients have been discharged or transferred out from your ward during past 12 months?

<table>
<thead>
<tr>
<th>Type of Transfer</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number discharged to community setting:</td>
<td></td>
</tr>
<tr>
<td>Number transferred to lower secure setting:</td>
<td></td>
</tr>
<tr>
<td>Number transferred to another medium secure setting:</td>
<td></td>
</tr>
<tr>
<td>Number transferred back to prison:</td>
<td></td>
</tr>
<tr>
<td>Number transferred to high security hospital:</td>
<td></td>
</tr>
</tbody>
</table>
(viii) Of the patients discharged or transferred from your ward in the past 12 months what was the average length of stay?

Write in number of months: 

B3. Treatment and activities provided:

(i) Please tick any of the following interventions, treatments and therapies that are available to your patients, and write in the percentage (estimate or actual) of women admitted to your ward who have used them in the last year?

- Individual psychological therapy
- Group therapy
- Creative therapies (e.g. art, drama)
- Complementary therapies (e.g. Massage, nutritional)
- Well-women sessions & screening

(ii) Is a programme of Dialectical Behaviour Therapy available to your patients?

☐ Yes. (Group)
☐ Yes. (Individual)
☐ No.

(iii) Do you provide any other specialist therapy or group work for women, for example for those who experience eating distress, substance misuse, self injury, or therapy to address patterns of offending (e.g. fire-setting)

☐ Yes.
☐ No.

If Yes: Please give details

(iv) Has your ward introduced a harm-minimisation or harm-reduction approach to managing self-injury?

☐ Yes.
☐ No.
(v) Which of the following activities are available to your patients, and approximately what proportion of women admitted to your ward have used them in the past year?

Write in percentage (estimate or actual) of patients who used:

- Education sessions provided on-site
- Education Courses off-site (e.g. at local college)
- Vocational training on-site
- Vocational training off-site
- Work placements
- Parenting skills groups/training
- Health promotion course/groups
- Creative arts (e.g. pottery, artwork, crafts)
- Sports and exercise (e.g. basketball, gym, etc)
- Social events (e.g. quiz nights, etc)
- Community inclusion (e.g. leisure facilities, shops, etc)

THANK YOU FOR YOUR TIME AND EFFORT COMPLETING THIS QUESTIONNAIRE
Please return it to your service manager or whoever asked you to help by completing the form.

7.2 First interview with women service users

Evaluation of Women’s Medium Secure Services: Repertory Grid Technique

- **Purpose of the evaluation:** to learn about women and staff’s experiences and views of the secure service. To feed into developing services in the future.
- **Who we are:** not from the secure services but completely independent. All have spent a lot of time talking with other women patients in secure settings as part of research and evaluations.
- **Discussion is informal:** it will take between an hour and an hour and a half and is confidential.
- **Use of tape recorder/note-taking:** Audio-tape, how we use it, keep it – go through confidentiality statement.
- **What happens to the information:** it will be compiled into reports which feed into making recommendations for the future.
- **Consent forms:** for this interview and explain others for subsequent participation.

Repertory Grid technique will be used to freely elicit elements and personal constructs from women patients to enable them to describe and evaluate their experiences of the secure unit where they are detained, in their own words, and using their own value systems to report what is important to them. The interview will take
the following form, and the topics and issues covered will be decided entirely by the interviewee based on what they believe is important to their safety and recovery.

**Eliciting Elements:**

Each woman will firstly be asked to list everything and everybody at the secure unit that they feel impacts in an important way on their care/treatment, safety and recovery:

**Researcher:** We would like to know about all the people and/or things here that **you** think are important to your safety and recovery at the unit. Can you name at least six people at the unit or things (e.g. an activity, a room, a rule, or anything else) about the unit, that you feel are important to helping you get well and making you feel safe?

**Prompts:** Any others? Is that all?

Once the researcher is satisfied the women has listed all the elements (people or things) that she feels are important to her care and safety at the unit, the interviewee will be offered a short break (Offered hot drink/toilet/etc). During this break the researcher will write out the names of elements on to cards and organise them into triads (groups of three) using a random method, to then be presented back to interviewee in order to elicit personal constructs.

**Eliciting Personal Constructs:**

The number of triads presented to the interviewee will depend on the number of elements elicited from them. If only the minimum number of elements were elicited (six) then nine triads will be presented to her, and up to a maximum of twenty triads will be used to elicit their personal constructs.

**Researcher:** [The first triad (3 cards with name of an element on each) will be shown to interviewee and read out: The Researcher then asks:]

In what way are two of these similar but different from the third?

**Prompts:** Can you explain a bit more what you mean by ...............? Is there any other way those two are similar but different from the third? Are another two of them similar in some other way but different from the third?

**This will then be repeated for each triad.**

### 7.3 Second interview with women service users

**Evaluation of Women’s Medium Secure Services: Topic Guide**

- **Purpose of the evaluation:** to learn about women and staff’s experiences and views of the secure service. To feed into developing services in the future.
- **Who we are:** not from the secure services but completely independent. All have spent a lot of time talking with other women patients in secure settings as part of research and evaluations.
- **Discussion is informal:** it will take between an hour and an hour and a half and is confidential.
- **Use of tape recorder/note-taking:** Audio-tape, how we use it, keep it – go through confidentiality statement.
- **What happens to the information:** it will be compiled into reports that feed into making recommendations for the future.
- **Consent forms:** for this interview and explain others for subsequent participation.
Early days

- how did you get to the unit
- arrival and admission
- first impressions
- layout and access
- own rooms/décor/choices/involvement in choice
- improvements to environment
- location of the unit/close to relatives and friends
- relevance/difference this makes to them
- environment/security/appropriate areas
- involvement in process/who

Services provided/needed:

- range/level of care/treatment/support services
- choice of care/treatment/other services
- access to/ use/ views of creative/ complimentary therapies
- access to community and opportunities to do activities outside the unit
- physical health care

Experiences/practicalities of service provision/daily living:

- education/training
  - choice if what do
  - views of training/providers
- psychotherapy/counselling
  - choice if what do
  - views of training/providers
- medical and drug treatment
  - choice of having/not having drugs/other treatment
  - information provided about treatment
  - how raise concerns/with whom
- social activities
  - choice of what do
  - views of activities
- user involvement
  - local arrangements
  - personal involvement/ how happened/ what do
  - usefulness of user groups/need for/improvements

Safety in the environment:

- risks and dangers
- physical and emotional safety
- provided via policy/practice/ patient involvement

Rules/regulations and policies:

- know what they are/how find out
- who decides what can/can’t do
- appropriate/inappropriate attitudes or behaviour
- how dealt with
- new policy/rules needed/what/why

Formal staffing arrangements:

- levels and roles
- relationships with staff/what want/need
- non-clinical staff/role/relevance
- ancillary staff
- health care workers
CPA and women’s involvement:
- when and how takes place/with whom
- knowing the care coordinator
- level of involvement
- review process/level and range of input
- role of different professionals/meaning of multi-disciplinary team
- keeping a copy/knowing what’s in the care plan

(Complete Section A of CPA audit form)

Other relationships:
- relationships with family/friends
- how system supports them or not
- other women in the unit
- contact with men (in mixed services)

External agencies:
- statutory/non-statutory (advocacy/support)
- relationships/what want/need
- accessing college/education
- volunteering
- using advocacy outside the unit

How women can have control over own lives:
- becoming empowered/what means/how happens
- control over own lives/participation in planning
- how this can be created

Discharge (if relevant):
- concept of rehabilitation
- contact with outreach/community services
- resettlement/where/how
- support given/required

Change and improvement:
- what important to keep/how/why
- what needs to be changed/how/why

At the end of the interview, ask the interviewee to rank order our list of ten service attributes in the order that she believes are most important to ensuring good care to women patients in secure units.

7.4 CPA audit form for use in second interviews with women

EVALUATION WOMEN’S SECURE SERVICES: SECOND INTERVIEW WITH WOMEN CPA AUDIT FORM

| Interview Reference no: |

SECTION A: (Ask service user during their interview within section of topic guide on Care Planning/CPA)

SERVICE USER INTERVIEW
WARD NAME: 
UNIT/HOSPITAL NAME:
1) Do you know what the Care Programme Approach is? (It is also known as CPA)
   Yes / No (If NO give brief explanation of CPA and importance)
2) Do you know who your care co-ordinator is? Yes / No

114
If Yes who is it: __________________________________ (name/role)

3) Who else is involved your CPA process? (list roles)

4) Do all the professionals involved work together as a team? Yes / No

Any Comments:

5) Do you usually attend your CPA review meetings?

   Always / sometimes / never

   Attend whole meeting / attend part of meeting

Any comments:

6) If attends review meetings: Do you feel able to take part in the discussions at your review meetings and put forward your views and requests?

   Yes / To some extent / No / don’t know or not sure

7) Do you have someone to support you at review meetings?

   Don’t need / advocate / named nurse / someone else / No

8) Do you get to read the CPA reports before your review meeting?

   Yes / sometimes / No / DK

9) Are you asked to put you own views in a report?

   Yes within a professional’s report / In own separate report / No

10) Were you asked to sign a copy of your Care Plan? Yes / No / DK

11) Were you given a copy of your CPA care plan to keep? Yes / No / DK

12) Are you happy with the amount of involvement you have in drawing up your written care plan?

   Yes / Yes to some extent / No / DK

Any comments:

13) Are you happy that your written care plan takes account of your own views of your strengths and weaknesses?

   Yes / Yes to some extent / No / DK

Any comments:

14) Are you happy that your written care plan takes account of and provides for any needs you may have as a result of any past experiences of being a victim of violence and/or abuse?

   Yes / yes to some extent / no / not applicable / DK

15) Are you happy that your written care plan takes account of and provides for any needs you may have relating to self-injury or risk of self harm?

   Yes / yes to some extent / no / not applicable / DK
16) Are you happy that your written care plan takes account of and provides for any needs you may have for contact and involvement with family members (including children) or friends from outside the unit?

Yes / yes to some extent / no / not applicable / DK

SECTION B: (Interviewer review/audit of CPA reports/care plan)

INTERVIEWER AUDIT OF CPA DOCUMENTS:

1) Was the Care Co-ordinator Identified in CPA Care Plan? Yes / No

2) Who had contributed written reports to CPA review? (list by role)

3) Were service user views recorded in CPA reports/care plan? Yes / No

4) Was the name of person responsible for implementing each action in the CPA care plan? Yes / No

5) Were any needs identified for which no help was available? Yes / No
   If Yes: Give details:

6) Was there any evidence that the impact of gender had been included in the case formulation and care planning? Yes / to some extent / No

Comments:

7) Has future care pathway and appropriate lower secure/step down facilities been identified or searched for? Yes / No

8) Has S.117 discharge planning commenced? Yes / No

9) Needs associated with: Was this identified as need in the care plan? Does care plan say how these needs are to be met?
   Relationships with family & friends Yes / no Yes / No
   Relationship with own children / or loss of children Yes / No / NA Yes / No / NA
   Relationships on ward/unit Yes / No Yes / No
   Index offence/behaviour Yes / No Yes / No
   Work and education Yes / No Yes / No
   Cultural (including ethnicity) Yes / No Yes / No
   Physical health Yes / No Yes / No
   Well Women /sexual health issues Yes / No Yes / No
   Emotional Yes / No Yes / No
   Self injury Yes / No Yes / No
   Risk of suicide Yes / No Yes / No
   Substance misuse Yes / No Yes / No
   Experiences of violence/abuse (inc. impact on trust and relationships with professionals) Yes / No Yes / No
   (Inc. potential for re-victimisation and or retraumatisation) Yes / No Yes / No
   Sexuality Yes / No Yes / No
   Advocacy Yes / No Yes / No
   Other (gender sensitive/specific) Yes / No Yes / No
7.5 Stakeholder topic guide

<table>
<thead>
<tr>
<th>Service attributes</th>
<th>Service delivery</th>
<th>Service specification</th>
<th>Gender Equality duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>- what YOU consider most important for women’s recovery</td>
<td>- identifying women’s needs</td>
<td>- local meeting the requirements of national spec</td>
<td>- impact of legislation on provision as yet/If any</td>
</tr>
<tr>
<td>- reasons/if and how provided for</td>
<td>- range/level of care/treatment/support services</td>
<td>- methods of review and monitoring services</td>
<td>- nature or staff commitment</td>
</tr>
<tr>
<td>- 10 most featured construct types/service attributes perceived to be most important to women patients and rated here</td>
<td>- surviving child sexual abuse or other abuse/violence</td>
<td>- existing policies: how find out about/how used in practice</td>
<td>- how communicated to women</td>
</tr>
<tr>
<td>- effectiveness of referral/assessment process</td>
<td>- women who self-injure</td>
<td>- women-only settings: advantages/disadvantages for women and/or staff</td>
<td></td>
</tr>
<tr>
<td>- appropriateness related to patient mix, security</td>
<td>- women with specific index offences (eg fire-setting) and offence related rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- in-reach to women prisoners who need transfer</td>
<td>- gender appropriate risk assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- how pathways are identified before admission/do they work/get women who should be there</td>
<td>- choice of care/treatment/other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- access to/use/views of psychological therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- access to/use/views of creative/complimentary therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- experiences/practicalities of service provision/daily living</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- physical health care</td>
<td></td>
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</table>

Evaluation of Women’s Medium Secure Services: ‘Stakeholder’ Topic Guide

- **Purpose of the evaluation:** to learn about women and staff’s experiences and views of medium secure services. To feed into developing services in the future. Funded by Forensic R&D, DoH but working with NHS and independent sector services.
- **Who we are:** not from the secure services or DoH but completely independent (LondonMet base). All have spent a lot of time talking with women patients, staff and others with an interest as part of research and evaluations.
- **Discussion is informal:** it will take between an hour and an hour and a half and is confidential.
- **Use of voice recorder/note-taking:** Audio-recording, how we use it, keep it – go through confidentiality statement.
- **What happens to the information:** it will be compiled into reports which feed into making recommendations for the future and **Consent forms:** for this interview.)
- Service standards
  - local/regional/national
  - existence/knowledge of
  - need for/purpose served
  - measurement of standards met/unmet/significance

- Staffing arrangements
  - levels and roles
  - effects of women on 1-1 obs on general staff activities, e.g.
    escorts for access, on/off ward activities
  - use of de-escalation/no and trained to maintain stability
  - do levels and roles allow for allow for good/adequate
    interaction with women in ward settings?
  - training/support provided to staff
  - supervision on women's
    needs/gender/ethnicity
  - own relationships with other staff/what want/need
  - non-clinical staff/role/relevance
  - ancillary staff/health care workers

- Care planning process:
  - when and how takes place
  - level of involvement of staff/team members
  - review process/level and range of input
  - role of professionals/meaning of multi-disciplinary team
  - their experience of involvement in care planning

- CPA taking account
  - of women's experiences of violence/abuse/CSA
  - ensuring care, safety, recovery and
  - prevention of re-traumatisation/victimisation within service

- Liaison and collaboration
  - joint working with community and CJS agencies
  - supporting opportunities to interact with community
  - levels of integration
  - External agencies statutory/non-statutory (advocacy/support)
  - relationships/what want/need

- Safety in the environment
  - risks and dangers/how assessed/how addressed
  - physical and emotional safety/how perceived/assessed/addressed
  - provided via policy/practice/patient involvement

- Relational security
  - definition/meaning in this context
  - efforts to ensure high levels of relational security for women
  - what helps/hinders implementation of relational security

- Built environment:
  - layout and access/safety/ease of working
  - rooms/décor/choices/involvement in choice
  - improvements to environment

- Levels of autonomy and control
  - importance for women or not/how achieved

- Discharge (if relevant):
  - concept of rehabilitation/what means/how practiced
  - contact with outreach/community services
  - resettlement/where/how
  - support given/required

- Frustrations
  - factors make difficult to meet women's mh needs
  - how staff cope with these frustrations
7.6 Mapping service provision January 2009

TEMPLATE FOR WOMEN’S MS SERVICES MAPPING/DIRECTORY

Service Name:
Address:
Tel no: Email: Contact Name:

IF NHS
Trust name: Commissioning team: Locality served:

IF INDEPENDENT
Provider Any block NHS contracts? Main Catchment area(s) served:
Organisation: contracts?

Women only site: □
Women-only ward(s) on mixed-sex site (with no mixed-sex activities) □
(Please tick)

No: of women’s MS wards

How many beds in each women’s MS ward:

Does the service have a women-only rehabilitation or pre-charge ward? Yes / No
Does the service also have a women-only low secure or step-down facility? Yes / No
Does the service accept women who’s main presenting diagnosis is Borderline Personality Disorder? Yes / No
Does the service accept women with learning disabilities? Yes / No

Other questions to ask/update on phone:

1) [If not women only site]
(a) Is there a dedicated Multi-disciplinary team for the women’s service? Yes / No
(b) Is there a dedicated ward team(s) for the women’s ward(s)? Yes / No

2) Can we check again which of these policies you currently have in place?

Management of self-harm
Management of aggression/distress
Sexuality and Relationships
Anti-bullying or harassment
Implementation of Relational security
Child Visiting
Equality and diversity
Are these policies
Trust-wide / Unit-wide / specific to the women’s service

3) Do you have a written/agreed model or philosophy of care document for your women’s service? Yes / No
   (If yes would you be able to email/post us a copy??)

4) FOR NHS Services: Are you commissioned to provide a Gate-keeping Role for women requiring
   Secure services in your locality/region? Yes / No

   IF YES – Approximately what percentage of women requiring medium secure care are placed in
   Independent/Out of Area Services?

5) Do you provide an in-reach service for women in prison? Yes / No

6) What percentage of your staff working in women’s service have undertaken Gender awareness
   and/or gender specific training?

7) AND What percentage of your staff working in women’s service have undertaken Gender awareness
   and/or gender specific training in the past 12 months?
Service specification for integrated, dedicated secure services for women

Client group:
Women with complex mental health care needs. Women in this group often:

- have more than one diagnosis including mental illness, substance misuse, learning disabilities,
- eating disorders and personality disorder, particularly borderline personality disorder;
- have a history of significant and sustained violence and abuse and significant experience of separation
- and loss, including that of their children;
- experience intense feelings of powerlessness and vulnerability with difficulties in forming
- trusting relationships;
- present with self-harm, offending behaviours, pervasive anger, depression, mood instability,
- dissociation and/or anxiety;
- are managed in conditions of physical security greater than their needs.

Structures:

- short assessment and longer-term placements;
- a range of inpatient settings that can cater for the range of needs including intensive care, challenging behaviour, remand assessment, rehabilitation; for women with a diagnosis of personality disorder, women with learning and associated disabilities; women within the prison service who require a secure mental health setting given their high levels of psychiatric morbidity;
- services for the *small* number of women, currently in high secure care, who have committed severe offences or who have very challenging behaviours who could not be catered for within existing
- medium secure care, but who do not need Category ‘B’ high secure care;
- multi-disciplinary, multi-agency teams to support inpatient services.

Services ideally need to be large enough to support at least two multi-disciplinary teams to enable mutual learning and support, and to provide specialist cover for times of additional need/holidays, etc.

Physical design:

- environmental security provided by the built environment, wherever possible, rather than perimeter fences and specifically address maintaining an environment that reduces as far as possible the capacity for serious self-harm;
- ward lay-out in which zonal observation is a realistic alternative to high levels of one to one, or more, nursing;
- crisis suite(s) i.e. bedroom, day and bathroom area(s) that are separate, or can be separated off;
- child/family visiting areas;
- women-only secure outside space;
- wards with no more than 12 beds;
- quiet/low stimulus area(s).

Access is also required to non-specialist, non-secure services including acute inpatient and community settings (e.g. assertive outreach teams, high support community residential placements) that will accept women with challenging/offending/self-harming behaviours.

Physical health care:
Inpatient services should have dedicated primary health care input including well-woman sessions, dentistry and general practice and suitable arrangements for the provision of specialist, secondary physical health care when required. Health promotion services should also be provided.
Forensic community teams:
These should be multi-disciplinary and include input from the following disciplines: psychiatry, psychology, psychotherapy, social work, occupational therapy and nursing. Sessional input from other services/disciplines such as substance misuse and eating disorders may be required. It may be appropriate to arrange secondments from learning disabilities/rehabilitation/probation services to increase the range of experience, the likelihood of recruitment and the capacity for inter-agency liaison.

Outreach – consultation, liaison and crisis intervention
Support to:
- criminal justice system: probation service (including bail and probation hostels), courts and prisons;
- local adult and child and adolescent mental health and learning disabilities services, giving advice on how women may be cared for without admission to secure beds;
- private sector/out-of-area placements.

Assessment and care planning:
- assessment should inform a formal care planning process under CPA;
- should be multi-disciplinary, holistic and comprehensive including violence and abuse, self-harm, substance misuse, eating disorders, sexuality and gender sensitive assessment of risk.
- will need to take place in a variety of settings including the community, family and residential homes, and distant secure placements including prisons, high secure hospitals and the independent sector;
- links with local court/police diversion and liaison services should be explicitly agreed.

Treatment and continuing care
Teams should provide the following:

Therapeutic and non-institutionalised ethos
which consistently incorporates the following in all areas of the unit e.g. ward, activity areas, psychological therapy settings:
- a high level of relational security;
- a positive expectation of hope and recovery;
- recognition of the strengths, abilities and competencies of women patients;
- development of ‘non-punitive’ strategies for the management and reduction of threatened and actual aggression towards staff and patients;
- ensure that, in all aspects of clinical practice, situations are not created that may be perceived or experienced as abusive by women patients (or staff).

A range of outpatient and inpatient interventions including:
- a range of integrated psychological therapies that are psycho-dynamically informed e.g. family, systemic, cognitive/behavioural approaches in group and individual settings to help women address e.g. their self-harm, substance misuse, eating disorders, patterns of offending (particularly fire-setting) – the therapeutic process should be fully informed by an understanding that these presentations are inter-linked symptoms of primary distress located in the lives and experiences of women, notably childhood sexual abuse;
- creative therapies;
- complementary therapies;
- medication: to be maintained at the lowest level possible for satisfactory therapeutic benefit without undue suppression of feelings/emotions and/or undue weight gain.

An integrated ‘daily living’ programme including:
- education (including basic numeracy/literacy), creative arts, sports and opportunities for exercise, occupational activities, health promotion, development of coping, social and parenting skills, social/leisure opportunities.

Activities should be tailored to an individual’s ability and level of confidence to enable
women to learn new skills and increase their self esteem through concrete achievement. **Note** To minimise women’s sense of isolation and enhance their movement towards independence, services should facilitate their involvement/contact with all relevant community settings and activities.

**Community follow-up** of all women discharged from secure care including those who do not require secure placement, but whose behaviours are too unusual/severe to be contained by local general mental health teams, and those with established forensic/offending problems and mental illness/personality disorder.

**Service standards, evaluation and monitoring procedures**
These need to be developed in close consultation with women patients in all new service models of care.

**Operational policies and procedures**
Policies and procedures should include the following:

- **Clarity** regarding the operational management of an environment with a high level of **relational security**.
  **Note:** This relates to the nature and quality of therapeutic relationships developed and sustained between patients and staff, primarily nursing staff, within the context of safe, contained and fully explained boundaries. It is dependent upon high staff: patient ratios; the appropriate level, attitude and quality of staff engagement with patients; appropriate staff training and activities/interventions provided by the staff group. Relational security needs to be informed by an understanding of the impact of surviving severe violence and abuse on women’s profound sense of powerlessness and vulnerability. A positive experience of ‘here and now’ relationships is crucial to the recovery process, those that address the ways in which women have been silenced and begins to give them a ‘voice’.

- **Mixed-sex activities**, if and when, clinically appropriate.
  **Note:** Women-only activities should be the norm with the potential for mixed-sex activities confined to the recovery/rehabilitative process. Any mixed-sex activity should be organised with around equal numbers of women and men. Decisions on appropriateness should be made on an individual basis: the inclusion of women patients should be dictated by a woman’s ability to make safe and informed decisions about her welfare; the inclusion of men patients should be based on a risk assessment to ensure that they have the ability to engage in mixed-sex activity in a safe and appropriate manner.

- **Observation policies** sensitive to women’s need for privacy and **least restrictive care** such as zonal observation, high level of staff : patient engagement (see **relational security above**) and additional support plans.

- **Self-harming** behaviour including agreements with local emergency care providers (see Section 8.5).

**Workforce**
Development of:

- a dedicated, appropriately skilled staff group with capacity for cross cover and the development of specialist skills;
- a stable staff group which will help consistency in practice and the development of therapeutic relationships;
- an appropriate gender mix of staff (existing women-only services often use a minimum of 70% female nursing staff with access to women staff at all times).
Staff should be recruited who have made an active and appropriate choice to work with women patients, are committed to working holistically and have an understanding of key gender issues relevant to women in secure care. The introduction of shared posts/secondments/reciprocal placements across secure and general mental health services would provide a means of extending
staff skills, promoting a greater mutual understanding and knowledge and reducing the risk of staff ‘burnout’.

**Training**
The service will need to be able to provide training to other organisations and professionals as well as appropriate training for its own staff group.

**Staff support**
This should be integral to the organisation of services and include supervision, space for reflective practice and access to work-related confidential counselling and crisis support.

**Management**
Multi-disciplinary/multi-agency management teams to help create gender sensitive organisational culture, policies and practice.

**Research**
Sufficient funding should be available to ensure that services are established with a culture of research and audit. Formal links to an academic base should be made.
### Appendix 3: Provider directory: January 2009

#### East Midlands

<table>
<thead>
<tr>
<th>Provider</th>
<th>Address</th>
<th>Tel:</th>
<th>Provider</th>
<th>Contact</th>
<th>No of medium secure beds for women</th>
<th>Rehabilitation ward</th>
<th>Low secure/step down</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>Arnold Lodge, Cordelia Close, Leicester LE5 0LE</td>
<td>0116 225 610</td>
<td>Nottinghamshire Health NHS Trust</td>
<td></td>
<td>20</td>
<td>No</td>
<td>No</td>
<td>Includes WEMSS pilot</td>
</tr>
<tr>
<td>East Midlands NHS</td>
<td>Arnold Lodge, Cordelia Close, Leicester LE5 0LE</td>
<td>0116 225 610</td>
<td>Nottinghamshire Health NHS Trust</td>
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<td>Includes WEMSS pilot</td>
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<tr>
<td>Independent</td>
<td>Calverton Hill, Ramsdale Park, Calverton Road, Arnold NG5 8PT</td>
<td>0115 966 150</td>
<td>Partnerships In Care</td>
<td></td>
<td>32</td>
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<td>Independent</td>
<td>St Andrews Healthcare, Billing Road, Northampton NN1 5DG</td>
<td>01604 616000</td>
<td>St Andrews Healthcare Group</td>
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<td>41</td>
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<td>Includes a Specialist Learning Disability unit</td>
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<tr>
<td>East of England NHS</td>
<td>Runwell Hospital, Runwell Chase, Wickford SS11 7XX</td>
<td>01268 366040</td>
<td>South Essex Partnership University NHS Foundation</td>
<td></td>
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<tr>
<td>Independent</td>
<td>Kneesworth House, Bassingbourne-cum-Kneesworth, Old North Road, Royston SG8 5JP</td>
<td>01763 255700</td>
<td>Partnerships In Care</td>
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#### London

<table>
<thead>
<tr>
<th>Provider</th>
<th>Address</th>
<th>Tel:</th>
<th>Provider</th>
<th>Contact</th>
<th>No of medium secure beds for women</th>
<th>Rehabilitation ward</th>
<th>Low secure/step down</th>
<th>Notes</th>
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<tbody>
<tr>
<td>NHS</td>
<td>12 Kenworthy Road, London E9 5TD</td>
<td>0208 510 229</td>
<td>East London and City University NHS Trust</td>
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<td>Yes</td>
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<td>Independent</td>
<td>Shaftesbury Clinic, Springfield Hospital, 61 Glenburnie Road, London SW17 7DJ</td>
<td>0208 6825899</td>
<td>South West London and St Georges NHS Foundation</td>
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<td>10</td>
<td>Yes</td>
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<td>Temporarily relocated due to fire</td>
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</table>
The Orchard Unit
St Bernards Hospital, Uxbridge Road, Southall UB1 3EU
Tel: 0208 3548354
Provider: West London Mental Health NHS Trust
No of medium secure beds for women: 50
Rehabilitation ward: No
Low secure/step down: Yes
Notes: Includes WEMSS pilot

North East
NHS
Hutton Centre
St Lukes Hospital, Marton Road, Middlesbrough TS4 3AF
Tel: 01642 283300
Provider: Tees, Esk & Wear Valleys NHS Foundation Trust
No of medium secure beds for women: 14
Rehabilitation ward: No
Low secure/step down: No

North West
NHS
Edenfield Centre
Prestwich Hospital, Bury New Road, Prestwich M25 3BL
Tel: 0161 7723159
Provider: Greater Manchester West Mental NHS Foundation Trust
No of medium secure beds for women: 18
Rehabilitation ward: Yes
Low secure/step down: No
Notes: Includes WEMSS pilot

Guild Lodge
Guild Park, Whittingham Lane, Goosnargh PR3 2AZ
Tel: 01772 406600
Provider: Lancashire Care NHS Foundation Trust
No of medium secure beds for women: 16
Rehabilitation ward: Yes
Low secure/step down: Yes

Scott Clinic
Rainhill Road, St Helens WA9 5BD
Tel: 0151 4306300
Provider: Mersey Care NHS Trust
No of medium secure beds for women: 8
Rehabilitation ward: No
Low secure/step down: No

Woodview
Calderstones, Mitton Road, Whalley, Clitheroe BB7 9PE
Tel: 01254 822121
Provider: Calderstones NHS Trust
No of medium secure beds for women: 6
Rehabilitation ward: Yes
Low secure/step down: Yes

Notes: Specialist Learning Disability Service

Independent
Alpha Hospital Bury
Buller Street, Bury BL8 2BS
Tel: 0161 7627200
Provider: Alpha Hospitals
No of medium secure beds for women: 23
Rehabilitation ward: Yes
Low secure/step down: Yes
Notes: Includes specialist secure service for deaf women

Arbury Court
Townfield Lane, Winwick, Warrington WA8 8TR
Tel: 01925 400600
Provider: Partnerships In Care
No of medium secure beds for women: 22
Rehabilitation ward: Yes
Low secure/step down: Yes

South Central
NHS
Thames House
Littlemore Mental Health Centre, Sandford Road, Littlemore, Oxford OX4 4XN
Tel: 0845 2191027
Provider: Oxfordshire & Buckinghamshire Mental Health NHS
No of medium secure beds for women: 24
Rehabilitation ward: No
Low secure/step down: No

Independent
Chadwick Lodge
Chadwick Drive, Eaglestone, Milton Keynes MK6 5LS
Tel: 01908 608600
Provider: The Priory Group
No of medium secure beds for women: 20
Rehabilitation ward: No
Low secure/step down: Yes

South East
NHS
Amber Lodge
Ashen Hill Unit, The Drive, Hellingly BN7 4ER
Tel: 01323 440022
Provider: Sussex Partnership NHS Foundation Trust
No of medium secure beds for women: 6
Rehabilitation ward: No
Low secure/step down: Yes
Trevor Gibbens Unit
Hermitage Lane, Maidstone ME16 9QQ
Tel: 01622 723100
Provider: Kent and Medway NHS and Social Care Partnership
No of medium secure beds for women: 15
Rehabilitation ward: Yes
Low secure/step down: No

Independent
The Dene
Gatehouse Lane, Goodards Green, Hassocks BN6 9LE
Tel: 01444 231000
Provider: Partnerships In Care
No of medium secure beds for women: 80
Rehabilitation ward: No
Low secure/step down: Yes
Notes: Includes a new learning disability unit

South West
NHS
Fromeside
Blackberry Hill, Stapleton, Bristol BS16 1EG
Tel: 0117 9583678
Provider: Avon and Wiltshire mental Health NHS Trust
No of medium secure beds for women: 12
Rehabilitation ward: No
Low secure/step down: No

West Midlands
NHS
Ardenleigh Unit
385 Kingsbury Road, Birmingham B24 9SA
Tel: 0121 6784400
Provider: Birmingham and Solihull Mental Health NHS
No of medium secure beds for women: 30
Rehabilitation ward: Yes
Low secure/step down: No

Yorkshire and Humber
NHS
Newton Lodge
Ouchthorpe Lane, Wakefield WF1 3SP
Tel: 01924 327352
Provider: South West Yorkshire NHS Mental Health Trust
No of medium secure beds for women: 10
Rehabilitation ward: No
Low secure/step down: No

Independent
Stockton Hall
The Village, Stockton On the Forest, York YO32 9UN
Tel: 01904 400500
Provider: Partnerships In Care
Total no of medium secure beds for women: 16
Rehabilitation ward: No
Low secure/step down: No