Working for change

Liz Mayne, Director of WISH (Women In Secure Hospitals) talks to **Mary Eaton**.

WISH was set up in 1990 as the only national charity working with, and on behalf of women, primarily in high security hospitals, medium secure units and prison psychiatric

units. We have two main objectives. First, to support women within the system and to work constructively with staff and managers, to improve the quality of their care and treatment. Our second objective is to work to influence change for women so that dedicated gender-sensitive services are developed to meet the needs of women requiring security. Certainly I feel there has been a positive shift, since I became the Director of WISH, which is nearly three years ago, and we are at the stage of cautious optimism. At least, we are at the stage where there is an acknowledgement that there needs to be a dedicated service for women and there is considerable evidence now that the needs of women requiring security are not being adequately met within the current system. More women are detained at a higher level of physical security than is necessary and this is a major civil rights issue. Even four or five years ago the conservative estimate was that 78% of women in high, only require medium, physical security and 69% of medium, actually only require low security. There are significant gender differences in the social and offending profiles of women that need to be fully acknowledged in the planning and development of appropriate services.

In 1996 the High Security Psychiatric Services Commissioning Board - which assumed purchasing responsibility for high secure care, with a remit to develop a new commissioning strategy - held a seminar jointly with WISH with leading people of different disciplines within secure psychiatric services. The report from that seminar formed the basis of an initial strategy for women, which was submitted to Government in Autumn 1998, and it plainly stated that there needed to be a dedicated service for women and that the views of women should be listened to and believed.

Since that time, there have been other relevant developments. First, it has been agreed that each of the high security hospitals should be incorporated into an NHS Trust, which means that they have to come into line with standard practise within mainstream mental health services. And secondly, purchasing responsibility has been transferred to the NHS regions and this means that those NHS regions hold the purse strings for high and medium secure care and it's logical to assume that they will scrutinise the kind of service that they are receiving. Certainly we are planning to work with those emerging commissioning teams in the NHS regions, to encourage them to scrutinise the services. During this time there have been other developments and there are some emerging women-only units. Regrettably the private sector seems to be taking the lead in this area. The first women-only unit was opened in Chesterfield nearly two years ago - Hazelwood House, run by 'Pastoral Homes' - and they are due to open a second women-only unit in the Midlands in September. There's another women-only unit, also in the private sector, in Milton Keynes, although it is a ten-bed women's unit within a larger unit containing three ten-bed units for men. There are plans to start to open women-only units in the NHS, but it's a lot slower.

At government level there's now a definite process within the NHS executive. The plan is to have a service strategy in place for women, to be submitted to the Minister for Mental Health, before the Christmas recess. There's a recognition of the wider issues that can impact on women's mental health. Obviously some issues are more pertinent to women particularly self-harm, domestic violence and sexual abuse; but in the wider arena, there are issues like poverty, homelessness, unemployment, health. While I welcome the process of considering the mental health needs of women in a wider context, I have some reservations that the tight timescale won't do justice to this broader based process. In addition, although it is positive that they are exploring those broader issues, which is in line with governmental concerns about social exclusion, I hope that this won't mitigate against the development of a very specific service strategy for those women who are currently detained and suffering within the system as it stands at the moment.

WISH is actively involved in the Women's Project Panel which is assisting the NHS Executive in the national strategy process. It is very important that WISH is in there doing all we can to influence and to ensure that the strategy fully addresses the specific and different needs of women patients. Certainly in terms of the view of John Hutton, who is the Minister of Mental Health, the high security hospitals and the secure mental health services in general, because of the greater numbers of men, are not well suited to the needs of women. A high priority has therefore now been given to the preparation of strategies for more suitable services for women, so that services will meet their individual care and treatment needs and provide security arrangements which are appropriate for the degree of risk they are deemed to present.

There is obviously a range of

key issues that need to be taken into account in the development of services for the women, but one issue which is raised continually is 'should it be women only or should there be a degree of integration?' We feel that these very damaged women need to be cared for in women-only units, at least until they get to the stage in their recovery process, where they can begin to build up their self-esteem, and have a sense of their own identity, so they are actually at the stage that they can make safe and informed choices about whether they want to mix with men and have relationships with men. We feel it is important for them to have the experience of positive role models and therefore, of course, it is important to have male staff, but male staff who are positive role models. There are gender issues to address both with women and men staff. You often find it is the female nursing staff who are more likely to patronise or infantalise the women.

Women patients represent only 16% of the high secure population and 10% of medium secure. I'm afraid to say that we are still supporting women in medium secure units where they are the sole woman. We feel that there has been a dramatic increase in awareness from medium secure units, that the needs of women are not being met, when they are in such a tiny minority. We are trying to ensure that all the medium secure units that we work with have a basic written set of standards that should be in place for women; basic things, like locked rooms, separate bathing facilities, choice of female primary nurse, or therapists. If there are not enough women to have a women-ward, at least within the unit, there should be a women-only space.

We also need written sexuality policies and I'm afraid to say I am still seeing some draft sexuality policies which condone sexual relationships between men and women patients in the unit. Women with severe and prolonged abusive histories have only learnt to relate sexually with men and men patients are often serious sex and violent offenders. Too many units are condoning it rather than being pro-active to ensure that it doesn't happen. To a woman bereft of benefits, to have regular sex with a male patient in exchange for cigarettes is a straightforward and necessary transaction. The concept of 'consensual' sex is outside her frame of reference. Does this represent the NHS's concept of care and treatment for a deeply disturbed and damaged woman? I don't think so.

Women do have very serious security needs but it is not such an issue of physical security. They need a high intensity of care with a much greater emphasis on relational security, building up strong and trusting relationships with their carers. What we get all the time is that women are difficult and challenging, that they are more aggressive and violent than men. From WISH's point of view, the two indicators that women are not receiving the care and treatment that is appropriate are the high levels of self-mutilation and the levels of assaultive behaviour on the wards.

In the early years, WISH's growing credibility and influence came from the organisation's knowledge of the women through close and consistent contact with them. More recently, we have recognised the need to spearhead collaborative projects[1] to strengthen and inform the argument for change. Currently the first formal patient consultation exercise is underway with women in high, medium and low secure care to ensure that their views and opinions are fully considered as part of the national strategy process. Women patients must be listened to and believed. ■

Liz Mayne is the Director of WISH (Women in Secure Hospitals).

Reference:

1. Eaton M. and Humphries J. (1996) *Listening To Women In Special Hospitals* was produced as a result of collaboration with WISH and is available from the authors at St. Mary's College, Strawberry Hill, Waldegrave Road, Twickenham TW1 4SX.

WISH (1999) *Defining Gender Issues: Redefining Women's Services* is based on an analysis of the high security hospitals' Case Registers. The report is available, price £5.00 from WISH, 15 Great St. Thomas Apostle, London EC4V 2BB.

Listening to women: research with women in secure hospitals

Julie Humphries argues that the 'lived experience' of women patients in secure hospitals is too often ignored by those in charge of their care and treatment.

Little is known about women patients in Broadmoor, Rampton or Ashworth. What is known is based largely on the view of psychiatrists or other health care professionals. This article will draw on a pilot study[1] and argue that it is time for innovative research to be undertaken with this group of people so as to ensure that their lived experience plays a role in developing policy and practice for their care and treatment. Up until this present time, far too much emphasis has been placed upon professional's accounts of the women and their experiences and too little attention paid to the women's own views and perceptions.

There are two issues which are key to carrying out research into women in special hospitals. Firstly it is important that women have an opportunity to talk in their own words about what is important and significant to them; and secondly, that they be able to discuss this with professionals who are not involved in medical treatment and who have no other influence over the women's lives. To date most

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research on women in special hospitals has been conducted by psychiatrists. There is a power relationship between psychiatrist and patient which cannot be eliminated in the interview situation. Women are likely to perceive that there is a 'right' answer and to fear the consequences of a wrong answer. One of the issues that was continually raised in most of the interviews was the patients' feeling that they could not tell the truth to their psychiatrist because they feared information and evidence would be used against them when their reviews or tribunals took place. One woman said: *they only hear what they want to hear and I've learned that over the years, so you tell them what they want to hear.*

In this research we wanted to obtain a picture of these women patients from them, rather than from the views of medical professionals, psychiatric records and case notes. Much of the research carried out so far has been quantitative in nature, which whilst undoubtedly valuable, is very limited in providing explanations. Statistical data, for example, informs us that a large proportion of women self harm and are aggressive towards staff, but is unable to provide information on the reasons for this behaviour. It is important that research seeks the patients' views and thoughts on their behaviour, in order to gain an understanding of what treatment might be able to help these patients. A paradox is that one of the reasons given for the proportionately high number of women special hospitals patients is that they are there because of their aggressive behaviour, yet little is being done to try and understand this behaviour and the reasons for it.

Listening to women

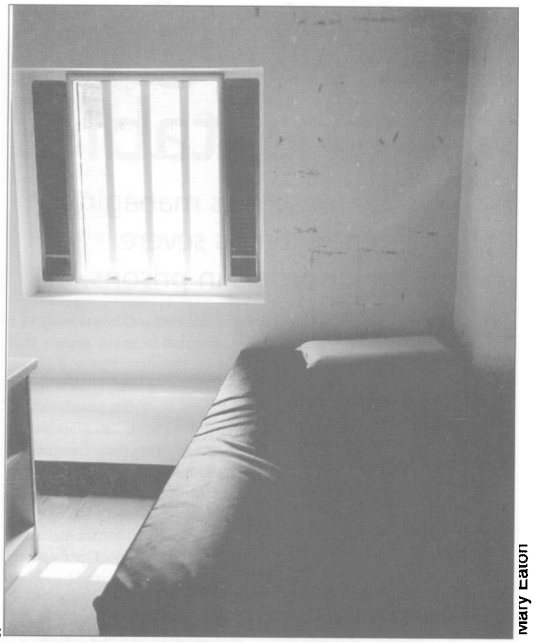
The aim of this research therefore was to explore the women's views of their lives. One of the common themes throughout this research was the women's frustration at not being given the opportunity to interpret or explain either their behaviour or experience. Instead, we found events had been interpreted, or misinterpreted by psychiatrists, while the meanings the women would give were ignored. All of the patients interviewed felt strongly it was important that the psychiatrists listen both to their account of the events and also, to what those events meant to them.

One of the women interviewed felt that psychiatrists had misinterpreted events which were not significant to her. For example, her psychiatrist said that she was abused by her husband and by her mother, but her interpretation of events was different: *in their way they were both rather selfish people and they both expected adoring love, I mean but I can't really see that's abuse. They tried to make out that I was abused as a child and connect it.*

Another patient felt that her psychiatrist prioritised information provided by other members of her family. The psychiatrist subsequently based his interpretation of her behaviour on their account of events and not hers: *They've got a lot of information on me that actually came from my family and my family had no better idea than I did at the time as to why I acted or behaved or said the things that I did.. Yet they (the professionals) seem to take it at face value.*

This patient recounted a story of a fight with her sister and how the sister had told the doctor that she believed she would be killed. However, the patient explained in the interview that this was not her intention; it was just a fight. Moreover she did not accept the explanations which were given for her behaviour: *I was never asked why, they simply told me that this is why I had done it, that it was strong feelings about my mother, but it's like nothing to do with my mother, I mean I was totally flabbergasted, where does my mother come into this?*

In these instances, and in many others, the patients are not asked for their interpretation of the events. They are often not asked, either, to provide explanations for their behaviour. Patients frequently referred to doctors listening to anyone other than the patient themselves. One woman said: *they don't ask you, only what other nurses have put and what other doctors have put, but they never ask you why you did something, they don't get to know a person, they get to know a past of a person and that's it.*



Mary Eaton

"I was never asked why, they simply told me that this is why I had done it."

Respecting the patient's voice

Overall, women are expressing resentment at a construction of their lives which disregards their point of view. Failure to listen to women has several consequences. Women feel that because they are not listened to psychiatrists are only seeing them in relation to their past, and that because of this psychiatrists only see the negative side of them. Not listening is also obviously linked with women not receiving the care and treatment they need. Patients frequently complained that they hardly ever see their psychiatrists and when they do it is just for five minutes; they are: *always too busy*. As with any patient seeking treatment, women want to be respected sufficiently to have their point of view listened to. They want to be given the opportunity to provide their own explanations for their behaviour. A patient cannot be effectively treated if they are not given an opportunity to express their own thoughts about themselves and their behaviour.

Our research has shown that there is a real need for the patients' subjective interpretation of their behaviour and experiences to be heard. Listening to women's experiences and their views of these experiences is paramount in gaining an understanding of these women and their behaviour. As WISH have commented, women are not receiving the care and treatment they need and this is indicated by the high proportion of women who self harm and their assaultive behaviour on the wards. It seems that one of the ways to improve the provision of care and treatment would be not just to take into account the women's experiences but for women to feel their views and thoughts are respected, valued and given the significance that surely is any patient's right.

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***Julie Humphries** is Lecturer in Sociology, St Mary's College, Strawberry Hill.*

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1. Eaton M. and Humphries J. (1996) *Listening To Women in Special Hospitals* was produced as a result of collaboration with WISH and is available from the authors at St. Mary's College, Strawberry Hill, Waldegrave Road, Twickenham TW1 4SX