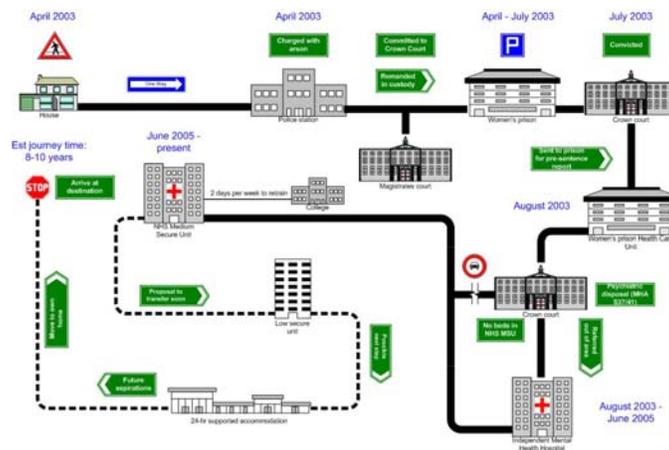


My life: in safe hands?

Summary report of an evaluation of women's medium secure services (2009)



Introduction

In 2000, there were 39 medium secure services in England. Of these, almost all were mixed provision with only 14 NHS and 79 independent sector medium secure beds in dedicated women-only services¹. By 2009, there were 27 dedicated women-only medium secure services (nine independent and 18 NHS) with a total of 51 wards and providing 543 beds (261 in the independent sector and 282 within NHS services)². There was at least one service in each health region of the country; with six in the North-West and only one in the South-West. Of the 27 services, 19 had a gender-specific care pathway with either a women-only rehabilitation or pre-discharge ward, or a women-only low secure or step-down service. Four of the 27 services were women-only sites with five on mixed sites but with no regular mixed activities. Seventeen were on sites where some activities were mixed.

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

Setting the scene

The quality and safety of secure mental health provision for women has been the subject of wide ranging discussion noting that women in mixed-sex services have been disadvantaged by their minority status. They have also experienced the adverse effects of gender and other inequalities on their treatment and care.

Successive policies across the Criminal Justice System and mental health have argued the need to provide gender sensitive services which help to reduce women's offending rates, respond to the specific needs of women and ensure women's safety in single-sex provision.

The more recent development of medium secure services for women, supported by the Department of Health, was a response to the perceived vulnerability of women which has resulted in a variety of research studies, policy developments and operational changes in service provision. Developments included the closure of all but one high secure service for women, the opening of three Enhanced Medium Secure Services for Women, the setting up of four pilot residential high support therapeutic services for women, the expansion of women-only medium secure services.

Service provision in England

Two separate mapping exercises for this evaluation (in 2006 and 2009) showed there was considerable variation across women's medium secure services in terms of the type, size and range of provision. In January 2009 there were 15 NHS Secure Services and eight independent hospitals providing medium secure care for women in single sex wards. These were women-only services or women-only units within mixed secure settings providing a total of 386 beds across 38 wards. Independent sector services tended to provide a higher number of beds for women. However, they also had more than the recommended number per ward/unit.

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

Women's journeys through the service

Key factors affecting women's routes to recovery were determined through the use of repertory grid technique³ to elicit the elements (people involved in enabling their care) and constructs (how women discriminated between their experiences of and relationships with all the elements/people). Women's 10 most frequently referenced factors were:

- Relationship with staff
- Trust
- Positive expectations
- Empowering approach
- Reducing isolation
- Good daily support
- Relational security
- Holistic approach
- Meeting emotional needs
- Offering a range of interventions

There was consensus among service users and professionals about the most important attributes of a women's medium secure service in relation to recovery.

Philosophy, models and policies in practice

Essential to service provision was the development of a coherent and thought-through **model or philosophy of care**. The case study services had adopted a variety of approaches including

Attachment Theory, Mentalisation, models of therapeutic communities, gender-sensitive approaches, the Tidal Model and RAID (Reinforce Appropriate, Implode Destructive). Where there was no clear model in place, staff and women described more tension, confusion and a higher number of difficult incidents. Staff in these services were also less likely to receive regular support and supervision.

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

Single sex policy and provision

At the centre of the DH Women's Mental Health Policy⁴ was the importance of offering women safe places to work towards their recovery including access to women-only services where appropriate which meet their needs. There was agreement across women and professionals about the importance of single sex provision although this varied in the case study areas. Some women preferred single sex wards but wanted the opportunity to mix with men in off-ward areas. Male staff were considered important in providing positive role models although it was not always easy to find men who wanted to work with women service users.

Women's safety and security

Women and professionals involved in their care were clear, regardless of terminology, about the importance of a number of key factors and in particular **relational security** which underpinned what services should work towards. For this study, relational security was defined as embodying high staff-to-patient ratios, time spent in face-to-face contact, a balance between intrusiveness and openness and working towards high levels of trust between patients and professionals. However, the initial survey showed that policies about relational security were only in place in half of services. In the case study areas, services described ways in which their practice aspired to or was already consistent with this definition even if they did not use the same language to define what they experienced. However, there was considerable inconsistency and even where a policy was in place, staff were sometimes

unclear about what this meant in practice. Women described what they valued about the service in terms consistent with the ideas underpinning relational security. This included:

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

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

Day-to-day for women

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

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

be intrusive, one-to-one observations helped to ensure staff were available to provide escorts and be involved in on and off-ward activities.

Services offered a range of **interventions, treatments and therapies**. They were concerned that women found ways of talking about their traumatic experiences despite varied views about the type of psychological therapy to provide and when it should be offered. In addition to psychological therapies, some offered specialist therapies from healthy living to eating disorders. Formal, structured timetables were mixed with informal leisure activities and across services responding to the initial survey almost two thirds of women took part in community outings, shopping and social events. Women and staff recognized the value of 'informal' activities. Women wanted to do what was 'ordinary'. Some staff and other professionals saw this as having a therapeutic potential in the same way that more formal interventions were intended to have.

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

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

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

A further aspect of day-to-day life for some women

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

Care pathways, planning and discharge

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

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

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

Women service users and professionals agreed that there was a lack of suitable move-on accommodation. Access to rehabilitation wards or low secure services was severely limited. This had resulted in a bottle-neck situation until such time as appropriate provision could be provided. In January 2009, only 12 of 27 women's medium secure services provided a rehabilitation ward and just over half (14) had access to their own low secure services. There was some evidence of increased support provided by

community forensic teams to enable women to move into the community.

Day-to-day for staff

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

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

Building on experience

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

Delivery of differential care to meet the specific needs of women

1. **Philosophies of care** for working with women were embedded within the daily practice of most case study services based on gender sensitive practice, promoting a psycho-social

approach taking account of the context of women's mental distress and acknowledging the impact of trauma and abuse on women's mental health.

2. **Staff recruitment policies** aimed to achieve a 7:3 female to male gender ratio, with male staff providing positive role models for women, although not all services had managed this yet. They also sought to appoint ward staff with an active interest in and desire to work with women, and in most areas, the induction and on-going in-service training included women's mental health issues and gender specific practice.
3. **Dedicated psychologists for women's services** were able to undertake formulation-based assessments and treatment planning incorporating psychological and social perspectives acknowledging the importance of the woman's story and life experiences and seeking collaboration with the woman, with her views and objectives being noted.
4. **Purpose-built facilities** as stand alone or attached to main mixed-units usually offered structured programmes of therapeutic gender specific activities as well as women being able to access mixed-sex sessions if available and appropriate.
5. **The Assessment and Care Planning Approaches** in place suggested that some were formulation-based encompassing a biological, psychological and social perspective and acknowledged the woman as an expert in her own "story" providing a basis for women to feel they were involved in their care planning.

Maintaining women's psychological and physical safety

1. **Relational security** was well provided for in most case study areas within regular professional practice by staff members on the wards and the strong therapeutic relationships they built with the women. Staff were provided with opportunities to develop reflective practice and were supported to develop therapeutic relationships within appropriate professional boundaries through regular group and individual supervision.
2. **Extra Care, Intensive Nursing Suites or High Support Areas** on women's wards allowed women who were acutely ill to be cared for

away from the main ward area. These areas were used as a short term facility only. They provided women who were acutely distressed and at risk of harming themselves or others with a safe but comfortable environment without the need to isolate them completely, but where intensive nursing input and emotional support from staff was available to them.

3. **Clinical nurse and other specialists** were employed within some women's services providing risk assessment, care planning, support and therapeutic and educational interventions for women who, e.g. self injure, as well as advice and support to members of the team involved in their care.
4. **The gender sensitive practice** developed on wards supported staff to work towards de-escalation using means other than control and restraint techniques for managing women's behaviour and it was reported that the use of these techniques had become less frequent.
5. **The physical layout of the women's wards** was more likely to have been designed to allow zonal observation within the main day areas as an alternative to intensive one-to-one observations, which women often found intrusive.
6. **Team nursing approaches** were developed across most women's wards so there was always a member of each woman's team on duty who was familiar with her care plan and individual formulation.

Facilitating recovery for women, rehabilitation and resettlement

1. **Seamless care pathways** Having identified the need for a gender-specific route out of medium secure care, some services worked with regional teams and commissioners to develop a seamless care pathway for women. Several wards worked with *internal care pathways* for women with markers for progress. One service began the process pre-admission. Another described its access to a Community Forensic Team for women who required this support once discharged from the inpatient service.
2. **The therapeutic treatment approaches** on some women's wards meant that women were supported to develop knowledge and awareness of their own mental health needs. This was facilitated by the women being given the opportunity to explore their life stories and

experiences in their own time and within the context of a trusting therapeutic relationship, to reach a shared understanding of how this impacted on their mental well-being.

3. **Women service user involvement** in service planning and development had enabled some women to take on responsibility for facilitating user group meetings and being representatives at external user networks and meetings.
4. **Social and vocational opportunities** In one service, women had access to a voluntary organization commissioned to provide education and work-related training and social opportunities including, for instance, office work, desktop publishing, participation in the running of a social club/café for service users and advice about external training and career opportunities. Women were also contributing to decision making about ward and other activities in some areas.
5. **Provision of family/child visiting suites** appropriate for children were seen as a considerable improvement on previous facilities.

Structural and organisational factors

1. **Multi-disciplinary teams** brought key staff and women service users together in decision-making processes. Staff across case study areas appreciated the value of this model of working.
2. **Streamlining administration** wherever possible from referral to discharge helped to ensure a smooth pathway into and through a service. This included new computerized systems for recording information and completing CPA documentation. One service worked with staff on how they wrote reports to reduce judgmental language and improve the overall balance of their reporting.
3. **Monitoring activity** was required in all services to provide data to commissioners and/or parent organisations. Several had introduced additional ways of capturing service delivery, e.g. through satisfaction surveys in one case designed with women service users, staff training needs analysis and take up of training and support, as a means of service development. Two case study services were developing research to determine meaningful ways of measuring outcomes.

Professionals and women service users also identified significant gaps and areas where there was room for development and improvement. On the

basis of the case studies and review of documentation, we have listed a range of areas which policy makers and service providers may wish to consider for future development.

CONSIDERATIONS: Processes

Models of care:

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

Referrals and admissions:

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

Care plan development and implementation:

- The *development of individual care plans needs to be consistent* within individual services. Training for staff on the care plan approach with clearer guidance would help to ensure greater consistency.
- The *implementation of individual care plans* needs to be consistent to avoid patchiness of provision, e.g. situations where rehabilitation for some women was compromised due to the lack of availability of staff.

- There is a need for *gender sensitive risk assessments and for histories of abuse* being adequately taken into account in the development of care plans.
- The recent guidance on CPA⁵ recommends that in future *service users are placed at the centre of the CPA* process and are fully involved in reviewing their own care plans.

Discharge planning:

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

Meeting diverse needs:

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

Practicalities

Environment:

- Due to the new Standards⁶ for medium secure services there is now a requirement for 5.2 metre perimeter fence for all medium secure units, including women's services even if this is not seen as appropriate. However, *environmental security is still important* and should be emphasized due to the risk of self harm.
- Policies need to be implemented which address how to deal with *environmental risk and its review*.
- Services not in purpose build units need to consider *how best to provide zonal rather than one-to-one observations*.

- Wards need to have 10 and a *maximum of 12 beds*.

Activities/OT:

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

Service user involvement:

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

Staffing:

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

Training and supervision:

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

Primary care:

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

to a female GP and Practice Nurse, and to appropriate screening and well-women services.

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

enable many women with multiple needs take their lives back into their own hands.

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Authors

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