GOOD GIRLS:
surviving the secure system

Over 50 women had a story to tell.
Their 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. With little responsibility or choice over their daily lives and futures, women said:

'we're expected to behave like adults
but we get treated like children'.

A consultation with women in high and medium secure psychiatric settings

Commissioned by:
WISH
(Women in Secure Hospitals)

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Foreword

A note about the title. We thought long and hard about the title for this report. We had two. We could have called it "Having our Say: life in secure hospitals", which would illustrate the purpose of the report, and our attempt to produce a document which reflected as reliably as possible the views of the women who talked to us. But it would not tell the casual observer anything about what those views were. Or we could have called it, as we have done, "Good girls: surviving the secure system", which we hoped would say something about the content of the stories we were told. We feel we owe it to the women to explain this decision.

We were left with two over-riding impressions at the end of this consultation exercise. The first was that the women were often not treated with the respect that most people would expect to receive on a hospital ward, nor enabled to participate in an informed way in decisions about their treatment. Given that the women are spending not just weeks, but often months or years in the treatment setting, most people would hope to be full participants in decisions - about rehabilitation, and about every other aspect of life in the hospital. Although there were of course examples of good relationships with staff and good practice, the overall impression from the consultation was that "we're expected to behave as adults, but we get treated like children." Hence the word "girls" in the title.

The second issue was of needing to 'toe the line', to take the medication, follow the prescribed course of therapy, obey the rules, and not to challenge or make a fuss. Real objections to any of these had to be weighed against the possibility that refusal to comply might set back the date for discharge. Hence the word "good" in the title. Together these two conclusions suggest to us that the partnership between patient and provider, advocated in so many Department of Health policies, is still developing in the secure settings.

The report covers a wide range of issues about life in secure settings, and aims to illustrate all points made with quotations from the women, and short profiles. The women have all been given new names and none of the real names of those who spoke to us appear here. The following chapters were written by Georgie Parry-Crooke, who along with Chris Oliver, undertook all the interviews with women.

We very much hope the women feel this report does justice to their comments.

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We are indebted to the 56 women who agreed to take part in this consultation. They put their trust in us and were prepared to be open with their stories for which we are extremely grateful. Thank you to the staff in the secure settings who helped arrange the discussions with women and ensured that the process was as smooth as possible. Thank you also to the Director and staff at WISH who provided us with a bridge to the women we met. We are also grateful to the Consultation Steering Group for their time and consideration throughout the consultation. Finally, we would like to thank the AlIen Lane Foundation and the King's Fund for agreeing to support this innovative piece of work.

1. BACKGROUND TO THE CONSULTATION

1.1 Why consult with women patients?

A first of its kind, this consultation was commissioned by WISH (Women in Secure Hospitals). WISH is a national charity which works with and on behalf of women detained in secure hospitals, secure units and prison psychiatric units.

The consultation arose as a direct response to the current strategy work being undertaken by the Department of Health, the prime focus of which was women with complex mental health needs who are cared for in secure mental health units. The purpose of the consultation was to provide the views and experiences of women patients in high and medium secure units as formal evidence to the strategy in line with the Department of Health's policy on user involvement.

The strategic direction of the High Security Psychiatric Services Commissioning Board (HSPSCB) encompassed a number of key areas for consideration. First, there was a need to address how *high secure provision could be integrated into a wider spectrum of care* for people with mental health problems. Second, the Board was aware of *the need to develop new services for women* alongside other priority groups. Third, they wished to examine how *patients who do not require high secure care could be moved out* and finally, it was clear that there was a need *to develop new long-term secure services and rehabilitation pathways.*

A joint HSPSCB/WISH seminar held in 1997 concluded that a dedicated women's service was essential and that "women's views must be listened to and believed". It recommended an immediate "consultation with women patients on the model, including the issues of single sex or integrated provision".

A literature review of women and secure psychiatric services (Lart et al 1998) carried out on behalf of the NHS Centre for Reviews and Dissemination described two principal types of services where women's needs appeared to be addressed as either "an afterthought" or within services which were "gender blind".

Either way, women's needs have been consistently neglected and in particular, efforts to seek their views have been rare. It has been widely acknowledged that the majority of women detained in high secure care do not require that level of physical security. For example, in 1996 the Special Hospitals Service Authority (superseded by the HSPSCB) *conservatively* estimated a figure of 22% of the total number of women (just under 200) as requiring high security.

Beliefs that underpin the work of WISH:

- *Women in high and medium secure care have the potential to make valuable contributions to society.*
- *Women are judged by a different value system than men and, as a consequence, are more harshly judged in the secure psychiatric and criminal justice systems than men.*
- *Women in high and medium secure care are amongst the most vulnerable and damaged people in our society and require understanding, encouragement and sensitive treatment.*
- *Most women in high and medium secure care are detained for different reasons to men and have different needs.*
- *Women detained in high and medium secure care often have little confidence and have little opportunity to control their lives.*
  (WISH 1999)

There is *"a need to facilitate the involvement of women patients as stakeholders in the planning of their care and treatment. This is important not only in relation to empowerment, but also for therapeutic reasons."*
(Lart et al 1998)

1.2 Knowledge of women's previous experiences

Stafford (1999) described key similarities and differences between the men and women in high secure settings. Whilst the study showed a range of similarities between them, an analysis of case register data also demonstrated that women were more likely (than men) to have experienced the following during their lives prior to admission to high secure care:

- Disruptions and changes in their care as children and institutional care in a children's home or hospital before the age of 16
- Sexual and/or physical abuse during childhood
- Parenthood
- Lack of employment
- Dependency on social security benefits
- Detention under Part II of the Mental Health Act as civil patients rather than in connection with a prosecuted offence
- Classification of personality disorder and to meet the diagnostic criteria for Borderline Personality Disorder
- An index offence of arson
- Admission because of damage to property, suicidal or self-harming behaviour or as a result of aggressive behaviour towards staff in psychiatric hospitals of lesser security.

"Women are still expected to look pretty, speak quietly, and act gently, and if we deviate from such behaviour we are often judged as 'bad' or 'mad' or both."
(Stafford 1999)

This analysis demonstrated a significant difference between men and women and found, for example, that men by way of contrast were more likely to:

- Have victims who were strangers
- Have an index offence relating to serious physical or sexual violence against a person(s)
- Be admitted because of their sexual behaviour or symptoms of mental illness
- Have a prior offending record for physical and /or sexual violence
- Be admitted to high security provision for a second time.

"Equally important is the need to assess the needs of women not only in respect of their individual pathology but also to take account of the social and economic context of their mental distress, offending and behaviour."
(Stafford 1999)

What is surprising about secure provision is that, despite a body of research, it has not developed with an awareness of the different life experience and therefore, the different needs of women and men.

Lart et aI's review (1998) argued for research which explored "wider aspects of women's lives and the impact of gender and inequalities" (p. 3) and "ways of measuring need, to complement the use of diagnostic groups as a way of describing women and planning service responses".

They further suggested that a range of qualitative methodologies were introduced in order to gain a better understanding of women's needs.

1.3 The structure and content of the report

This report sets out to provide the views of the women who spoke to us about life in a secure setting. All women in the three high secure settings in England (with 196 women) and five medium secure settings were invited to take part. In the high secure settings, just under a quarter (46) initially agreed - most of whom participated. A total of 56 women were subsequently involved in the consultation. Of these, 46 took part in in-depth interviews most of which were one-to-one, but a few chose to be interviewed with a friend from their ward. In one setting, six women agreed to meet us as a group and four chose to provide a written submission. The discussions covered the following key areas (see Appendix A for details and a description of the women who took part):

- Women's likes and dislikes
- First impressions: admission to the secure setting
- Daily routines and activities
- Rules and regulations
- Mixed or single sex settings
- Changes and improvements needed

The rest of the report is divided into a further eight sections.

- *Two* is concerned with women's previous experience and their arrival at the secure settings.
- *Three* examines the day-to-day activities of secure settings, including education, leisure and social events.
- *Four* explores how and where women reach for support in their relationships with staff and other patients.
- *Five* looks at the role and use of care plans, medication and talking therapies, identifying gaps between policy and practice.
- *Six* examines how women learn about the culture of the secure setting, how they perceive the function of rules and the ways in they are listened to and heard, drawing on their experiences of participation in local forums.
- *Seven* addresses women's views of mixed and single sex provision.
- *Eight* sets out women's priorities for change in secure settings.

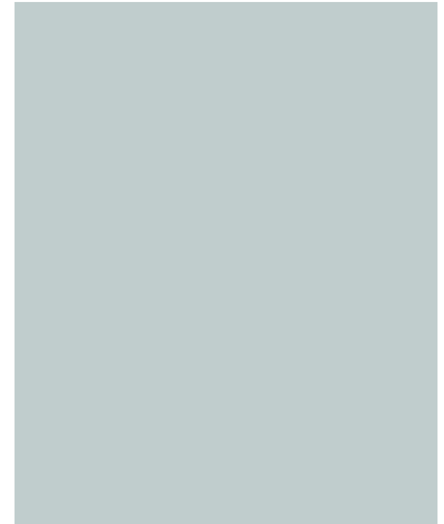
Throughout each of these sections, three key themes and their inter-relationship is explored. They are:

Empowerment or how far the service enables women to make real decisions and have choice within the setting.

Appropriateness or the extent to which the activities, structures, environment, therapeutic programmes and support provided are appropriate in the women's views.

Respect and dignity or how far the responses of staff are acceptable and respectful in women's terms.

The women who took part showed how important these themes were for them through the stories they told and the views they put forward. The following provides an illustration of one woman's perspective which reflected experiences similar to many other women.



Agnes: the ups and downs of high secure settings
I was very ill when I came here and don't recall many things. But I do remember that they restrained me, put me in seclusion, took your clothes off. They say there's no men but there were. I've said it's not right but staff say they turn around so *they're not looking. Bullshit! I like the fresh air, to go in the garden - I had to wait six months to be trusted to go. Most other activities are boring and I like to be active. As for the functions - well that's disappointing as they often don't happen. The foods nice - I've put a lot of weight on.*

If I'm not feeling well, I can talk to someone, to staff and that's good. But I don't like them running us down. If you say you heard your name being mentioned, they say you're hearing voices! I want more understanding, to be more open - not have them slagging the patients off when we can hear. Who do I talk to? The other women, we get on OK - but I wouldn't recommend it. They can be nasty too, talk about each other and make snide comments. What should they change for us? The men! There are rapists and all sorts here. And the treatment of some women. I'm able to stand up for myself but some get left in the dark and forgotten about. They are often older and don 't need this. Some don't even talk now about when they might leave. It's not right. Everyone should be treated the same.
(High secure)

2. PAST AND PRESENT COME TOGETHER: ARRIVAL AT THE SECURE SETTING

Women said:
- **Admissions procedures had improved over the years**
- **Arrival at the high secure settings was often frightening**
- **Arrival at the medium secure unit tended to be much less so**
- **There was too much use of seclusion and too little attention to care**

2.1 Women's backgrounds

We did not ask women why they were in the secure setting as neither their index offence nor their past experience were integral to the consultation. However, many women chose to talk about their offences and their lives in order to make sense of their current experience and views. We learned that these women shared significant and often painful memories of lives disrupted by abuse, violence, deteriorating mental health and institutional care. By the time they took part in this exercise, many were able to identify events which impacted on where they were then as well as relate this to their need for care and help. It is within these contexts that women talked about their arrival at the secure settings.

2.2 Arriving

Whilst a proportion of women had been in the secure settings for many years, the majority were more recent arrivals. Women's previous experience of prison, of other institutional care, of psychiatric services and of life in general tended to colour their perceptions of catching their first sight of the setting and the way they were treated. What emerged from the consultation was that women had strong views of their arrival and connected these experiences to their initial feelings about being in a secure setting.

The interviews revealed that there had been considerable change in the high secure settings over the years. One woman, who had been there for more than 20 years, described being thrown naked into the garden. Another described a similar experience.

"I saw the bars on the windows and thought - this isn't a hospital." (High Secure)

"I hate it here. I'm under a civil treatment order not the Home Office. I didn't even go to court. When I came I saw there were bars on the windows, staff wearing uniforms - they're like screws." (High Secure)

Anne: in the old days
When you came, I remember even though it's more than 18 years, you had to stay in the day room. There was a loo round and you all queued at once. For the wash room, you then had to strip off and quite a few times a man was present.

> *I knew one who made remarks about women's bodies. We bathed in cold or lukewarm water. And if you were punished - I was pushed naked into a yard, a cape and slippers were thrown out and I had to walk round and round. It's changed a lot since I came here - it's not so brutal. It has changed for the better.* (High secure)

More recently, however, a few women related a much more positive view of their arrival. Their memories of the moment were of friendly staff, the setting being much 'nicer' than expected and in one high secure setting in particular, that the physical appearance was less daunting than previously believed to be. One woman described the environment as more pleasant than the image she held and realised that this was a result of coming from prison.

Women speaking about the medium secure units also appeared to have a more positive view of their arrival. They were aware of attractive environments, of a friendly approach and of people who had a reasonable level of freedom. Some women subsequently discovered less attractive facets to the setting but said that their entry had been relatively smooth. The combination of a pleasing physical space and friendly staff contributed to a more tolerable experience of some of the medium secure units.

The contrast between these women's experiences and many of those in the high secure settings was marked. Their accounts were of an arrival which only inspired fear and anxiety and then clearly impacted on how these women were able to be assimilated (or not) into the system.

Some women were aware of being unwell at the time and that any retrospective account may have been overshadowed by this. Yet they were able to describe in detail the reception they received. Women arriving at the high secure settings talked of being very frightened by the physical environment and the way they were treated. A number of shared concerns emerged from the interviews, including:

- ***Being faced with 'mad people':*** a few women across the high secure settings commented that they just were not used to being with others who self-harmed or were suicidal. These women had usually come from prison and had no previous experience of secure settings. They said they felt frightened by what they saw.

- ***The use of seclusion on arrival:*** some women were aware that they were not just unwell on arrival. They were also angry and frightened at finding themselves in such places and then with their initial treatment. Where this resulted in showing anger and fear, they said the use of restraint was common and that seclusion frequently followed admission. They did not always know why

"I was frightened as I'd heard horrible things about it but when I got here it was all right." (High secure)

"At first I thought the staff were out to get me and I was very frightened. But they help you a lot and I got to understand that they are here to help me rather than hurt me." (High secure)

"It was a big place - bright, pretty, lovely. It looked free - people coming up and down." (Medium secure)

"I was out of it and they did their best to make me feel OK. Here the main impression was not having to be locked in." (Medium secure)

"I wondered what I'd come to. There were just mad people here, cutting up and I've never done that. I had a supervised bath and then seclusion for three days. I had no say - you can't tell them what you want." (High secure)

"I thought it was hell. I didn't know who to confide in. I didn't know the routines and they locked me up. They let me out for a day and then locked me up again. They didn't say why. It was a real struggle." (High secure)

they were put in seclusion. For some, it was explained as for their own safety.

- ***An absence of care:*** when women described being afraid on arrival, they also expressed a need to be cared for and given support. Few suggested that they received this as part of the admissions process. They were more likely to express surprise at the lack of explanation for what was happening to them; the exclusion from any immediate discussion about their stay and the lack of dialogue with named staff.

"The main thing I remember was they said I'd be here a long, long time - what a horrible thing to say!" (High secure)

Bea: on arrival

A mansion for monsters! I wanted to go back to prison. I was so scared. I saw the doors of the rooms and thought it was even worse than prison. I was shocked. It was overwhelming - doors with bolts on them. It had such an effect on me. The staff were quite friendly but I had to sit for a long time and wait for everyone to be ready. They were talking to the doctor so I couldn't smoke for hours and hours. 1'd no idea what they were doing as I was not invited into it.

3. DAY-TO-DAY ACTIVITIES

Women wanted:
- **To take responsibility for some of their daily activities and planning**
- **A wider range of (women-only) activities to choose from**
- **More information to help them make choices**
- **More and varied social events for women only**

3.1 Education and other daytime occupations

A key question for women was what do they do all day in the secure settings and to what extent were they able to choose how to pass the time? Women in high secure settings said they were rarely given any choice in most aspects of their lives. However, many believed that choice and taking responsibility for themselves was an essential part of 'getting better' and that daytime activities were an area where this could be given. An absence of information often resulted in their being unclear about the activities or the social life they were likely to be offered.

Many women talked about *'getting off the ward'* as one of the most important factors in how they viewed the secure setting. A key means of doing so was through both educational and social events. Hence for some women, choice of activity was much less important as they would do anything to get off the ward as often as possible. It was more important to be able to choose *where* they went and *who* they went with.

Women described a wide variety of local differences - between settings and between wards within a single setting. From their accounts, it appeared that there was less on offer on acute or admissions wards in the high secure settings. However, as women progressed to other wards, there were an increasing number and range of activities available. Women in medium secure settings also experienced some variation but were likely to have greater freedom and wider opportunities.

Cate: a day in the life of - high secure
What do I do? I was just writing to my sister about this. At 7.30 you wash, dress and have breakfast. After medication at 8.30, the corridors are cleared by 9. *After* 9 *o'clock, there is nothing to do. You can lie on your bed from* 9 *to* 12, *thinking, watching TV At 12 it's lunch. But then after lunch there's nothing to do until* 3 *when you get one hour of occupational therapy. From* 4 *to* 5 *you sit about. At* 5, *tea, then medication.*

I have a bath then for something to do. After 6 you sit around and listen to music until 7. Between 7 and 10 I watch television by myself. I like going to sleep at night. Sleep blocks everything out.

Clare: a day in the life of - medium secure
The day varies, I don't have a typical day. Monday is usually the activity planning meeting. There's a menu and you choose what you want to do. Yesterday, there was a breakfast group and so we went shopping. I was supposed to do the DIY group but it didn't happen due to staff sickness. I also have a one hour pass which I try to use most days. I rest in my room and listen to music. I can go to the pub once a week although I've not been recently. We're regulars and most of the boys go. Sometimes I go to the pictures. A few more females to do things with would be good.

Women were aware that, to create a life for themselves, they needed a combination of appropriate activities and some self-motivation to gain from whatever was on offer. Many were self-motivated and we interviewed some women who had identified a niche through their decision to get involved, for example:

The Gardener: on seeing a neglected patch outside the ward, one woman sought permission to work on it. With only a plastic trowel, she dug and planted, achieved agreement with the setting to pay for soil and plants and now has responsibility for its maintenance. (High secure)

The Waitress: in a desire to keep occupied and to see areas other than the ward, another woman had put herself forward for a number of different (paid) jobs. She was responsible for the kitchen on the ward, worked in the canteen four times a week and provided the teas and coffees for the visitors hall. She preferred working to attending classes. (High secure)

The Charity Fundraiser: based now in a medium secure setting, this woman put time, effort and her own money into making things for raffles, selling tickets, raising awareness about local charities and involving others in these ventures. (High secure)

Some choice was clearly possible albeit to few of the women participating. Where this worked well, it resulted in women feeling they had some control over their daily lives. They were also able to make informed decisions about interesting and appropriate activities. Overall, however, there were few choices available.

"I had an assessment to choose workshops. You do choose classes and I could do religious studies in the evening but don't know if I want to commit to another evening." (High secure)

Education:

Educational opportunities were at the core of possible activities for women in all the settings. These often included a variety of academic subjects: English, maths, sciences and history. Some courses led to certificates including NVQs. Whilst for many, these sessions were an important and enjoyable part of their day, women raised a number of issues about the education provided.

- The wider the range, the greater choice there was for women to identify their own interests.
- Teachers who were not employed within the setting were viewed favourably.
- There was a need for more all women options. Women found themselves isolated in a group of men and sometimes opted out for this reason.
- Women who had access to a women only centre appreciated the safety and security it offered particularly when they were new to the setting.
- For some, the level of education was viewed as basic. One woman was, however, being encouraged and supported to take educational programmes from outside the setting.
- The range of activities women were offered had decreased over the last two years. In one high secure setting, creative writing was no longer available and an in-house magazine had folded. Women who enjoyed writing hoped they might be reinstated.
- Classes in high secure settings were often disrupted due to a lack of escort staff.

Some women did not want to attend sessions either because they felt unwell or (and more usually) because they did not see any potential benefits from doing so. Where illness was a factor, staff were more likely to be sympathetic. In the main, however, there was little choice but to attend. Women described being unable to refuse and that to do so risked "going against the treatment plan" and getting into trouble.

Other daytime activities:

All settings additionally provided occupational therapy (OT) and some provided art therapy, aromatherapy and health and beauty sessions. Whilst not part of the educational programme, these activities formed an important part of women's daily lives. OT usually included basket weaving, sewing, pottery and dressmaking. Women's views of this varied - some enjoyed making items, whereas others found it boring and uninteresting.

There was greater enthusiasm for aromatherapy and health and beauty sessions. The former was viewed as a useful alternative to drug or talking therapies. Health and beauty sessions were important and often fun.

"The staff have a good attitude. I take my classes seriously and I like to pass everything. I've just passed professional catering and I'll use that when I get out." (High secure)

"Where the separate women's stuff takes place seems a bit girlie - sewing and cooking. It's like school. I'd like to do a mixture. It seems men get a wider opportunity of activities but if I thought I'd be the only woman in a class, I'd opt out." (High secure)

"I'm in my 50s now and I hate classes. I didn't learn much when I was at school when I was there under 15 so I'm not going to start now!" (High secure)

"They deserve praise for things like the well women clinic, but these things are long overdue." (Medium secure)

Exercise was also important for some women. Access to gyms in the high secure settings appeared to be limited with few women only sessions. Women attended mixed sessions but found the competition and sometimes, intimidation difficult to ignore. They requested more time for women only, with women escorts and staff.

3.2 Social events

Discussions revealed that a wide range of social events had been taking place in all the settings. These included discos, bingo sessions, occasional parties or barbecues. However, in the high secure settings in particular, there had been increasing problems in organising such events. Women said this was as a result of staff shortages and that they sometimes did not know until the last minute that, for example, their 'night out' had been cancelled.

"They used to be every night - film evenings, folk evenings, games evenings. But there are hardly any now. We blame it on the staff and they blame it on having to provide 24 hour care - there's no staff to cover functions." (High secure)

Women's views about events which included men were mixed (see also section 7). A few women said they enjoyed the opportunity to be with men, several had met boyfriends through social activities and there were those who said that these events mirrored the 'world outside'. By contrast, there were many more women who found mixed events extremely stressful. Their concerns were focused on:

- Not knowing what might happen
- The offences men had committed and what this said about them
- Fear of being approached, hassled or intimidated
- The ratio of men to women being overwhelming
- Fighting amongst men

Usha: on social events

There are functions and you get men mixing with the women. There's music, coke and lemonade and so on. You can choose to go but I don't. I think there should be more for women not mixed with men all the time. Once a month it's women only. We chat - you know, about women's problems. Sometimes women need a breathing space away from men and when there's men, there's trouble or they're angry and can get nasty. (High secure)

In the high secure setting, ultimately, women wanted to have a variety of social events which included more than discos. They saw a need for more women only sessions, games and quiz evenings, and opportunities to get together with other (women's) wards.

Social events in the medium secure settings were different. In one, women said they had very little to do. In others, they were more likely to revolve around going out, for example where women had permission, for pub lunches or shopping. In some settings, there were also opportunities to visit other wards. In one setting, however, it appeared that planning for events had come to a standstill due to a shortage of funds. Whilst trips out for women had been stopped, those for men continued.

"They should ask us what we'd like to do. We tell them but nothing gets done. Things like swimming. Siting around not doing things doesn't do us any good." (Medium secure)

3.3 Getting off the ward and out of the setting

Getting off the ward had different meanings to women dependent on where they were in the system. For some this related to going to workshops and other areas of the secure setting.

For others, this involved being able to leave the secure setting sometimes unescorted. Women talked about gaining different levels of freedom to move around as they progressed over time.

"Men can walk off the wards to the gym or to the canteen. I don't know why there's this discrimination - we've been given no reasons." (High secure)

Of similar importance for some of the women was the opportunity for **parole** (getting off the ward and outside into the open air). In one high secure setting, there had been no parole for over a year and women were frustrated at their lack of fresh air and exercise. They were denied access to outside recreational time and women felt this was even more unreasonable where male patients seemed to fare much better.

Parole *outside* the setting was also problematic where women were a long way from home, not yet integrated into local services and requiring intensive staff input.

Many women were prepared to participate in whatever was being offered. They wanted to be occupied during the day and have access to a variety of social events. However, their experience suggested that all too often choice was limited, events were cancelled and 'getting off the ward' proved to be much harder than they had anticipated.

4. RELATIONSHIPS WITH OTHERS

Women wanted:
- **To establish relationships with ward staff who were accessible and listened to them**
- **To continue good existing relationships with staff running classes and activities**
- **Clinical staff to be more accessible to them**
- **Ward staff to show them more respect**
- **Their support needs (where they can confide) to be met by ward staff and others**
- **Increased access to relatives and children**

4.1 Staff roles and support

The staff within each of the settings were clearly a very important factor in how women perceived events and experiences. Women made a number of distinctions between the different staff groups and in the main were better disposed to the non-medical staff they met through activities, workshops and education than to the clinicians and ward staff. Their views of these different groups are outlined below.

1. Ward staff: A small number of women had been in the high secure.settings for 10 years or more. They described some of the changes that had taken place over time and were thankful, that in their view, staff behaviour and attitudes towards patients had changed considerably for the better. Comments about ward staff varied from the very positive through to extremely critical. Some women had established rewarding relationships with individual members of nursing staff and saw them as someone to go to when needing support. Where these relationships worked well, women identified the following contributory factors:

- Staff making themselves accessible, giving time and listening to patients
- Staff doing what they say they will do for a woman
- Being able to trust staff and believe in the confidentiality of discussions
- Being able to choose or agree to a named nurse

Some women from the medium secure settings were also able to name individual members of ward staff with whom they had established a good relationship.

"I've had several primary nurses and you hope you're going to get on. It takes time to get to know them. It's easier if they make time for you and some haven't. Some you feel like you are pestering them to get them to talk to you. Some say they are too busy and you feel like a nuisance." (High secure)

"My primary nurse is quite good. We get on well. I've had four changes. This one makes a point of sitting down once a week and then gets things done!" (High secure)

Jo: feeling supported
You do have to push for support from staff but if you go to them, they respond. Best to talk to your named nurse if they are on duty as they're more important for you than even those in charge. Shifts have qualified staff and carers and your named nurse, you hope. I chose my named nurse - a man. He's really supportive and does help. In fact, I don't know what I'd do without him as he's easy to talk to. He plans trips with me, talks to the doctors about my medication and reports to meetings. The staff aren't bad - they don't bully and are mostly respectful. Not like the high secure I came from where you'd expect to get your arm twisted. (Medium secure)

Whilst almost a third of women described having established a good relationship with their designated key or primary nurse, they and others were likely to be critical of ward staff in general. There were also individual situations where relationships have not worked well and women identified the following contributory factors:

- *Staff did not make themselves accessible,* especially where they say they are too busy to talk
- Women felt *they were not being believed* and were told that as they were mentally ill, they must be making things up
- Staff showed *a lack of attention* and understanding
- Staff *treated women like prisoners* not patients
- *Younger staff were sometimes perceived as less sensitive* than older, more experienced people
- Women were *treated with little or no respect,* for example, in relation to seclusion; requests for help or practicalities and meeting women's needs

One of the main concerns women raised in relation to ward staff was the extent to which they felt they were *"expected to behave as adults but get treated like children"* (High secure).

"I don't know if you have a choice. They put your name on a board and that's how you find out. Not talked to beforehand. If they're going to be your primary nurse, they should sit down with us, to see our views, what we hope to get, see if we're compatible. Mine's not happy having got me as I speak up too much!" (High secure)

"I've only had one session with my named nurse in two months. She was on another ward for six weeks. Then when I asked - said too busy!" (High secure)

"Staff don't talk to me. When I want to self-harm, I can't go to them so I just go to my room and then I self-harm there." (High secure)

Mary: treated like a child
It feels like a nursery school - the routines, the discipline. I don't need someone to tell me to shower at a certain time and I hate it When they say 'if you were on the outside...'. I've been on the outside, I know what it's like. Here they treat people like children. I'm perfectly capable and I haven't lost the ability to manage. Some do need more control than others but you have to give people responsibility - you have enough taken away from you already. Why don't they wait until people show they can't make decisions for themselves and then take it away? (High secure)

Some women were aware that staff also felt similar constraints. Whilst they were critical of staff, they also said that, for example, staff shortages rather than staff themselves led to a sense of frustration amongst women when activities were cancelled. High staff turnover was a further concern where this resulted in a lack of continuity on the ward.

"The decent staff are being pushed out. There is only change but no progress." (High secure)

2. Clinical staff: Views about clinical staff (RMOs, Associate Specialists, Psychologists and Clinical Nurse Specialists) also varied and appeared to depend on how well women felt they got on with an individual. There appeared to be little difference between the views of women in high and medium secure settings.

In relation to *doctors,* where they were viewed positively, women again related this to being asked questions and listened to. In one setting, a new doctor was greeted with some incredulity because he came on the ward every day and chatted with women.

"Most wouldn't come into the day room and say hello. This new one - you can ask to see him, he asks you how you are and comes and sits in the day room!" (High secure)

For most, however, the experience was less positive and doctors appeared as distant figures in women's lives. Those who were more critical said they often did not actually get to see the doctor and at best they would see one every three to four weeks. Women often found it hard to get requests to see a doctor met by ward staff. Sometimes ward staff would relay queries to doctors for women. Whilst RMOs are responsible for decisions about women's treatment and discharge, many women said they had few opportunities to discuss their lives with them.

"They don't see you, they discuss you with the staff and the social work. You just hope and wait." (High secure)

Women were also concerned at how hard it was to hold an open dialogue which allowed them to discuss their concerns about proposed treatment and in particular, their medication. This needed "trust" and a "rapport" which they did not find. Many women described the impossibility of such a discussion and how, on occasion, they had sought a second opinion. Their experience was that these second opinions always agreed with the first. One woman described her reluctance to have ECT a year ago. She was told she needed it and decided to request a second opinion from a doctor who agreed with the original decision. She said *"I couldn't refuse as they make you go".*

"The new doctor is obsessed with medication and I had to go on it. I said I didn't want to and I asked for an independent doctor to come to a tribunal - he then agreed with the psychiatrist. If I don't take it now, they can force me." (High secure)

Women also talked about the *psychologists* they encountered in the secure settings. Whilst not all were clear about the difference between psychologists and psychotherapists, it appeared that well under a quarter (11) of women interviewed had seen or were seeing a psychologist. Their views varied. Some saw this as an opportunity to talk and resolve some of their issues. Others were less positive about their experience.

"The psychologist asked about my previous experiences of therapy. I felt I'd been asked and they were being quite sensitive to my experience of psychiatry." (High secure)

Indeed, across settings there were women who questioned why they were seeing a psychologist at all. They commented on the following:

- *The relationship between seeing the psychologist and their hope of discharge:* women in high secure settings were concerned that the only reason they had seen a psychologist was to fulfil a number of expectations pre-discharge. This was a wasted opportunity for support and they knew they could not refuse as too much depended on their compliance.

- *How far they could use the experience to work on their agenda rather than one conceived for them:women* described finding sessions unhelpful because they were unable to focus on the issues which were foremost for them. Thus, they did not find this time as beneficial as they might otherwise do.

"A psychologist wants to see me. I think she's a snob and treats me like a five year old. The RSU I'm going to say I have to do this. I don't mind if I get a better understanding but I don't want to be here any longer than I have to - so if they say see a psychologist, the quicker I get one, the quicker I get out!" (High secure)

3. Activities and teaching staff: women tended to speak favourably about the staff who ran educational and other day-time activities. Although some women found the classes and activities boring, they liked the staff. In all settings, they were described as approachable and accessible. One explanation for this was that these staff are independent from the hospital. A further view was that they enjoyed their work more than, for example, the ward staff. One of the few concerns raised was that these staff would be required to repeat what they heard from women back to ward staff and some women, therefore, felt they could not confide in them.

4.2 Finding support and someone to talk to

From the interviews, it was notable that women had very few opportunities to confide in others or find support. Some said they would not approach anyone for fear of not being listened to. Others found it difficult to ask for help when they needed it. The pool of potential support (including nurses, other staff and other women), was perceived as limited and where women did ask, they commented as follows:

Access to non-medical staff: although women spoke very favourably about staff in education and activities workshops, they did not see them as a source of support. As noted above, they in fact tended to approach named/primary nurses for help with a range of problems. Where an advocate was available, they provided a helpful source of support. The advocacy services were well received in the main.

"With the advocacy worker, you can put your complaint and talk to them. I see the worker as a friend. When I complained once to staff, it made things worse." (High secure)

However, some women were concerned that issues they confided to advocates may then be passed to ward staff which would have repercussions.

- **WISH staff** were noted as approachable and helpful. A number of women had WISH volunteer visitors and many more would have liked one. One woman said she too would like to volunteer for WISH when she left the system.

- **Other women providing support:** women in all settings were divided about how feasible friendships and support from other women were on the wards. The tendency was for some women to have one or two friends they confided in or whom they looked out for. However, it was also common for women to feel that either other women would gossip and therefore could not be trusted or that they were already burdened with their own problems so to confide would not be fair. The women who took part in a group discussion did so because they felt they had developed a level of mutual trust and they wanted to provide support as well as receive it. This appeared to be a relatively rare situation.

- **Women and friendships in mixed medium secure settings:** for those who were often the only women or one of very few, opportunities for support from other women were limited. These limitations centred on the lack of choice of women to make friends with and uncertainty about making friends with men.

"There are certain people I would count as friends. I might say if I was upset but not the detail. I assume they wouldn't be malicious but some are." (High secure)

Aysheh: taking opportunities for support
The one-to-one sessions can be very constructive but staff do play mind games with you here - it depends on who you see. I've had a lot of different nurses which is very unsettling. I can now go to my named nurse but that's because I like to keep my problems away from patients. They have problems of their own so they don't need mine and I don't want them knowing mine as well. It's not that I don't trust them but they may tell someone else and then the whole place will know. I have spoken to the advocacy worker which was useful, it managed to help me to change things at a personal level. (High secure)

Tessa: finding support in mixed settings
Mostly there's only two women on the ward. Mostly I go to staff and I do chat to the other patients. But I would prefer to be on an all women ward. There's safety and freedom to express yourself and it's easier if you're feeling vulnerable. The staff approach can be different on a female ward with more balance, they're more consistent.

The men are more macho, aggressive and competitive - they're always messing around. For example, when Grant on East Enders was threatening to hit one of the women in the show) the other men here were saying 'go on, hit her, she deserves it'. I found that disturbing. (Medium secure)

- **Visitors and visiting:** many women did have visits from family and friends on a regular basis. Others would have liked to have done so. Their importance was expressed as an ability to bring in the outside world. Whilst there were some criticisms about privacy, further issues women raised about visits included:

    - *Problems with smoking restrictions.* in one high secure setting smoking had been stopped. Women were unclear why this was the case and concerned that often it was their visitors not just them that wanted to smoke.

    - *Distance of setting from friends and family:* some women said that their families were just too far away. Many would consider mixed settings if this was closer to family and friends.

    - *Access hours for people who have travelled a long distance:* one woman described how her family, who can only visit twice a year because of the distance, were once delayed. They only had five minutes together before leaving as the visiting time was over.

    - *New restrictions placed on children visiting:some* women were unclear about new regulations. Hours and days had been changed and they perceived having less access. Women without their own children but who were close to, for example, nephews and nieces had stopped seeing them as a result.

Visiting medium secure units was a much less restricted event. The hours tended to be longer, there was greater privacy and any children were accepted on visits. Some women described being able to go home, both with and without escorts, or out with family for an extended visit.

The views women expressed in describing their relationships with others illustrated the importance for them of finding someone they can confide in, who can be trusted and who does not already have too many problems of her own.

“Visitors are important as you hear rumours in here so I like to hear about the outside world. It’s false in here, you can’t have a proper, a normal way of life. You can smell the fresh air on visitors - there are different smells from the outside. here it’s tobacco and that’s it.” (High secure)

“There are so many rules and regulations and you can’t talk freely when someone is behind you. The visits are very hard and inhibiting here on the ward - you watch what you say. In a big hall it would be easier as the nurses are not so close.” (High secure)

5. TREATMENT AND CARE: GAPS BETWEEN POLICY AND PRACTICE

Women said:

- **They were not well informed or active participants in developing care plans**
- **They saw them as part of a contract of compliance with goals set by staff**
- **They were concerned that non-compliance was linked to delayed discharge**

- **Most were taking some medication whilst few were receiving other types of therapy**
- **They were poorly informed about their medication and felt powerless to influence decisions**
- **There was little consistency about who got talking therapies**

- **They appreciated the benefits of talking therapies, if focused on issues they felt important**
- **They were concerned about the lack of choice to talk to a woman therapist**
- **Secure settings were not geared up to deal with specific needs including experience of child sexual abuse and self-harm**

5.1 What is a care plan?

All patients in psychiatric hospitals should have a care plan which has been discussed and agreed with them, addressing their mental health needs and preparing them for life outside hospital.

However, only just over half the women who took part in the consultation (32) even knew they had a care plan and even fewer said they had been involved in its development or review. Most women were either unclear or sceptical about both the nature and purpose of care plans. Only two of the women we met in high secure settings had actually seen and kept them. It was no surprise that some women questioned where the 'care' was in the care plan.

According to these women, care plans were linked here with rules and compliance rather than with treatment. This was because women did not describe them as jointly planned sets of aims and objectives relating to needs. Rather, they were presented as the embodiment of rules as well as non-negotiable check-lists of behaviour and activities related to compliance and possible rewards.

Descriptions of ***the content of care plans*** varied widely and included individual plans related to smoking, diet and education through to behavioural change and reduction in self-harm. It was notable how women did not see the plan related to how to achieve something, but only to a specific goal. How far they were agreed with women is unclear.

"The named nurse wrote my care plan and someone gave it to me to sign. It said something about knowing the ward routines but I thought you have the decency say 'here's the care plan' with time to talk." (High secure)

"The aim for me is to minimise or cut down self-harm, the objective is for me not to do it and then I sign it. It doesn't say how you're going to do it. The nurse does it, we're not asked then we read it and sign it. If it's not signed, it still goes against you as they say you are not complying with your treatment." (High secure)

"If you disagreed, they'd probably talk it over with you but if they feel strongly, they won't budge." (High secure)

- Women who knew about care plans identified a number of concerns.
  - The plans related to single problems rather than an overall set of aims and objectives
  - They rarely defined methods for achieving the intended aim
  - They did not offer a helpful method to women wishing to achieve their own goals
  - They were sometimes used against women, e.g. by being punished for not doing something in the plan rather than reviewing the appropriateness of the goal that had been set

Sarah: on care plans
I have one but nothing in it is finished. Some are for people who have to be checked on. Others are for smoking, dieting, cutting up, being abusive to staff or patients. I had one for my walkman and my diet but I don't know how they get drawn up. Are they useful? I don't know. It is one way for people who are a bit out of it. They keep an eye on them. They said you make your own care plan. They said it's like building bricks. It didn't feel like that to me. (High secure)

The situation in medium secure settings was similar and women described the plans as *'a load of waffle', 'rubbish'* and as *'having no goals to work toward"*. What differed was that women in medium secure settings did not perceive care plans as linked to compliance. However, they clearly did not see any benefits from a plan which had no goals and therefore no purpose.

"It (the care plan) means nothing. I was asked if I'd read it and I said I'm not a moron. But it had lots of contradictions so I took no notice." (Medium secure)

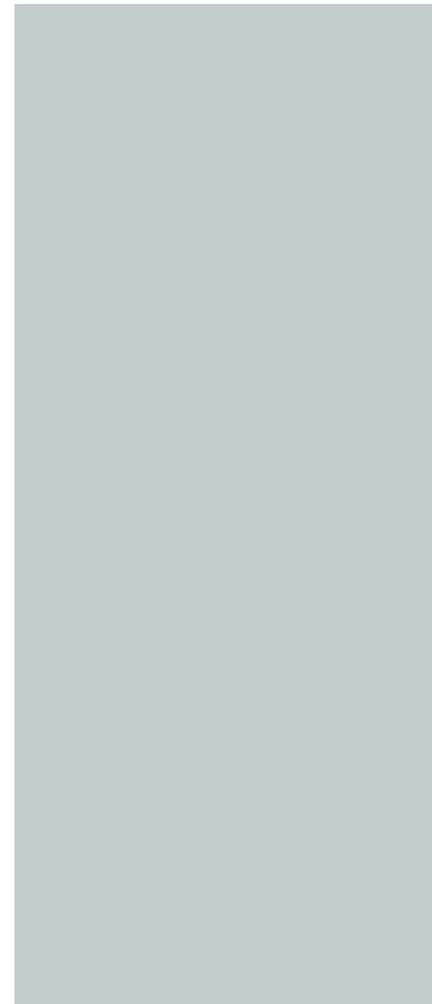
5.2 The range of treatment and therapies used

Choice in therapy, medication or other treatment such as ECT, was extremely limited and women raised the following points:

- Decisions about appropriate treatment were taken by staff with no consultation.
- There were few opportunities to contest such decisions. Where women did so, they said they were often ignored.
- Where women sought a second opinion, they were not surprised that it concurred with the original decision

"They (staff) told me to read the care plan and say what I thought. I'm not happy with it as it said there was the possibility of ECT. I said I didn't like it but was told I had no choice." (High secure)

Of the women who took part in individual interviews, at least two thirds were taking medication for their mental health but only one third of them were involved in some form of talking therapy.



- **Medication:** Only a very few women said they had any ***involvement in decisions about taking or changing medication***. Many did not know what they were taking, what side effects to expect or how long they would be on a certain drug. There appeared to be no room for negotiation even where women complained that they were, for example, tired all the time, gaining weight or felt unwell as a result of their drugs. The lack of choice about whether and what to take caused most concern among women particularly where second opinions were viewed as a method for backing-up the existing decision.

  A few women were aware that their medication had indeed helped their condition. They described being more in control of their lives and generally better able to cope. However, many others raised specific issues about the use of drug therapy which included:

  - The reluctance of doctors to discuss and change medication
  - The lack of information about the side effects of medication
  - The potential for medication to be forced onto women even where women believed they did not need it

  One woman described being put on medication after many years without it because her discharge was dependent on successful drug therapy.

Martha: on taking medication
There's no choice whether you take it or not You can discuss it and you might get a second opinion. Once I felt so sick, I felt I couldn't take the stuff but staff said they weren't going to let me refuse. I was sick anyway so it was a waste of medicine. I then had a new one written up and didn't know anything about it. I had to wait a week to discuss it. I think it did work a bit but it's cheeky to do it and not tell a person. What the nurses tell you is poor and you don't know much about what's happening. They don't tell you about the side effects but it's important to know. I had a fit once because of the drugs. If you know more, you have insight and understanding about what's happening. We're legal addicts now.
(High secure)

- **Talking therapies:** The number of women who had been or were currently seeing *a therapist or counsellor* was very low. They represented less than one third of women who took part in the consultation. At the same time, both some of those that had and those waiting to get therapy (seven women said they had been promised this) were clear about the potential benefits:

"No-one has ever discussed why I did my crime, to try and understand why I did it. Not to change me but to help me understand. I'd like someone to talk to." (High secure)

- An opportunity to talk about problems
- Learning to understand what they had done
- Finding ways of changing for themselves

However, therapy also raised less positive feelings and in particular, women said there was insufficient support after emotionally demanding sessions. They found sessions difficult and wanted to return to their wards knowing that there was some (informal) follow-up available. They described *"being left with the feelings and that there is no one to talk to"*.

Women who had experienced therapy raised a further set of concerns suggesting a high level of dissatisfaction with the service. These included the following:

- Lack of choice over male or female therapists
- Focus on understanding their crime rather than the context or underlying issues and previous life experience
- Attendance at therapy as an issue of compliance, i.e. in relation to discharge or other opportunities within the setting
- Lack of therapy related to child sexual abuse and self-harm

Three women in high secure and one in a medium setting said they had never been offered therapy. However, the most common response was that they had been offered therapy or even informed that they must have it but then faced a wait of months or even years. In addition to waiting a long time, some women were concerned about working with male therapists especially on issues which related to them as women. There was no choice of the sex of the therapist.

A few women had been involved in different ***therapy groups*** including arson groups and women's groups. The arson groups tended to be seen as useful in relation to learning new behaviours. Women described being able to *"hold a lighter"* or watch *"London's Burning on television"* without feeling out of control. Views of these and other groups varied and whilst some were keen to attend them, others were less inclined to share their feelings with others.

The women's group in one high secure setting was perceived as a useful place to talk about a range of topics including *"voices, fears and dreams"*. Here there appeared to be a sufficient level of trust for women to participate.

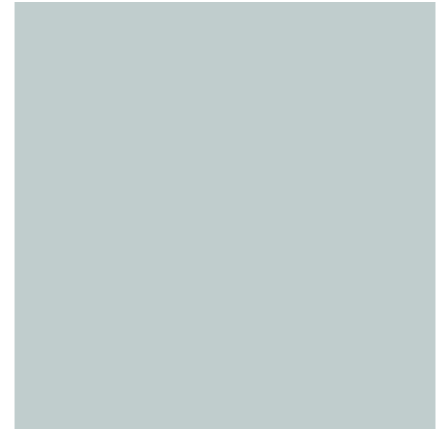
Women in the secure settings frequently talked of having self-harmed yet it seemed to them that the more they did so, the less likely they were to obtain therapy. In fact they were more likely to

“I’m finding answers now. I thought it was me all the time but I’m not blaming myself so much and I see I’m not the only one.” (High secure)

“If you let the feelings out when they see you for an hour, you’re then left to the next week.” (High secure)

“I didn’t want a man but I had no choice then or now. I was severely abused as a child so I didn’t want to go and talk to a 60 year old man.” (High secure)

“I said I’d like counselling about the sexual abuse when I was younger but it’s never been offered. The doctor said ‘the more you talk about it the worse it gets’ so I walked out.” (Medium secure)



be put in seclusion or therapy was put off until she 'behaved herself'. Some women noted that acts of self-harm, which led to being under observation, were missed opportunities for talking about their problems to staff.

Many women were critical of the paucity of talking therapies available; the difficulty of seeing a therapist even when recommended to do so and in particular, the inappropriateness of choices made by staff on their behalf.

6. LEARNING ABOUT THE CULTURE OF SECURE SETTINGS

Women wanted:

- **More participation in decision making on matters which affect their lives**
- **To be able to participate in meaningful consultation forums**
- **More effective functioning in existing consultation forums resulting in concrete outcomes**
- **Less male dominance of the Patients' Councils which discouraged women from joining**

- **Rules to be made explicit and explained**
- **Rules to be applied consistently**
- **Rules which focus on personal safety and respect of other people**

- **More effort to work with women rather than force compliance with the system**
- **To benefit from what was offered, e.g. therapy, rather than feeling punished by it**

Learning about the culture of individual settings began with a woman's experience of arrival. Clearly, different settings have developed different cultures. Where one was more open to women's participation in decision making, another was more likely to prevent them from doing so. However, across these settings there were a number of ways in which women shared concerns about the culture of the institutions.

6.1 Women being listened to and heard

Each of the high secure settings has a variety of forums in which women can participate. These usually include a Patients' Council (for male and female ward representatives), ward meetings and in two settings, a women's group. Knowledge of these activities was extremely variable.

Fewer than half the women interviewed in high secure settings knew of their existence and of those that did, only a handful said they understood their purpose. Amongst those who were aware of the *Patients' Councils,* some saw membership of and participation in such meetings as an opportunity to be listened to, to influence change and to make a difference on an individual and collective basis. Women believed that the principal of participation was a good one, especially to provide them with a voice.

The reality, however, had so far proved to be a disappointment and on balance, women perceived these meetings as yet further empty opportunities to be heard.

"It's a good idea because patients get to say what they want. Because the staff have their meetings, so it's only fair that we do." (High secure)

"The equal opportunities group has looked at why they pay less (wages) for females, and two or three times more for men. A lot don't like it, but it's a voice for the patients." (High secure)

They were not convinced about how they worked in practice and their main concerns about the Patients' Councils included:

- The ***male dominance*** of the Patient's Councils where women were often outnumbered. This led some to feel intimidated and unable to represent women's interests.
- Women commented that all too frequently that ***no notice was taken*** of what they said. This included requests for changes.
- Where change had been agreed through the Patient's Council or ward meetings, women noted ***the slowness of implementation.***
- They felt that the Patient's Councils were used as *a* ***PR exercise.*** In the wake of public concern about the high secure settings, one woman commented on the way in which the Council was put forward to that effect.

"It's used for the public. When stuff came out about the hospitals, they invited people, journalists in to meet the Council and show how the patients get everything heard." (High secure)

Grace: participation in the Patient's Council
I was on it for five or six years. The boss of it finally had it in for me and I had to get off. The Patient's Council is just power for male patients, slagging the staff off all the time - making it a real them and us. Patients forget what they are and where they are. When I went on, I thought it was about working with staff but there was nothing useful there. (High secure)

In two high secure settings, *designated women's groups* had been established and ward meetings were held as a further forum for discussion. Very few women we talked to had been involved in the designated groups and how they viewed them varied. In principal, women appeared to be in favour of a group for them and for some it was an opportunity to talk about issues and problems. For others, these sessions were nothing more than a chance to get off the ward.

"There are ward meetings and they (staff) say what we do and we say what we need but we never get things." (High secure)

Ward meetings, as a mechanism for being heard, were also viewed with some scepticism in two of the three high secure settings. Women commented that all too often issues were raised on several occasions to no effect and that the meetings did not produce results. In the third setting, however, one woman had been a ward representative for some time.

Meetings were held every two weeks with the Women's Services manager and without staff. She commented that she *"can get much more sorted out on the ward than through the Council".*

Medium secure settings had no formal patients' forum and were less likely to hold ward meetings. Women were unable to identify clear routes through which they could make complaints or requests other than directly to staff.

6.2 How rules get made, their purpose and use

Apart from two women in high secure settings who said they had been provided with a rule book on arrival, no others could remember being given anything. The consensus amongst them was that either they learn the rules through experience or rules are actually made up as they go along. This left women feeling confused and concerned about what they could and could not do from one day to the next. One woman commented that staff too were often unclear as rules could change so rapidly. In addition, some women suggested that the introduction of new rules should be backed by adequate explanation.

Some rules were seen as essential. These included rules about security, for example in tool shops and the use of sharp instruments in workshops. Women clearly valued discussion and flexibility around rules, and felt that ward meetings should and sometimes did provide ***an opportunity to change the rules.*** However, more often than not, it was considered impossible to influence how rules were established and implemented.

The key criticism women made about the setting and use of rules was the **lack of information or explanation.** They described many examples of this:

- When rules were changed, women in all high secure settings said they felt that they were neither ***consulted nor informed.*** Nor were they given reasons for the changes and were left confused. Several women described a scenario where someone would break a rule without knowing it existed and then get 'bawled out' for doing so.

- Some new rules had been made since ***staff were required to provide 24 hour care.*** Whilst the positive aspects of this were appreciated by women (such as access to their rooms, hot drinks at night and greater freedom on the wards), there were some concerns about how staff dealt with this.

- Rules which women feel have ***been made to suit the purpose of staff*** in particular the new room search procedures where women have been required to limit their belongings in order that staff can search within agreed time scales.

"I didn't get told about the rules. I don't know how you get to know about them. I just try to be good. I had to learn when I came in, I had to learn from my own experience." (High secure)

"Rules can be open to change for example, with managed observations on a care plan, it said we couldn't get up until 8.30 but if you're going to work and wanted a bath ... so I asked if we could get up and got permission to get up at 8.15 - it's negotiation. If we can give them some reason why, I know they will look at it." (High secure)

"It has changed for the better but now the problem is we're not sure where we stand. In the olden days, you knew what you had to do and what not." (High secure)

"We were told that if you abuse the staff you have to go to bed at 10.30. When I challenged the nurses, they just said it was a new rule." (High secure)

Ursula: how the rules work
In the evenings we could do what we wanted but then someone else came along and said we couldn't. Years ago, when you asked for something you didn't get it. Staff want things to go back. They don't like 24 hour care - the old rules made it easier for them. It's ideal for them if we're locked in or have to stop out (off the ward) as they wouldn't have to do so *much. Not many say things because if you do, they say you're causing trouble. They say there are ward policies and they're not going to change that. With new policies, we're told there and then. We're told there will be a few changes and we'll discuss it at the ward meeting - but they just sit there and say it - bang!* (High secure)

- Rules which ***vary between wards,*** for which the women did not know the reason. For example, in one high secure setting only one ward had a rule about smoking. These differences reinforced the perception that rules are made on an ad hoc basis.

"The hospitals should be treated individually. If one messes up, it should be dealt with but not then to the same to us." (High secure)

The medium secure settings appeared to vary in their approach to rules and rule setting. In one, women described and were concerned about the lack of rules. They felt that they could get away with almost anything and that, while on the one hand this allowed them a greater level of freedom, on the other they had no boundaries.

"There's no consistency and it's a problem having no basic guidelines." (Medium secure)

In other medium secure settings, there was a stronger sense of rules being in place and of punishment for breaking them. Rules included no drugs or alcohol or sharp objects as well as restrictions on certain behaviour. Women commented that there was less need for rules here.

6.3 The importance of compliance

Women in almost all settings said that compliance was expected in most areas of their lives from work and educational activities through to treatment and therapy. A number of women linked compliance or lack of it to their hopes for discharge from the secure setting. They said that the more compliant they were (regardless of how they felt) the more likely they would be in achieving their dream of discharge.

"I have psychotherapy once a week. It's hard. I don't want to have it but they say do I want to leave here? I need to have it to leave." (High secure)

- Many women described being put in ***seclusion*** when they were admitted to the hospital. They also described the use of seclusion as a punishment for certain types of behaviour. Some described going to nurses because they feared they would self-harm and instead of being able to discuss their fear, were taken immediately into seclusion. Others were concerned about the inconsistency of approach in relation to the amount of time spent in seclusion.

- In the same way women commented that they had little choice about treatments and therapy, they also suggested *that refusal to attend therapy or to take medication* could have a series of consequences. These included exclusion from social events; deductions from weekly income and a reduced chance of discharge. What confused them was the mixing of something which was meant to be good for them with something that felt like a punishment.

  For one woman, this proved to be extremely difficult and she found herself struggling with the desire to leave the setting and her belief that therapy was not able to help her.

"If you don't take your medication, they force a depot on you. If you refuse the depot, they deck you and jab you. You get a cross if you refuse like you get ticks if your room is tidy. It affects the money you get." (High secure)

Lakshmi: on compliance

There was no choice about therapy - they said I'd been assessed, they read the report and said if I don't do it, I won't get out. I didn't want to do it and I pulled out twice but I had to go back. I was under pressure to do so and they said I will benefit from it by understanding my offence. Again they said, if I pull out, I won't get out. But I can't see how it will be of use, it's pointless. If someone had just come in, she may need it but I've been in the system for eight years already. (High secure)

7. MIXED AND SINGLE SEX PROVISION

Women said:

- **They believed that men received preferential treatment**
- **They wanted to be on women only wards**
- **Whilst some preferred to be in mixed units they felt this was not appropriate in high secure settings**
- **They did not want to be placed in vulnerable positions**
- **They did not want to be on mixed wards when they were very much in the minority**
- **They wanted male staff to be respectful of them**

The debate about mixed or single sex provision is a complex one which women taking part in the consultation recognised. Their responses were not as simple as suggesting that one system was better than another. Indeed, for many it was a question of weighing up their priorities to see if one model was preferable and often they concluded that there were potential advantages and disadvantages to a variety of models. However, a clear message that came from all settings was that women did not want to be marginalised; they did not want to be made even more vulnerable than they already felt and they wanted to be consulted about the type of provision which was appropriate for them.

7.1 Difference of treatment of men and women

In the high secure settings women were frequently critical of the different treatment of men to women. They suggested that staff treated women more harshly and that men received privileges. They felt that men got off lightly whilst they experienced a more punitive regime, for example:

- Men are paid more for some work areas than women
- Men have more parole and greater freedom generally than women
- Men have more access to some facilities, e.g. the gym
- Staff are less likely to confront men who may be physically more threatening

"Men get away with it. If women do something they get a harder time. With drugs and if they suspect you, they do random urine tests, then we have to have visits on the ward, functions stopped and get searched. Never happens to blokes of six foot odd. Staff don't want to pick on people like that." (High secure)

Despite these criticisms, a view which emerged from the discussions was that most women would prefer to be in settings which reflected life outside, i.e. mixed. They were also clear that *the high secure settings were not ones which offered an appropriate mirror to the world.* Women's knowledge of men's offences made a mixed environment extremely difficult for them.

"It's more natural to mix male with female. All female is bitchy and all male is macho. But most of the women are wary of men in a place like this - a lot of them are rapists." (High secure)

They were often afraid of being in certain situations with men, of feeling vulnerable and open to exploitation.

As a minority, women often felt targeted by unwanted attention from men. Some said that on arrival, they received letters and notes from men who then were over attentive at social events. They said that as so many of them had experienced sexual and other forms of abuse from men, it was inappropriate for them to be placed in situations where, for all they knew, the men attending were rapists, paedophiles or sex offenders of other kinds.

"I don't like it. If you go out with men, you don't know what they've been doing. It's unsafe - men are a lot stronger than me, they think differently and they have different crimes to women - like rape and child molesting. They don't hassle me now as I'm past my sell by date! But women only is safer and more secure." (High secure)

Choice in the activities women pursued was limited if they preferred not to share with men. There were *frequent requests for more single sex workshops* and *social events.* Women's reasons for this included:

- Feeling uncomfortable as in the minority
- Fear of sexual harassment
- Feeling under pressure to respond to men's attention

Women were asked their views about two potential scenarios for high secure settings. They responded as follows:

- **Women only wards in mixed settings:** the existing situation was acceptable to some women provided single sex wards and women only activities and services were available. At the same time, these women were aware of the level of pressure men could place on them, the difficulties of conducting relationships within the setting and the vulnerability of some women. Some women felt that staff should give them more support when difficulties arose with men. However, nearly one third said they would prefer to be in this type of mixed setting if it meant they were closer to friends and family.

"It's the first time I've been on a ward with all women. It drives me mad too but it feels quite contained and I haven't felt like this before. I feel supported to say what I feel." (High secure)

- **Women only settings:** whilst fewer women said they would prefer women only settings, they were also very clear about the advantages to this. Their awareness of vulnerability and the way in which they sometimes felt less well treated led some to consider very small women only units as an appropriate option.

"I had one bad incident and now I feel unsafe, scared, vulnerable and isolated. It would be better if this was for women only - sometimes I don't even feel safe with the staff on the ward because they are men." (High secure)

On balance, these women were aware of their own and other women's vulnerability, yet in an ideal world believed in mixed settings. In reality, they were almost all concerned about the nature of men's offences, the possible risk they were placed at and the lack of support when dealing with harassment.

In the medium secure settings a different picture emerged. Some women were in women only units. Others in mixed settings, however, were placed on mixed wards with no other women, or small numbers of women and up to 16 or so men. Unlike the high secure settings, they had limited choice in terms of participating in mixed activities and sometimes experienced men as overbearing and potentially dangerous.

"There's sixteen of them and they dominate. I'm always having to stand up for myself and then I explode. The staff then say I'm violent and threatening" (Medium secure)

In one mixed setting, a woman had been more successful in ensuring a level of provision she considered appropriate. She had keys to a female bathroom and was entering negotiations to locking a sitting room set aside for her use. Staff encouraged her to complain to management and further changes had been made to create a safer environment. However, she also said it would be better to have other women on the ward.

"A few more females would be good as a mixed ward is natural. You have to mix with both when you get out into the community." (Medium secure)

In a different setting, women had less opportunity to have their requests met.

Pat: on mixed wards

I don't like the sexual banter that's directed at me. I was raped and sexually abused in the past so I just don't like it but there's nothing I can do. My key worker said 'well! That's men for you!'. There's no privacy here, no locks on bathroom doors, my bedroom is not separated from the men's so I never leave the door open because they'll just look in. I would choose an all women setting - there's nothing good about a mixed place. I want an all female ward, for staff to appreciate women's needs more and I want more dignity. (Medium secure)

Maggie: on mixed wards

I was in an RSU before. I've been the only woman on a ward of 14 men. It seems frequent in the medium secure units. I feel better off here. If you're a woman, there's some special services for women in the high secure places. In medium secure, they don't really want you there at all. They had a seclusion room and it came straight out onto the day room so you'd walk out in your nightdress with the men sitting there gawping at you. If they can't manage women appropriately, they shouldn't have women on the ward at all. (High secure)

7.2 Views about male nursing staff on women's wards

Wards in both high and medium secure settings have small numbers of male staff and views of this were varied. Women described events where they had felt physically safer with male staff and had appreciated male perspectives on particular issues or problems. Some women had male key workers or named nurses and said that they had established reasonable relationships with them.

"When I started therapy I wanted a woman. But the team nurse who is male made a difference. I had to go to hospital for a knee operation and he showed me respect.

I was sat in underclothes and a sheet and he left me alone." (High secure)

However, there were those who also said, had they been given a choice, they would have preferred a woman. They did not feel entirely comfortable discussing 'women's problems' with men.

Being treated with respect and being able to trust were clearly key to women who were prepared to accept male staff on the wards. Other women, however, described situations where they believed male staff behaved inappropriately. This was in relation to seclusion and room searches.

In a small number of situations women described being put into seclusion and having their clothes removed whilst there were men in the room. Another woman raised her concern about male staff going through her underclothes during room searches and believed they should be carried out by female nurses. Their wish was that, if there have to be male staff, they should behave in acceptable ways when working with women.

7.3 Finding a balance

It appeared that women in all settings were aware of their own needs in relation to mixed or single sex provision. Clearly, there were some women for whom mixed settings in their own view were entirely inappropriate. Others held views of more complex needs, recognising some advantage to mixed settings but again rejecting the idea of mixed wards. Some considered women-only settings as restrictive and leading to gossip and bitchiness. What they wanted included the following:

- To feel safe and respected
- To be able to resist or avoid unwanted attention from men
- Greater support from staff over incidents of harassment

In relation to male staff, some women saw the advantages of mixing with men in this way. As noted, it could provide an opportunity to develop positive and healthy relationships with men and indeed, some women had found male staff helpful in a number of ways. However, they also made it clear that male staff needed to understand something about them as women, to address their needs as women and to behave in ways that were appropriate and respectful.

8. WHAT WOMEN WANTED CHANGED

8.1 Structural, day-to-day and attitude changes needed

All the women who took part in the consultation were asked what their priorities for change would be. Much of what they said has been covered in earlier sections of the report. However, in addition to this, women's views on change were focused on the three key areas of services described below.

Structural changes: In the high secure settings, women suggested there should be:

- women-only units, not women-only wards within mixed settings
- better security for women in relation to men
- more staff on the wards to ensure women can participate fully in activities and the life of the ward generally
- greater freedom on and off the wards
- more opportunities for trips outside the setting as preparation for moving into the community
- wards which were more homely
- ways of ensuring that women who should not be there are able to move on quickly

"I want more freedom - to go to the drop-in when I like, to go to my room to get a drink and to go out for fresh air." (High secure)

"There are lots of fears of moving on as you get used to very tight security and may feel it's too open out there. More trips out would help us learn to cope in the community." (High secure)

Women in mixed sex medium secure settings were clear that the most important change for them would 'be to have women only wards if not units.

Day-to-day changes: Women from the high secure settings suggested there should be:

- greater choice of women-only activities and classes
- increased responsibility in making decisions which affect their lives
- appropriate talking therapies which concentrated on women's experience of sexual abuse and self-harm
- increased access to talking therapies
- relaxation of the rules about possessions kept in their rooms
- relaxation of the visiting rules

Changes to care and support: Women in high secure settings suggested there should be:

- changes in staff attitudes to women
- more understanding of women's needs
- greater respect for women

"It's the way they look at patients. If you have a disagreement, the patient always goes up and says sorry but we can't be wrong all the time. Someone asked 'how come these patients are always in the office?' I wanted to say 'without these patients, you wouldn't have a job!'" (High secure)

Once again, these women reiterated their wish to have dignity, to be respected and to be given responsibility within their daily lives.

APPENDIX A: CONSULTATION METHODS AND PARTICIPATION

Initial approaches: Prior to approaching individual women, WISH and UNL sought approval from management and ethics committees within the secure settings. This took some time and proved to be both a help (where useful suggestions were made) and a hindrance (where decision making was slow) to setting up the consultation. Once agreed, WISH managers and staff were able to discuss the exercise with ward staff and women patients.

Gaining women's interest and agreement: An introductory letter was provided to women outlining the purpose of the consultation and seeking their agreement to take part in either a group, an individual discussion or through a written submission. At the same time, women were asked to formally give their consent. Once obtained, each woman's RMO was asked to give their agreement that this was a suitable and appropriate exercise for their patient. Given the nature of consultation and the potential to exclude women through statistical sampling, an open invitation was issued to all women unless otherwise agreed as inappropriate by the RMO.

Access to women: the contribution of WISH staff made a fundamental difference to the consultation process. Women were clearly briefed and indeed, many were waiting for the interviews to take place and ward staff were usually aware of the nature of the visits and their importance. Different settings had different responses and there were some occasions where access could have been smoother. However, the interviewers were usually given opportunities to meet women in appropriate confidential settings and where this was not possible, was said to be due to a lack of private space.

Number of women participating:

Participation method	Interview	Group discussion	Written submission
High secure settings	36	6	4
Medium secure	10	0	0
Total*	46	6	4

Many of the women said they enjoyed the experience and were very enthusiastic about the process. Only a few seemed to find the interviews difficult as the result of tiredness caused by medication. We were led to believe that interviews would be brief. However, they often lasted between one and one and a half hours. All the women who participated seem to have fully understood the purpose of the consultation and the importance of their contribution. They were frequently open and trusting of us and the process. The women were offered the choice to have WISH staff present which some seemed to find reassuring. Others preferred to be seen alone. One woman requested to have a nurse with her and a second was required to do so after instructions from the RMO. As the woman wanted to go ahead, it seemed appropriate to continue.

Although the table above shows 56 participants, a total of 64 women initially agreed to meet us on these visits. The remaining women were either too unwell at the time or had revised their decision. Almost all women completed a short pro-forma which asked them for background information to see how far participants were representative of the total population of women in high secure settings (there was no medium secure setting comparative data). Given the anonymised information provided, it has not been possible to exclude the non-participants and data are presented for 53 in high secure and 11 in medium secure settings.

Representativeness of the sample of women in high secure settings agreeing to take part:

Characteristic No=50		Number & % of women		% of total women (1996)*
Age ranges	under 25	6	12%	12%
	25 - 34	20	40%	42%
	35 - 44	19	38%	27%
	45 - 54	1	2%	12%
	55 and over	2	4%	7%
	Not stated	2	4%	-
Ethnic group	UK White	46	92%	80%
	Afro-Caribbean	3	6%	12%
	Other	1	2%	0.4%
Main spoken language	English	47	92%	No information
	Other European	3	6%	
	Sign	1	3%	
Physical disability or health problem	Asthma	9	18%	No information
	Epilepsy	3	6%	
	Deaf	3	6%	
	Other	1	2%	
Mental health diagnosis**	Schizophrenia	8	16%	-
	Psychopathic/Personality disorder	18	36%	35%
	Mental illness & personality disorder	5	10%	9.5%
	Borderline personality disorder	3	6%	-
	Mental illness	1	2%	47%
	Mental impairment	1	2%	5%
	Mental illness & mental impairment	1	2%	1%
	Not stated	13	26%	-
Hospital	Broadmoor	18	36%	25% of total
	Ashworth	13	26%	39% of total
	Rampton	19	38%	29% of total
Section of the Mental Health Act	3	7	14%	26%
	37/41	33	66%	33%
	47/49	4	8%	9%
	Not known	6	12%	-

* Source: Special Hospitals Case Register 1996
** As defined by women

Characteristics of women in medium secure settings

Characteristic		No	Characteristic	No
Age ranges	under 25	2	Mental health diagnosis**	
	25 - 34	5	Schizophrenia	2
	35 - 44	2	Psychopathic/Personality disorder	2
	45 - 54	1	Borderline personality disorder	2
	55 and over	1	Bi-polar mood disorder	1
	Not stated	-	Not stated	4
Ethnic group	UK White	7	Section of the Mental Health Act	
	Afro-Caribbean	3	3	4
	Asian	1	37/41	6
			Not known	1
Main spoken language	English	10		
	Gujerati	1		
Physical disability or health problem	Asthma	3		
	Back problems	1		

** As defined by women

Validity of the data: This was the first systematic consultation of women in secure settings to take place and it has been vital to demonstrate that the data collected is robust and of a high quality. In order to achieve this, the two interviewers jointly facilitated early interviews to ensure common coverage and styles. WISH staff attended some and not other interviews and the data from samples of each have been checked for consistency in the coverage and range of views. An independent evaluation of the consultation has been carried out which will explore women's experience of the process. A report from this will be available with the final consultation report.

Data analysis: the data was analysed using Framework[1] which, through a system of charting enables within and across case analysis. Of particular importance were three over-riding issues and their inter-relationship which emerged for women during the consultation.

[1] Ritchie, J. & Spencer,L. in Bryman, A. & Burgess, R. (1994) **Analysing Qualitative Data** Routledge

APPENDIX B: TOPIC GUIDE

- *Purpose of the consultation* - to learn women's views about their lives in the setting. Currently, Government looking at how the needs of women are met in secure settings. Developing a strategy focusing on the services provided, preventing admission, rehabilitation and community support. Others are looking at these - we are interested in the service itself. Idea is to provide more options from services which are more accountable and working together.
- *Who we are* - not from the hospitals or WISH but completely independent. Both spend a lot of time talking with women like them as part of consultations and research about variety of issues
- *Discussion is informal,* takes about an hour and a half and is confidential
- *Use of tape recorder/note taking* (go through confidentiality statement/approach)
- *What happens to the information* - it will be complied into a report feeding into a wider national strategy
- *What women patients get from it* - chance to give views and receive a digest of findings

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Women's likes and dislikes:
- one/two things like about setting
- one/two things don't like about setting

Admission: first impressions
- buildings/environment
- attitudes
- role in what was going to happen
- how individual input made a difference

Daily routines:
- describe a typical day/typical activities
- *food and meals*
    - choice of what and when
    - views of this
- *social activities*
    - choice of what do
    - views of activities: mixed/single sex
- *education/training*
    - choice of what do
    - views of training/attitudes of staff
- *therapy and counselling*
    - choice of what do
    - what means to women
    - views of therapy/attitudes of staff
- *medical and drug treatment*
    - choice of having/not having drugs/other treatment
    - information provided about treatment
    - raising concerns about drugs/treatment effects
- *visits from friends and family*
    - choice of who/when/how
    - privacy/levels of access
    - views of visiting arrangements
- *informal support*
    - who go to/how easy
    - when/where find support/enough time with people
    - preferred ways of spending time

Use of care plans:
- care plans at start and now
- initial involvement
- how involved in changing/reviewing plan
- what means to women to have a plan

Rules in the service:
- do they know what they are
- how do they find out
- who decides what they can do
- what happens if break rules
- appropriate/inappropriate attitudes
- women's input to how behaviour dealt with
- role of Patients' Councils
- unnecessary rules/new rules needed

Mixed or single sex settings:
- what's good about mixed/what's not good about mixed
- advantages of mixed/single sex (whichever not in now)
- disadvantages of mixed/single sex
- if have choice, which would they choose
- reasons for choice
    - safety/risks
    - social
- access to female staff/clinicians/views of staff

Location of hospital:
- close/far from relatives and friends
- difference makes to women
- what's more important service or location

Change and improvement:
- what prevent them/others coming here
- what is important to keep in the service
- what needs to be changed

APPENDIX C: References

Lart,R. Payne,S. Beaumont,B. MacDonald,G. & Mistry,T. (1998) **Women and secure psychiatric services: a literature review** NHS Centre for Reviews and Dissemination, University of York

Stafford,P. (1999) **Defining Gender Issues: Redefining Women's Services** WISH