A move from ‘What’s wrong with this woman?’ …

...To ‘What happened to this woman?’

Informed Gender Practice
Mental health acute care that works for women
July 2008
**Informed gender practice: mental health acute care that works for women**

**Jennie Williams, Jennifer Paul, National Institute for Mental Health in England**

**June 2009**

**PCT CEOs, NHS Trust CEOs, SHA CEOs, Care Trust CEOs, Foundation Trust CEOs, Medical Directors, Directors of Nursing, Directors of Adult SSS, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Communications Leads, Inpatient ward based staff, multi-disciplinary teams, commissioners**

**Voluntary Organisations/NBPs**

This best practice guidance is intended to support improvements in acute inpatient care for women. It progresses implementation of the women's mental strategy, complements generic health and mental health guidance and is part of a resource portfolio to assist poor performing trusts as per the findings of the Healthcare Commission acute inpatient mental health service review.

**Women's Mental Health: Into the Mainstream (DH 2002) and related implementation guidance (DH 2003), Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse (DH 2006), From Values to Action: The Chief Nursing Officer's review of mental health nursing (DH 2006), Laying the Foundations (CSIP-NIMHE/DH Estates 2008)**

**Sue Waterhouse**
National Lead for gender equality and women's mental health
sue.waterhouse@londondevelopmentcentre.org
07966-620291
### Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>2</td>
</tr>
<tr>
<td>Forword</td>
<td>4</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Purpose</td>
<td>5</td>
</tr>
<tr>
<td>Sources</td>
<td>5</td>
</tr>
<tr>
<td>Who is this guidance for?</td>
<td>6</td>
</tr>
<tr>
<td>How to use this document?</td>
<td>6</td>
</tr>
<tr>
<td>2 Background</td>
<td>8</td>
</tr>
<tr>
<td>Acute inpatient care</td>
<td>8</td>
</tr>
<tr>
<td>Why gender informed care?</td>
<td>8</td>
</tr>
<tr>
<td>3 Gender informed service principles</td>
<td>10</td>
</tr>
<tr>
<td>First principle: equality</td>
<td>10</td>
</tr>
<tr>
<td>Second principle: knowledge and commitment</td>
<td>12</td>
</tr>
<tr>
<td>Third principle: relationships</td>
<td>12</td>
</tr>
<tr>
<td>4 Gender informed service provision</td>
<td>14</td>
</tr>
<tr>
<td>Safety</td>
<td>14</td>
</tr>
<tr>
<td>Physical safety</td>
<td>14</td>
</tr>
<tr>
<td>Sexual safety</td>
<td>15</td>
</tr>
<tr>
<td>Adverse incidents</td>
<td>16</td>
</tr>
<tr>
<td>Ward based practice</td>
<td>16</td>
</tr>
<tr>
<td>Information sharing and gathering</td>
<td>16</td>
</tr>
<tr>
<td>Power and control</td>
<td>17</td>
</tr>
<tr>
<td>Language</td>
<td>17</td>
</tr>
<tr>
<td>Partnership working</td>
<td>19</td>
</tr>
<tr>
<td>Relationships</td>
<td>19</td>
</tr>
<tr>
<td>Women as parents</td>
<td>20</td>
</tr>
<tr>
<td>Healthcare</td>
<td>21</td>
</tr>
<tr>
<td>Not only gender</td>
<td>21</td>
</tr>
<tr>
<td>Women from BME groups</td>
<td>22</td>
</tr>
<tr>
<td>Women asylum seekers &amp; refugees</td>
<td>23</td>
</tr>
<tr>
<td>Guidelines to enhance the care of lesbian women</td>
<td>23</td>
</tr>
<tr>
<td>5 Structure and culture of services</td>
<td>25</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>25</td>
</tr>
<tr>
<td>Board level leadership</td>
<td>25</td>
</tr>
<tr>
<td>Policies and procedures</td>
<td>26</td>
</tr>
<tr>
<td>Service development</td>
<td>27</td>
</tr>
<tr>
<td>6 Gender informed workforce</td>
<td>31</td>
</tr>
<tr>
<td>Recruitment</td>
<td>31</td>
</tr>
<tr>
<td>Training and education</td>
<td>31</td>
</tr>
<tr>
<td>Finding the words</td>
<td>33</td>
</tr>
<tr>
<td>Staff care and clinical supervision</td>
<td>35</td>
</tr>
<tr>
<td>7 Concluding points</td>
<td>37</td>
</tr>
<tr>
<td>Resources</td>
<td>38</td>
</tr>
<tr>
<td>References</td>
<td>41</td>
</tr>
</tbody>
</table>

### List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
</tr>
<tr>
<td>CHRE</td>
<td>Council for Healthcare Regulatory Excellence</td>
</tr>
<tr>
<td>DRE</td>
<td>Delivering Race Equality in Mental Health Care</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>HCC</td>
<td>Healthcare Commission</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
</tr>
<tr>
<td>MHAC</td>
<td>Mental Health Act Commission</td>
</tr>
<tr>
<td>MHF</td>
<td>Men's Health Forum</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NIMHE</td>
<td>National Institute for Mental Health in England</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
</tr>
<tr>
<td>NSPCC</td>
<td>National Society for the Protection of Cruelty to Children</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Psychiatrists</td>
</tr>
<tr>
<td>SCMH</td>
<td>Sainsbury Centre for Mental Health</td>
</tr>
</tbody>
</table>

If you wish to find out more about this document, make any comments or want more information, please contact Sue Waterhouse, National Lead, Gender Equality and Women's Mental Health Programme: sue.waterhouse@londondevelopmentcentre.org
Executive summary

Acute inpatient care is an essential part of mental health services. This has not been diminished by the expansion of community services and with presentation of increased severity of illness on admission ‘getting it right’ has become ever more critical.

Women and men’s needs

This guidance describes why and in what way women’s needs are different from men’s and how this affects their experiences on the ward, acknowledging the diversity of women who will become inpatients. The needs of men are not specifically addressed, although the need for informed gender practice for men is acknowledged and there is transferability in many of the points made.

Safe effective inpatient treatment

Inpatient treatment will only bring maximum benefit if it is felt to be safe, respectful and accepting. This can be achieved when

a) there is a commitment to equality and a just and transparent use of power

b) staff are supported to gain the skills and knowledge to practice in gender informed ways, able to respond to disclosures of abuse and understand the relationship of these experiences to observed behaviour, and

c) consistent and non judgemental relationships between staff and patients and within the staff group are the central element of engagement and recovery.

Who is the guidance for?

The guidance is aimed at multi-disciplinary teams who work with inpatients, their managers and commissioners of acute inpatient services. It should also be of value to community based staff, to women with experience of using acute care and to user groups that advocate for their interests.

What does the guidance do?

The guidance encourages all staff to take an approach that promotes understanding of a woman’s journey.

Core principles

The core principles of informed gender practice are equality, knowledge and commitment and relationships. The multi-disciplinary team must have a shared understanding of the ways that gender inequality can harm mental health – especially through a woman’s experience of violence and abuse – and be willing to address these as part of recovery.

Ward experiences

For many women the ward environment feels unsafe, particularly so if they have had previous experience of violence and abuse. Staff need to make clear that intimidation, harassment or aggression of either a physical or sexual nature by anyone living or working on the ward will not be tolerated and that sexual harassment is treated just as seriously as physical threat.
Management of risk

Risk assessment and management should be routine practice, staff should be aware of ‘trouble spots’ on the ward such as mixed social areas or those at a distance from the office and if an adverse incident does take place, it must be investigated and the potential psychological effects as well as physical effects taken into account.

Best practice

Ward based practices can make all the difference to a woman’s positive experience. These can be the availability of an induction pack, appreciation of individual differences in interpersonal, physical and psychological boundaries, understanding and working with coping strategies which challenge some ward practice, collaborative working between staff and patients, creation of an environment where secure, professional relationships empower engagement and exploration of the salient aspects of women’s lives.

Women are often mothers too. Their mental health problems may have impacted on their confidence in parenting or their ability to become a parent. It is important therefore to address these concerns as part of therapeutic intervention. Good quality physical and sexual health screening should be accessible, contributing to the restoration of a woman’s sense of well being.

Diversity of need

Gender may not be the only determining factor to consider. Women who use mental health services are not a homogeneous group. Additional inequalities can arise from class, minority ethnic status, sexual preference and age. Women from black and minority ethnic communities, especially those who are recent migrants and asylum seekers, may have more difficulty accessing services. Language difficulties, family shame and honour or services that feel alien all need to be overcome.

Successful change management

Organisational endorsement at the most senior level is a necessary condition for success in changing practice. This includes board level leadership and championship and building in values and principles systemically through clinical governance and the acute care forum. Services have responded to policy recommendations in the creation of women only spaces within wards but physical adjustments must be accompanied by changes in staff culture and attitudes. This guidance and others referred to in the full version offer support for these staff changes.

Staff training and education

Inpatient based staff represent a huge resource for women in distress and so it is crucial to enhance their confidence and skill. This can be achieved through training and education on equality and gender issues at pre-registration, induction and continuous professional development stages and should include input from women with experience of using services. Working in an informed gender practice manner is more satisfying and effective but also more emotionally intense and demanding. It is essential therefore to support practice through clinical supervision and mentoring.

Resources, tools and references

The full version of the guidance elaborates on all the points above and gives a range of pointers, exercises, resources and references to support achievement of evidence based best practice for women inpatients. The online version (www.nimhe.csip.org.uk) also includes endnotes to further assist in the identification of specific documentation. All these tools can be used by ward based teams as part of team meetings, an away day, working with the trust women’s lead and other identified champions as well as for individual study and reflection.
Foreword

As any woman who is a mother, daughter, sister, aunty and/or partner knows, we have a unique role and responsibility within society, our communities, families and amongst friends. Therefore when we break down in some way, society, communities, family and friends all have an interest in what support can be provided for us, and indeed, how that support can enable us to regain our confidence.

Working in partnership, within the right environment and where people can be ‘alongside’ us, offers a way back to who we are in essence. “At some point we can then resume life’s ordinary associations” (Henry Hawkins founder of Together: Working for Wellbeing 1879).

Of critical importance for women who access services in acute care are the lessons learnt and shared within ‘Informed Gender Practice: mental health acute care that works for women’ which when used effectively can bring about the beginning and continuation of positive change. The work that has gone into the writing of this document and within the National Gender Equality and Women’s Mental Health Programme Board has enabled a particular and very important perspective to be explored.

All people involved in supporting and receiving services, particularly those whose distress reaches a crisis, will be pleased to see the efforts placed into providing this guidance. Service users are becoming involved in a range of settings from board level through to running regular patient councils on wards. These developments are a great opportunity to highlight the positive aspects of working in partnership. All too often, when we are involved on a day-to-day basis, we get little chance to stand back and consider what is working and where improvements can be made.

Doing nothing is not an option. To not talk about, not consider and not take practical steps is as active a way to not deliver what we need as any other form of discrimination. I would urge people to get active, start discussions and take practical steps. A starting point would be to read on.

Anne Beales MBE  
Director of Service-user Involvement, Together  
Member of National Survivor User Network’s management committee  
Member of National Gender Equality and Women’s Mental Health Programme Board
Purpose

This document explains why and in what way women’s needs are different from men’s and how this affects their experience on the ward. It offers guidance to busy and hard pressed multi-disciplinary teams (MDT) on best practice in relation to care and support to women as inpatients.

It encourages all staff to take an approach which promotes understanding of the woman’s journey.

MOVE FROM
Basic question
What is wrong with this woman?

TO
Better question
What has happened to this woman?

This present guidance builds on that work by directing attention to the practicalities of providing gender informed care in inpatient settings. The guidance supports:

- the implementation of the Gender Equality Duty which places obligations on public services to ensure their policies on services and employment address the different needs of women and men, to eliminate unlawful discrimination and promote equality of opportunity, and
- local service improvement plans relating to gender equality resulting from the findings of the Healthcare Commission’s review of acute inpatient care, due to report in Summer 2008.

Sources

This guidance draws from a range of sources, which include:

- the experiences and views of those who use and provide inpatient services, including those from diverse backgrounds and BME communities
- relevant government reports and reviews
- related guidance from the UK and other countries
- the extensive literature on women’s mental health, and
- CSIP facilitated consultations.
Who is this guidance for?

This guidance is aimed at ward based staff from multi-disciplinary staff teams, their managers and commissioners of acute inpatient services but the content is very relevant to all inpatient settings. It should also be of value to women with experience of using acute care, and to user groups that advocate for their interests.

Don’t be put off reading this guidance if you are primarily concerned with the provision of inpatient services to men. There is ample evidence through the Men’s Health Forum and other references that men need gender informed services too, and this guidance should give you ideas about the ways forward.

How to use this document

It can support ward teams already developing gender informed care by signposting to resources and other relevant material in the field. This includes the academic literature referenced at the end of the document. The online version (www.nimhe.csip.org.uk) also includes endnotes which guide the reader to detailed references contained in the text in recognition that an increasing number of staff in acute care settings are interested in research, and in assessing the evidence base for their practice.

However, if taking different specific needs of women and men into account in delivering care feels new to you and your colleagues or you are finding them difficult to implement because of other demands, then this guidance may help by:

- Setting out why the provision of gender informed care is so important.
  - The Women’s Mental Health Strategy is an obvious starting place, so too is the Gender Equality Duty, and
  - Look at other key references mentioned in this report especially those that give voice to women service users.

- Earmark time to discuss this guidance and its implications with your colleagues e.g.
  - make ‘Gender Informed Care’ a standing item on the agenda of your team meetings, and
  - use it as a focus for an away day.

What women say about using acute care

If you haven’t done so already read some of these publications:

- Brent User Group, 2006 – a survey of women’s experiences
- Gilbert et al, 2004 – a focus group with South Asian women
- Jennings, 1994 – a woman describes her daughter’s experiences
- Patiniotis, 2005 – key issues from perspective of women users
- Perkins, 2006 – experiences of women and men service users
- ReSisters, 2002 – a survey of women’s experiences
Work in partnership with women service users:

- gender informed care needs to be developed in partnership with women service users, as individuals and as groups.
- the suggestions for change identified here mainly originate from women with first hand experience of using services, or have been refined in discussion with them and they should remain central to the process of change, and
- working in partnership also helps staff to stay on track and to get clear feedback on their efforts.

Ownership

Before embarking on any initiative try and ensure it is owned, not only by women service users, but by all the crucial stakeholder e.g. direct care staff, the MDT and service managers.

Developing gender informed practice is very satisfying because it works but it is not always easy. Gender and other inequalities thrive on invisibility so it can feel uncomfortable and threatening as well as liberating to draw attention to them. Prepare for this by doing some research to identify the people you can call upon for advice and support. Check the CSIP/NIMHE website for details of who in your region can offer support, especially if there is a regional lead for gender equality and women’s mental health. Find out too if your trust has an identified clinical lead for women’s mental health and utilise the Acute Care Forum.
Acute inpatient care

Inpatient mental health services are stimulating, busy and challenging places within which to work. The shift to predominately community based services has intensified the demands placed on inpatient staff who now work with a higher proportion of people who are very distressed. These days service users are usually only admitted to an inpatient care setting when in crisis and many are detained under the Mental Health Act. Staff have to continually tread the fine line between ‘looking after’ patients – meeting requirements arising from the law and/or their duty of care – and enabling them to take responsibility for their own lives and actions through partnership working.

Progressive modern services have close integration between crisis resolution/home treatment teams and acute inpatient services, ensuring that acute care is an integral part of person centred pathways to recovery. Services where care and understanding define the relationship between staff and patient is not only what patients’ want but staff report that it is rewarding to work in services where these values are achieved or aspired to.

What staff say

Staff nurse

“I felt my skills were at a standstill and came on this ward because I wanted support to practice from a gender perspective. The work here feels real – I know I make a difference.”

Why gender informed care?

It is still the case, as has been reported by the Mental Health Act Commission and others that admission to an inpatient ward can be a very frightening experience for a woman especially for those from cultures where there is little mixing with the opposite sex outside of the family. Gender informed practice in mental health services shares much in common with gender informed practice in other organisations and settings that are now required by law to provide fair and equitable services.
However, there are additional complexities that need full appreciation because gender and other inequalities have the potential:

- to harm mental health
- to affect how people experience and express mental distress
- to affect how psychological distress is understood, and
- to affect how mental health services are accessed and experienced.

A high quality service will be one where everyone who contributes to the service is:

- knowledgeable about the ways that gender, race and other inequalities can be detrimental to mental health
- willing and able to help service users talk about their gendered lives and experiences
- alert to and challenges the ways that gender and other inequalities undermine the safety and quality of services.

### Making a difference

What was it about M (staff nurse) which enabled Jane to begin changing her life? Among the important elements were patience, willingness to witness Jane’s life story, continued respect for her as a person, a sense of safety, and firm maintenance of appropriate boundaries in a way which never overrode human warmth.


These changes are beginning to happen, but studies find that most direct care staff still feel poorly prepared to help and support people whose distress is rooted in their experiences of disadvantage. Staff recognise that gender linked oppression, exploitation, trauma and abuse affect mental health but are unclear a) what the effects might be, b) what might aggravate or alleviate them and c) how psychological distress and damaging behaviours in everyday living may be rooted in childhood relationships and traumas.

Additionally, many mental health workers report feeling anxious and concerned that if they begin conversations with women that this will ‘open up a can of worms’ and have unmanageable and damaging consequences for women patients as well as for staff. Staff readily acknowledge their own fears of being ‘flooded’ with painful and disturbing stories; of not knowing how to ‘put the lid back on’ and of ‘stirring things up’ to no therapeutic benefit.

Staff of inpatient services represent a huge resource for women in distress and so it is crucial to enhance their confidence and skill at a time when there is clear evidence, as noted by Johnson et al (2004) that gender informed staff can really help women find their pathway to recovery, and that this is what women patients want. Leadership, guidance, training and relevant supervision is clearly needed to boost the confidence of many mental health workers to provide safe opportunities for women to talk.
Core principles

1) Equality: power used openly and fairly
2) Knowledge and commitment: staff able and willing to bring a gender informed perspective to their work
3) Relationships: staff authorised and supported to place relationships with patients at the centre of services

A service must have a shared understanding about the damage caused to mental health by inequality and abuse and have a common philosophy about how this should be taken into account. The distinguishing features of such a service are identified below; these gender informed principles share elements in common with other client centred approaches such as the Tidal model and trauma focused approaches developed in the US.

First Principle: equality

The challenge is to provide a service where there is a tangible, wholehearted commitment to equality and the just use of power shared by the staff group, the MDT and the patient group so that the service as a whole is safe, respectful and accepting.

The need for equality is the logical consequence of evidence that:

- social inequalities and of trauma experienced in unequal relationships with people who have power over them are the root cause of many people’s mental health difficulties, and
- the quality and safety of mental health services is impaired when gender and other inequalities are treated as irrelevant.

Feeling equal

We weren’t looked down upon because we had mental problems... it was great, to see the staff eating with you. It shows you that we’re not monsters.

Quoted by Johnson et al, p. 255

Building a partnership between those with power and those who use services is, therefore, essential.

In services committed to equality, staff are always looking for better ways of working with patients. Community meetings, for example, offer the means of genuine coming together of staff and patients to develop joint solutions, and to ensure that everyone can contribute to the way the ward is run. Below you will find some ideas about how to start thinking together about the issue.
Once you’ve done this – if you haven’t done so already – take a look at the Star Wards Initiative handbook. Although it doesn’t specifically address the needs of women as a group it is full of really good suggestions, pages 44-45 are particularly useful.

Second Principle: knowledge and commitment

Staff need to be well informed about the ways that inequalities are implicated in distressing experiences. They should also be aware of their possible relationship to behaviour, expressed or observed, that brings women to mental health services. Staff need to become competent and confident in translating this knowledge into practice; especially their relationships with women patients. This will go a long way to reducing staff anxieties of talking to women about their lives and experiences.

Ways of gaining this knowledge include:

- training and education
- Listening to women survivors talk about their lives and experiences;
- reflecting on personal experience of gender and other inequalities, and
- supervision from, and working alongside gender competent staff.

Your growing familiarity with gender inequality needs to be accompanied by the development of knowledge about the effects of other social inequalities such as race and class. A broad based understanding is crucial to meeting the needs of women who are multi-disadvantaged by inequalities including those from BME communities, older women and women with communication/mobility needs.

However, knowledge and understanding may not be enough. There needs to be leadership and a service-led commitment to translating this knowledge into practice: staff providing gender informed direct care need authorisation, support, and for their achievements to be acknowledged and valued.

Third Principle: relationships

It is consistently and frequently documented that women and men who use services want relationships with staff that are based on mutuality and respect and that this is central to the process of engagement and recovery.

Prioritising relationships

As we strive towards an all-encompassing state of evidence-based practice, the centrality of a loving, caring, containing relationship in challenging circumstances can easily become misplaced or, at worst, lost. The therapeutic work, which involves these characteristics and is evident in the acute care setting, is often taken for granted, as it all too often remains hidden in the mundane nature of everyday activities.

Deacon et al, 2006, p.755

In respectful relationships the exercise of power is transparent and used in a woman patient’s interest; the relationship is consistent and predictable and with a key worker of the gender of her choice. She is safe from abuse, shame and blame. Any tensions and differences in viewpoints are worked with openly, not closed down by staff.
These qualities should characterise all relationships a woman patient has with staff, however brief they are. Relational security promotes recovery and feelings of self esteem, well being and social inclusion.

Such relationships support change and development in staff as well as women patients. Staff can:

- learn from vivid life stories of women’s experiences
- value a woman’s strengths and resilience and the ways she has managed to survive her life
- shift the focus away from diagnoses and problems towards hopes about her future
- validate a woman’s choices and experiences and helping her find a pathway through services that works for her
- Provide opportunities for women using services to help each other, and
- take steps to ensure that feedback from women patients informs the development of the services.

CASE STUDY
gender unaware practice

A woman with the diagnosis of schizophrenia is receiving care management and medication from a community mental health team. She usually keeps appointments but after her step-father dies she becomes much less reliable and her care manager is worried that she may have stopped taking her medication. An assessment by the outreach team is requested. During the visit she is uncooperative and very abusive and eventually she is sectioned and admitted to the local psychiatric hospital. She appears frightened, and spends her waking hours muttering to herself and doesn’t want much to do with anybody. After complying with her medication regime she is discharged. There is brief mention in her notes that she might be a survivor of physical and sexual abuse, but no one who is part of her inpatient or outpatient treatment has felt in the position to be able to give her opportunities to talk about her past.

Naming Service Commitment to Equality

Book time with your staff team to answer the following questions.

How can we demonstrate to women patients that we are committed to equality and the constructive use of power?

- through the ways we relate to them
- through the ways staff relate to each other, and
- through the day to day life of the ward.

Then take the results to the next ward community meeting and ask for comments and help in getting it right.

This exercise is from the Working with women with mental health needs course provided by Inequality Agenda www.inequalityagenda.co.uk
CASE STUDY

gender informed practice

Myra, a 24 year old woman, is admitted to an acute admission ward from A&E because of her escalating levels of self-harm. She is evidently depressed, drinks heavily and takes any soft drugs that come her way. Her children have been taken into care, she has been the victim of domestic violence and she is heavily in debt. On admission the nurse takes time to develop rapport with her, and makes it clear that she is more concerned with helping her to feel at ease than completing the form she has in front of her. She is told that although this is a mixed sex ward, both staff and patients have signed up to make the place as safe as possible for everyone; and that they are proud of their record on safety. Myra accepts the offer of a woman key-worker who she meets later that day. Over the next few weeks they meet regularly. Her key worker shows a real interest in hearing about her life which is a painful and difficult story. She feels respected and gradually things begin to make sense, including some of the reasons behind her drug and alcohol use. It is the first time anyone had used the word ‘abuse’ to describe the behaviour of her father and her boyfriend – it was a huge relief. Although Myra is described as sometimes clingy and desperate, her key worker remains firm and kind and supports her to gradually take more responsibility for herself including her self-harm. The key worker is clear from the start that she will only be sharing Myra’s journey of recovery for a short time, and they plan for her discharge together. This includes: working through the detail of how she will keep herself safe when she leaves hospital; getting legal advice* about the way her children had been taken into care and about rights as a parent, linking her up with a community group for women survivors of violence and abuse; and liaising with a domestic violence worker to explore her housing options. She is in debt to the sum of £15,000 and found it very helpful to see a debt advisor while staying on the ward.

* She found help through the Rights for Women Website www.rightsofwomen.org.uk

I’m Over Here!

by Tracey Hayes

Excuse me, can you help…?
Don’t worry, next time you are passing will do
Can we talk now?
Ok it’s time for breakfast
I just wanted to…
“Medication, Please line up”
Later then maybe
Can you spare me a few moments?
“It’s time for OT now, sorry!”
Have you got a moment?
“Time for lunch”
Is it possible to have a chat?
“Medication, please line up”
Can I have a word please?
“Perhaps after Badminton”
It doesn’t matter…Why did I bother?
“Dinner time, line up”
“Time for your medication, orderly queue please”
“Hi, I have not got long as it’s the end of shift soon, you wanted a word?”
Just wanted to know what day it was?

© Tracey Hayes 2006
4 Gender informed service provision

Safety

1) Physical safety

Women and men experiencing serious mental health difficulties have a vastly greater risk of being victimised or exploited in relationships than the general population. These risks can be located in their families, communities and the services they use.

Staff need to make clear that violence and abuse is not to be tolerated by anyone living or working on the ward, that there is a commitment to minimise risk and to respond appropriately to any untoward incidents. No one should ‘put up’ with verbal abuse or physical violence in services or anywhere else, though it is documented that staff may underestimate the extent to which their services are unsafe for patients and indeed themselves.

The legacy of abuse and trauma for some women is a sense of violation of the body as well as the mind. Staff in a gender informed service will be alert and sensitive to the possibility of these feelings. They will be mindful that professional and ward based practice may reactivate feelings of threat, insecurity and trauma related distress.

The importance of staff remembering this when they undertake routine and day to day tasks has been strongly emphasised by women with experience of using inpatient services. It is for this reason that relational security is so important and in undertaking practices that infringe personal boundaries such as intramuscular medication, physical or intimate examination, restraint and observation staff should be mindful of the potential for reawakening dormant or unexpressed feelings. It is regrettable to note that a recent survey by the Royal College of Psychiatrists (2008) found that only 32% of nursing staff had received on-going competency training in observation practices.

Care planning and advanced directives are opportunities to find out from a woman about the ways in which she would like situations requiring restraint to be managed. In all situations physically restraining a woman should be a solution of last resort, involve mixed gender staff group who should log such interventions.

There should be a follow up with the woman patient the next day to discuss why restraint was necessary and for her to talk through the experience. A staff team committed to reducing the level of physical restraint should take heart from research which shows that involving patients and staff in a partnership of safety does make a real difference.
Few services have ideal layouts which for many women would be single sex wards. The majority of wards were commissioned and designed before current understanding and thinking about the impact of the physical environment on person centred approaches to health and well being, safety, privacy and dignity. Increasingly however new build and refurbishment is taking place and guidance by CSIP-NIMHE/DH Estates (2008) addresses gender issues in relation to physical configuration. It is important that:

- staff are fully aware of trouble spots such as kitchens, mixed social areas, clinic rooms, laundry room and areas which are located at a distance from staffed office
- safety and security is not managed by locking areas, except where appropriate e.g. a clinic room
- staff are alert to conditions that affect the risk to women of assault such as general dynamics on a ward, specific needs of individuals, staffing levels, time of day e.g. not making assumptions that there is a safe time of night and distractions such as an emergency admission or incident or visits to the ward
- handover is used to raise concerns, to maintain awareness of the potential for vulnerability, to regularly review risk management plans and the measures to be taken, to note and share changes in level of risk, and
- women patients are encouraged to talk about their safety in the service either as individuals or in groups, and that staff listen to what is said.

Greater awareness and information gathering about these issues will support managers to campaign, organise and fund appropriate services. This will require analysis of the impact of such issues to support the development of relevant business cases.

2) Sexual safety

The National Patient Safety Agency report (2006) gives an indication of the extent of incidents and makes recommendations for practice improvements in both preventing and responding to incidents that undermine the sexual safety of women and men. Sexual intimidation and violence should not receive greater tolerance than physical threat, and we can draw lessons from responses to physical violence. Complaints and incident reviews which take a gendered analysis are also a powerful way of raising the profile, highlighting concerns and getting action to prevent similar occurrences.

About consent

I do know that sexual relationships happen in wards. Most of them have not consented, either because people are on medication and stuff or because someone feels such a victim that they would just think ‘well this is what’s supposed to happen to me’.

Staff member quoted in Nelson and Phillips 2001, p

In the past staff have not always assertively intervened to manage risk of or discourage actual sexual activity. Staff working with women in mixed gender wards or settings need to be very clear about what defines consensual sex, most crucially that a woman needs to have the capacity to consent. Not being clear about these matters adds to the risk that women will be victimised or re-victimised. The Royal College of Psychiatrists (2007) online publication is a useful resource for exploring these issues. It is also important to acknowledge that women patients’ sexual safety and wider exploitation is not an issue that is restricted solely to the patient population. Despite professional codes of
ethics, misuses of power – including sexual exploitation – still occur between staff and patients. It is important that staff know how they can help prevent these problems and also what to do should they arise\textsuperscript{32}. The Kerr Haslam report (DH 2005b) gives recommendations in this regard.

3) Adverse incidents

When assessing the degree of harm caused by incidents of physical, sexual or emotional aggression, psychological effects as well as physical effects should be taken into account. Staff must consider whether sexual incidents that are said to be consensual have been the result of coercion or exploitation or where a woman’s capacity to consent may have been affected by her mental health\textsuperscript{33}. Where there is any doubt the incident must be investigated. Links must be established with the police in serious untoward incidents and to child protection and vulnerable adult policies.

Post incident de-briefing is a skilled job and requires someone from outside the ward staff group. It may be that an external, independent person will be best placed to facilitate the process with the staff group, as well as with the woman. Alternatively a senior member of the trust may be identified. It should not be left to the ward manager alone although there should be accountability from within the staff group on duty at the time of the incident. The process should be transparent to re-assure others that steps are being taken to restore a safe and secure environment on the ward.

There should be regular reports to clinical governance and risk committees, acute care forum and the trust board including dissemination of lessons learned and for identification of trends and patterns. A basic but crucial requirement is for all reporting to be disaggregated and analysed by gender.

Ward based practices

1) Information sharing and gathering

Arriving on the ward can be a daunting experience, especially if it is a first admission. Ward staff should have an induction procedure which recognises and minimises feelings of disorientation and unfamiliarity, including an induction pack with key staff names, mealtime arrangements and programme of activities.

During screening and assessment, staff need to reassure women patients that many of the factors that have led them into services are common and that their distress is understandable. It is important that staff team members agree who undertakes the assessment so that the woman is not overwhelmed by multiple assessments.

Record keeping also needs to work for the woman patient and limit the possibility that she will have to repeatedly provide the same painful and difficult information. From the outset each woman needs to be considered the authority on her own needs, care and risks, and centrally involved in developing and reviewing her planned care and support.
Staff handover should include a regular review of risks and risk management including risks to individual women arising from the patient mix, and those which might arise because e.g. of her sexuality and ethnicity, or anything on the ward that might trigger a trauma response.

2) Power and control
Inadvertently staff may act in ways that perpetuates issues of inequality.

Examples include:
- over-estimating the safety of the service
- tolerance of low level sexual harassment
- handing out sanitary wear items rather than making them available
- not seeking permission before entering a woman’s bedroom, drawing back curtains around her sleeping area or sitting on the edge of her bed
- not appreciating individual differences in maintaining interpersonal physical and psychological boundaries, and
- wearing name badges in places that draws attention to private parts of the body.

Staff don’t work in a vacuum and feelings of the need to control patients can be exacerbated by working in settings that are risk averse and lacking in resources. Power struggles, and issues of blame often start when a service identifies a woman as engaging in ‘difficult’ or socially unacceptable behaviour relating to e.g. her hygiene, food intake and/or self harm. However, when these are ways she copes with and communicates her distress, the attempts of staff to stop her from using such strategies commonly result in power struggles which do not contribute to recovery.

3) Language
Using language to ‘put women down’ happens in services as well as the wider society. There is much evidence throughout mental health services that negative and value laden language is used to talk about women and their difficulties. This language may offer staff an outlet for frustration and disappointment but it hides woman’s needs and adds to her day-to-day derogation. In contrast an informed gender perspective invites staff to use more respectful and meaningful ways of speaking.

There are good arguments for not using jargon and judgemental terms when talking to or about women. Women find it hurtful and diminishing and it saps optimism and creativity in staff. The challenge is to find alternatives which probably means using phrases rather than single words. Below you’ll find some illustrations.

Taking the lead on language
These young women patients evoke anger in us, extreme anger, frustration and irritation: but I never allowed my staff to use the word ‘manipulative’ about someone, because I thought it was a short circuit for something we weren’t acknowledging in ourselves, our own sense of helplessness. It was a way of avoiding the suffering behind the so-called manipulative behaviour, without even looking at it.

Consultant psychiatrist quoted in foreword by Nelson and Phillips 2001
<table>
<thead>
<tr>
<th>Jargon &amp; labels</th>
<th>Better ways of speaking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention seeking</td>
<td>She is trying to build relationships; she finds it hard to be alone with her thoughts and feelings</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>She is doing her best despite early experiences of deprivation and trauma</td>
</tr>
<tr>
<td>Controlling</td>
<td>She seems very unsafe and anxious and feels better when her life is as predictable as possible</td>
</tr>
<tr>
<td>Dangerous</td>
<td>She sometimes behaves in ways that puts herself and/or others at risk</td>
</tr>
<tr>
<td>Devious</td>
<td>She doesn’t feel able to ask for what she wants directly</td>
</tr>
<tr>
<td>Hormonal</td>
<td>I sometimes feel like her behaviour is linked to her menstrual cycle/menopause</td>
</tr>
<tr>
<td>Immature</td>
<td>She seems young for her age – she missed a lot of growing up</td>
</tr>
<tr>
<td>Malingering</td>
<td>At the moment she is expressing some of her distress through her body</td>
</tr>
<tr>
<td>Manipulative</td>
<td>She doesn’t believes that she is entitled to get her needs met if she is open about what she wants</td>
</tr>
<tr>
<td>Masochistic</td>
<td>She expects to be hurt by others and sometimes finds it easier to provoke a response than to wait for the inevitable</td>
</tr>
<tr>
<td>Paranoid</td>
<td>She experiences the world as very threatening and can feel very unsafe</td>
</tr>
<tr>
<td>Personality disordered</td>
<td>She is emotionally distressed, has low tolerance of frustration, and relies on coping strategies developed in situations of great deprivation</td>
</tr>
<tr>
<td>Secretive</td>
<td>She protects her privacy</td>
</tr>
<tr>
<td>Suspicious</td>
<td>She is not at the point of trusting us yet</td>
</tr>
<tr>
<td>Uncooperative</td>
<td>She doesn’t like doing what staff want her to</td>
</tr>
<tr>
<td>Untreatable</td>
<td>We are finding it difficult to help her.</td>
</tr>
</tbody>
</table>

An earlier version of this exercise was published in Williams & Scott, 2004
4) Partnership working

Collaborative rather than coercive relationships are the hallmarks of good practice. This would include joint care plans, advance directives, shared decision making about medication, opportunities to access therapy, a harm minimisation approach to self-harm rather than close observation or ‘removing’ women or her possessions to reduce risk; and a willingness to keep patients involved in determining important matters such as the service philosophy, rules and expectations.

There would also be a thriving ward or community meeting giving women space to share views about the safety and quality of services: and ward staff and managers would value and learn from the feedback from this group. The services would also welcome and seek out advocates willing to further the interests of individuals or groups, including women from BME communities and sexual minorities. Access to groupwork with a strong self-help philosophy would make it clear to everyone on the ward that the capacity to help is held by patients as well as staff.

You will find more ideas and examples of good practice in partnership working in the archive section of the Star Wards initiative and in the Delivering Race Equality programme.

5) Relationships

Women patients’ preferences for gender of key worker should be sought and honoured where possible. They may also benefit from access to staff who are similar to them in terms of ethnicity and culture (although this should not be automatically assumed) or who, at the very least, are knowledgeable about their community.

It is important that spiritual and religious needs are acknowledged and some women may benefit from access to traditional healers. Spirituality is not the same as religion or faith; it is important that staff listen to what a woman identifies as important to her and how she wishes to express or practice her spirituality, faith or religion.

The centrality of relationship and relational security to the process of women’s recovery should be evident throughout the service and in any, and every contact, between a member of staff and a woman. Staff relationships with women patients should be safe, consistent, transparent and non-judgemental. Women patients need opportunities for ongoing engagement that are collaborative and which empowers them to explore salient aspects of their lives including their gender, race, and sexuality. Staff need to bring to this relationship understanding and respect for personal space and individual boundaries. The therapeutic use of relationships can be demanding. For example:

- when intense feelings of e.g. rage or sadness are expressed it is important for staff not to back away or label them as pathological; instead to help the woman understand that these emotions are not as destructive as they may fear
- similarly when patients disclose past trauma staff should avoid minimising or disbelieving what they hear
- staff may find that they are expected to behave unprofessionally by women for whom being treated abusively is the norm e.g. responding to overly familiar or flirtatious remarks: at such times they need to understand what is going on and respond constructively.
A clear indication that a service has forgotten the healing power of relationships is when changes are made to staff groups without regard for the impact on relationships with patients. When changes are unavoidable women need to be told at the earliest opportunity and given time to say what they think and feel about what is happening to them.

**What Women Want**

We don’t need glorified baby sitters, we need staff who will empathise with our doubts and fears without judgement. Any inpatient treatment should be based on communication with positive empowering dialogue from staff.

© Tracey Hayes, 2006

6) Women as parents

Women with mental health problems routinely describe their relationships with their children or becoming a parent and being a good parent as extremely important to them. However, evidence suggests that it is not commonplace for services to appreciate and respond to the concerns of parents.

These are some of the issues women may appreciate staff acknowledging and giving them opportunities to explore in safe conversations:

- experiences of pregnancy and childbirth
- difficulties or fears they have about parenting
- distress and anger at losing custody of their children, either to their partner or into care
- anxiety about stigmatising her family
- feelings of failure at not being a proper woman
- difficulty in being accepted for IVF
- the impact of her history of abuse on being a mother, including possible fears and concerns for a child
- becoming a mother as the result of sexual abuse or rape, and
- the difficulties of being a parent when young, powerless and marginalised.

Multi-agency support involving primary care, health visitor, school nurse, Sure Start, local authority may be helpful in re-establishing and sustaining the woman’s role as parent. She may also require legal advice if there is a risk to her losing custody. For new mothers the recently published National Institute for Clinical Excellence (NICE) guidance is helpful in its focus on service provision to women experiencing antenatal and postnatal mental health difficulties. It may also be useful to search the National Society for the Protection of Cruelty to Children (NSPCC) website for relevant local projects and services.

The provision of a dedicated children visiting room is an important way that the mother-child relationship can be supported. The recent and very accessible guidance by Robinson and Scott (2007) will help services to address this task.

**The Family Room**

You want your mum even when she’s ill, especially when you’re just a kid. The room can make it feel a bit better, even though loads is going on in your head, it helps having that place.

Young person’s comment on a family room, quoted by Robinson & Scott, 2007, p.8
7) Healthcare

Those who use psychiatric services are likely to be in poorer health than counterparts elsewhere in the community. Access to good quality physical and sexual health and breast screening should be part of restoring and maintaining women’s health. Additionally recent research on medication identifies risk factors for osteoporosis, and highlights the relevance of bone density scanning for long terms users of these medications. Anti-psychotic medication is also associated with weight gain which is likely to be particularly burdensome for women already sensitised to issues of body image and self esteem.

The Healthcare Commission has also identified a pressing need for improvement in access to sexual health services by people using Acute Mental Health Services with attention being given to both disease prevention and health improvement. The key issues are:

- contraception
- abortion
- teenage pregnancy
- pre-cancerous change in the cervix, and
- sexually transmitted infections, including HIV.

The need for these services is likely to be greatest amongst women service users who have been sexually abused as children and/or adults. Understandably, they are also likely to find getting help about these matters especially fraught and will need the proactive and sensitive support of ward staff to access them.

Health Matters

People with severe mental health problems have higher levels of morbidity and mortality than other people. They are more likely to be overweight, smoke heavily and be physically inactive (NIMHE/Mentality, 2004). They are also less likely to get some routine evidence based physical health interventions than others. Physical health problems and nutritional deficits can also exacerbate or cause a range of mental health problems (MHF, 2006), while substance misuse may harm both physical and mental well-being.

Chief Nursing Officer, 2006, p. 32

Not only gender

Women who use mental health services are not a homogeneous group. Additional inequalities arising from class, minority ethnic status, sexual preferences and age are also important determinants of need, and define groups that are under-served by services: homeless women, including those with children, refugee and immigrant women, women carers, women from BME communities, women on a low income, women street/sex workers, women survivors of adult domestic and sexualised violence and torture, women identifying as lesbian, bisexual and transgender, women who are reliant on drugs and alcohol, women whose mental health needs become evident perinatally, women with a history of offending and women with eating distress.
Informed gender practice: women from BME groups

Below you will find suggestions of how thinking and practice can develop through focusing on a particular population – in this case women from BME groups. Although most of the published guidance for mental health service provision to people from BME communities is not gender specific, it represents a starting place from which to determine the relevance for women.

We need to recognise that women who are from BME groups – especially those who are recent migrants, asylum seekers and refugees – face particular problems in accessing mental health services and being involved in their planning. It is important to appreciate how cultural reasons e.g. family shame and honour, may deter some women from seeking help. We need to learn the lessons from the annual Count Me In audit and other references of the ways that services are used and experienced by women from BME groups.

It is important to collaborate with other agencies to improve service responsiveness to hard to reach groups including BME women survivors of sexual abuse or domestic violence, and those at higher risk of suicide and self harm.

Below are a number of other areas to be mindful of in providing a service that is both gender and race sensitive:

- acknowledge the role of alternative healers in identifying and treating some problems
- watch out for stereotypes e.g. that western cultures are superior to eastern cultures
- be aware of possible hierarchies within BME communities – ‘in and out’ groups
- be proactive in addressing language barriers so that women do not have to suffer in silence
- take account of good practice in working with interpreters and offer a choice of a female interpreter; those who are trustworthy and empathic are especially valued
- be aware of the additional difficulties for some BME women of using services provided by men, and/or also used by men; offer choice of female staff and services whenever possible
- be respectful of the high value some cultures place on personal modesty
- tell women from BME groups about relevant facilities (e.g. prayer areas) within the hospital or locality
- take account of culturally determined food preferences e.g. for Halal, vegetarian or vegan food
- be aware that women from BME groups may have specific needs and preferences relating to personal care e.g. looking after their hygiene, skin and hair
- give women opportunities to talk about the power relationships in their families and communities
- enable women to talk about what being a “good woman” means to them
- develop understanding of the language and conceptualisation of mental health and disorder of different ethnic groups – don’t expect western diagnostic language to map neatly on to their experience
- value culturally rooted resilience, empowerment and coping strategies, and
- complement what can be learned from listening to women from BME groups with formal training opportunities, and supervision from local experts.
Informed gender practice: women asylum seekers and refugees

Research and reports on the lives and experiences of women asylum seekers and refugees identify a number of issues that need to inform the provision of acute care to this group. These include high levels of exposure to trauma including experiences such as violence, rape, abuse, humiliation and destitution.

They may also have experienced widespread mental health difficulties e.g. depression, anxiety, loss and shame. They may have difficulty accessing help because of perceived dishonour to themselves or their families, language difficulties, lack of interpreters, lack of knowledge of available service, lack of expertise within health and mental health services, and current information about legislation and their statutory responsibilities. This may mean a woman dealing with immigration related concerns will not receive help at a time of additional stress. Her mental health needs may not have been formally documented so cannot be used to support her claim. Any acute mental health difficulties may interfere with her ability to present a coherent application for asylum.

This basic information allows us to begin identifying implications for the development of acute services e.g:

- training for staff in greater sensitivity to the needs of women refugees
- commitment to developing specialist counselling skills, and
- active development of links with relevant local and national centres and services, so that inpatient care is part of a coherent response to the mental health needs of women asylum seekers and refugees.

Informed gender practice: guidelines to enhance the care of lesbian women

In some instances there is already established good practice guidance that services can be used as a starting point for improving responses to women whose needs are often over-looked. For example, below is guidance published in Australia (McNair, 2003) which was developed from work in the USA. Though this guidance is for people working across health care services, many of the recommendations are relevant to mental health services.

Together with colleagues and women patients identify the practices on the list that are already established in your services, and then identify some priorities for change.

Knowledge and understanding

- be aware of the impact of sexuality-based discrimination on health
- be aware of how health risks and healthcare issues specifically relate to lesbian and bisexual women — sexually transmitted infections, common sexual practices, cervical health, reproductive health, mid-life changes, ageing, mental health, and substance-use patterns
- be knowledgeable about lesbian-sensitive referral networks, and
- be knowledgeable about lesbian-specific support and community groups (e.g., relating to lesbian parenting, domestic violence, “coming-out” support and youth support).
Communication skills
- use gender-neutral words such as “partner” and other inclusive terms to facilitate disclosure
- when taking a sexual history, be aware of the fluidity of sexual expression and the “coming-out” process
- specifically encourage disclosure of sexual identity, orientation and behaviour if they are relevant to the health issues presented, and
- give choice regarding documentation of next of kin and sexual orientation in the health record and letters.

Attitudes
- be non-judgemental
- avoid the assumption of heterosexuality
- avoid common assumptions about lesbians (e.g., that lesbians have never had or don’t continue to have sexual relationships with men)
- be willing to facilitate disclosure of sexuality
- be willing to involve lesbian partners in decision-making, and
- be aware of additional barriers that increase stigmatisation, including minority ethnic status, disability, age, or economic status.

Practice environment
- train reception staff to be sensitive to lesbian identity
- have a written practice policy on antidiscrimination, including the issue of sexuality
- design intake forms to be inclusive of same-sex relationships
- maintain confidentiality regarding the patient’s sexuality
- display and make available brochures and posters relating to lesbian and bisexual patients, and
- advertise practice services through lesbian and bisexual media.

The above examples illustrate ways that services can become more responsive to the mental health needs of women whose lives have been shaped by a range of inequalities, not simply their gender. Sometimes already published guidance provides a starting point for discussion and consultation, in other instances there has to be a greater investment in hunting down information and expertise. In both cases there is no short cut to managers and staff becoming more knowledgeable about the lives and experiences of women from under-served groups. This can be achieved through training, and by listening to and learning from service users and – in some instances – staff from these groups.
The following conditions will help establish a gender informed system; ideally they should be in place before any move to change clinical practice is initiated, though the process of change is rarely that ideal.

Clinical governance

Gender should be mainstreamed throughout the organisation for change to be achieved, and the organisation’s Gender Equality Scheme\(^7\) is one way in which to formalise intentions and responsibilities. Organisational resistance and lack of organisational support does occur and can be addressed through clinical governance, the acute care forum, audit, monitoring and reporting.

The disaggregation and interrogation of data by gender is central to defining goals and to effective change management, and impact assessments should support the development of gender sensitive policies and practices throughout the organisation. Where these assessments reveal disadvantage or adverse impact on gender grounds, the relevant director will be responsible for developing an action plan that address the problem: this can present a good opportunity to problem solve alongside women who have experience of using services. Local acute care forums are also tasked to produce service improvement plans, and should profile action that is being taken to enhance service responsiveness to gender.

Board level leadership

Senior leadership and championship is essential to establishing informed gender services for women. Leadership at board level can be developed through recruitment or identification of a board member with specific responsibility for gender equality, by ensuring there is equitable gender balance among board members and mechanisms to hear strong representation from women service users. Brief training can help the board tackle the task of mainstreaming gender across the activities of the organisation and its workforce.

As a matter of good practice, all performance and review reporting should be disaggregated by gender in the organisation’s role as employer as well as provider of services. This includes statistics relating to:

- service provision e.g. access to services, length of stays and incident reporting, and
- the workforce e.g. use of flexible working, turnover of staff, recruitment, grievances, disciplinaries, harassment, training and progression.
Policies & procedures

The Healthcare Commission, in response to the requirements of the Gender Equality Duty has summarised gender related policy recommendations for inpatient care.

This provides an overview of the ways in which acute inpatient mental health services can improve the quality of care to women. The overview of policy guidance by Owen and Khalil offers a useful supplement to this work.

Policy recommendations for acute inpatient care by gender

Recommendation

There should be an officer at senior level responsible for women’s safety (in both community and inpatient settings) 
DH, 2000; 2003a

The women’s lead should lead on the implementation of policies and procedures to address patient safety, privacy and dignity, including considering acute wards, psychiatric intensive care units (PICU) and high dependency units 
DH, 2003a

Risk of domestic violence should be picked up in assessments 
DH, 2003a

Trusts should consult with staff, referrers and women service users on preferred options for wards in terms of gender segregation. Once this is decided, referral systems need to be revised, and admission criteria agreed (the latter is only relevant for women only wards in the case of dual options, such as the provision of both single sex and mixed sex wards) 
DH, 2003a; NPSA, 2006

Service users should have access to same sex members of staff, and access to female doctors for physical healthcare 
DH, 2002b

Policies and protocols should be developed for the assessment and management of women who self harm, in consultation with them 
DH, 2003a

Services need to have a greater awareness of the risks of sexual vulnerability, and this should be part of the initial assessment. It should then be reassessed on a regular basis 
NPSA, 2006

Reports of sexual safety incidents need to be taken seriously 
NPSA, 2006

Trusts should not admit a female into a male ward (or vice versa) in response to bed pressures 
NPSA, 2006

Inpatient services should provide information on contraception, pregnancy and sexual health 
NPSA, 2006

There should be information available to service users informing them that allegations of rape and sexual assault will be reported to the police 
NPSA, 2006

Service development

In many localities it is the safety of inpatient services for women that provides the main focus of service development. A recent survey indicates that 55% of inpatients are not living in single sex accommodation: this is especially problematic for women who are fearful of further abuse because of their past experiences. It is obvious that the physical layout of services is important in supporting safe and best practice, and basic guidance has already been specified, reiterated and elaborated, most recently in Laying the Foundations (CSIP-NIMHE/DH Estates 2008). However, these changes have not been easy to implement: many Trusts are encountering difficulties because of lack of funding and the problematic layout of existing buildings.

The NHS is clear about the need to eliminate mixed sex accommodation, and that as a minimum requirement on mixed sex wards:

- there needs to be good physical separation of sleeping accommodation for men and women
- separate toilet and washing facilities which can be accessed without passing through a mixed sex area, and
- the physical environment should provide privacy and dignity and meet women’s needs in the range of ways documented in the organisation’s policies e.g. Trusts’ Vulnerable Adults Policy.

Women service users also make points about the access to women-only areas or activities e.g. day rooms, quiet areas, external space, classes. They want these facilities to be accessed without nurse escort and without passing through opposite sex facilities and sleeping areas.

The NHS Institute for Innovation and Improvement produced guidance and self assessment checklist which can help trusts do a gap analysis and prioritise actions for improvement. It is also the case that many staff and women service users continue to advocate for single sex wards.

That said, multi-bedded rooms in single sex accommodation can be disturbing and distressing and the provision of individual ensuite bedrooms should be the aim. It is also important not to assume that women’s sexual and physical safety will be secured in single sex wards. Abuses and misuses of power – intimidation, threats, bullying and physical, sexual and emotional abuse – also occur in these settings; single sex wards are not the sole solution to these issues.

Improvements in the physical environment need to be accompanied by attention to service culture, and staff working in difficult circumstances can take direction from research documenting the changes that help create safer services. For example, evaluations of the well documented Sanctuary Model, developed in North America and Canada shows that it has the potential to dramatically reduce the level of violence in inpatient mental health services and other settings, and to create a therapeutic environment that can offer women what they need to begin the process of recovery.
Sanctuary model

The model was developed in the US by Sandra Bloom and her associates and was first used in an inpatient acute care psychiatric unit where it dramatically reduced levels of violence. It is based upon concepts of the therapeutic milieu and trauma-based approach to treatment. It is well documented and evaluated and the material easily accessed www.sanctuaryweb.com/. It is relevant to meeting the needs of men as well as women.

The model assumes:

- the most severe effects of trauma relate to the social self
- only through social forms of treatment can we recover from the harm caused by trauma
- healing can only occur when a person feels safe, and
- only then can the task of making sense of one’s past life and of developing a new vision for the future proceed.

Bills & Bloom, 2000; Bloom et al, 2003

In addition to safety, women require a holistic and dynamic response to their needs and the complex reality of their lives. This cannot be achieved through the development of inpatient care alone but must include other parts of the health and social care system. To be able to offer a comprehensive service and women-centred pathways of care, there needs to be inter-agency collaboration with statutory agencies such as local authority and police as well as the voluntary sector. The goal of service development should be integrated service provision which can meet women's needs through a range of care pathways, and which provides inpatient staff with a range of referral options. It is important therefore, that service developments and service-recovery pathways are supported by commissioners and evaluated in ways that is relevant to service recipients as well as other stakeholders.

It is important to draw upon the expertise of direct care staff when developing services and to give them protected time so that they can identify relevant and achievable ways of improving their service to women. The process of admitting and discharging women alerts staff to gaps in service provision, and the need for alternatives to admission. It may also be helpful to consult the shortly to be published core service specification for high support therapeutic community residential services for women with multiple needs.

Inpatient staff may also find it useful to draw lessons from innovative services such as that described below as well as the Leeds Survivor Led Crisis Service which has received national recognition for its achievements.
Lessons from Drayton Park

The authors of an evaluation of this crisis service for women note that while some valued aspects of the Drayton Park service are specific to a non-hospital environment, others suggest ways in which ward environments could be improved.

They draw attention to the fact that talking about current difficulties is highly valued and appears to happen relatively little in hospital: helping ward staff to spend more time talking to patients might improve the experience of being on a ward for both patients and staff. This may require increases in ward staffing levels and some clarification or re-definition of the role of ward staff.

Greater awareness of therapeutic models such as the systemic model used at Drayton Park may also be helpful to ward staff in meeting patients’ perceived needs for discussion of their difficulties.

A focus for improvement of services is the reports that hospital staff are more stigmatizing than those in the crisis house. Reasons for this cannot be established from our data but might include the effects on staff attitudes and behaviour of the institutional setting and accompanying routines, and greater conservatism among staff working in traditional rather than innovative services.

Other aspects of crisis house care which could be reproduced in hospital are the availability of complementary therapies and, to some extent, the more pleasant and domestic environment.

Provision of women-only wards is obviously also feasible in hospital.

The loss of control described by many women admitted to hospital is not a necessary characteristic of the setting, especially considering that all in our sample were admitted voluntarily. Thus ways of improving availability of information and involvement in decision making should be considered.

Johnson et al, 2004, p.261

Understanding the roots of psychological distress helps to develop an appreciation of the importance of not taking control and power away from patients without a great deal of thought and discussion with the person concerned. The provision of meaningful choices is an important part of the process of:

- empowering patients
- delivering person centred care, and
- developing service based capacity to meet the needs of diverse groups.

There is an exercise in the table below that can help to identify the kinds of choices that would define a gender informed service. Begin by looking at the choices which have been identified by the government as key components of treatment packages in inpatient care. Then try and work through what this means for a gender informed service for women, or for women from at risk groups which are known to be poorly served. Again this task is best tackled collaboratively with colleagues and women using the service and their advocates.
<table>
<thead>
<tr>
<th>Choices within inpatient services*</th>
<th>Implications for developing a gender informed service for women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Environment:</strong></td>
<td></td>
</tr>
<tr>
<td>• single sex accommodation</td>
<td></td>
</tr>
<tr>
<td>• gender-segregated areas</td>
<td></td>
</tr>
<tr>
<td><strong>Choice of key worker</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Intensive therapeutic support</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Psychological therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Help and training on coping strategies</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Education and training</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Social skills development</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Occupational therapies</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Vocational support</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Supported medication management:</strong></td>
<td></td>
</tr>
<tr>
<td>• choice of appropriate medication</td>
<td></td>
</tr>
<tr>
<td>• chance to discuss different medication levels depending on how they are feeling</td>
<td></td>
</tr>
<tr>
<td><strong>Meaningful day-to-day activities should exist</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Options on leave</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ADD anything else you think is important...</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Choices in Mental Health (CSIP)*
Recruitment

Services should aim to recruit or identify at least one or two champions whose specific job is to model and support the development of informed gender practice.

Drawing from groups that have experience of inequality and abuse of power and the consequent potential of harm to mental health may prove helpful in bringing an authoritative voice to the issues. Such staff would include women from the survivor movement who have first hand experience of using mental health services. Staff recruited from these groups require tangible organisational endorsement to effectively disseminate the knowledge they have gained from experience.

Training and education

The mental health workforce is coming under increasing pressure – from service users, legislation and policy – to take account of gender, race and other inequalities in their work. For example, ‘respecting diversity’ and ‘challenging inequality’ are identified as two of the ten essential shared capabilities for mental health. However, it continues to be unusual for these issues to be mainstreamed in the training that prepares and supports people to work in mental health services.

Results of a staff survey by the Healthcare Commission (2007) found only 32% of specialist mental health trust staff reported receiving training in diversity awareness since they started work for their employer.

An even smaller number will have had the opportunity to develop competence in linking gender inequality to the mental health of individuals; or in providing empowering services that assume that users are experts on their own lives and full partners in their recovery.

Training about gender has to compete for resources with other training and awareness imperatives, so it is important to remember that formal training is held in high esteem within statutory services and provides a basis for authorising staff to take action.
The role of inpatient staff as a major clinical resource for their patients would be enhanced, and in terms of their own professional development, be well placed to develop more advanced clinical skills.

For women living in these services there would be opportunities to form safe, therapeutic attachments to well supervised staff in which the whole range of human experience and emotions can be acknowledged and worked with (sadness, rage, guilt, shame as well as joy, contentment).

The culture would be open and respectful, promoting mutual support, and patients would be regarded as adult partners working towards more socially and personally satisfactory ways of living.

Patients from minority groups would encounter staff who set importance by and are mindful of their cultural and faith needs, and sensitive to their specific needs relating to matters of dress, diet, religious worship, hygiene, personal appearance, social interaction, and family relationships.

Staff committed to recovery models would be aware that the processes and outcomes of recovery are gendered e.g. that the challenges involved in a person owning and safely expressing their anger are likely to be different for women and men.

In addition to knowing about the ways that gender and other inequalities can place mental health and mental health services at risk, staff would appreciate that gender and other social identities can be positive and increase a woman’s resilience in the face of adversity.

Almost certainly there would be fewer women inpatients.

Improved understanding would benefit community services also. They would be better able to work with the anger and distress underlying some of the relational difficulties – including self harm and aggression towards staff – that precipitate many women into hospital.

For mental health services to achieve this, staff from the receptionist to the operational staff to the board of directors, should be supported in understanding how gender inequality impacts on the lives of women service users. These issues have a known potential to impact on staff attitude and behaviour and need to be addressed in pre-registration, induction training and CPD training. Joint input with trainers who draw upon their experiences of using mental health services is particularly effective in achieving change. Training like this can then be reinforced by day to day practice, and supported by a senior member of staff or mentor.

An inclusive approach which addresses the needs of men and women patients deserves consideration, rather than train staff solely to work with women from a gender informed perspective. This is obviously a more ambitious endeavour but there are a number of factors in its favour:

- gender affects the mental health of men as well as women
- gender is rarely the only inequality that brings people to services, and
- the emergence of a single Equalities and Human Rights Commission suggests there is a growing support for an integrative approach to addressing the problems created within our society by inequality.
As a minimum mental health staff need to know ‘why, when and how’ to ask inpatients about oppression, abuse and trauma. It is evident that clients and patients find sensitive questioning acceptable and that to achieve this change requires responding to staff anxieties and providing relevant training. Short one/two day courses including those trialled in the Mental Health Trusts Collaboration Project on Violence and Abuse offer viable and cost effective ways for services to enhance the competence of their workforce.

Training Helps
Cascade training is beginning to enable more staff to routinely explore sexual, and other, abuse in assessments sensitively and appropriately.

McNeish & Scott, 2007, p. 46.

Finding the words

It is rare for anyone to come to mental health services saying they want help because of current or past oppression and trauma – these experiences are often unspeakable. So, it is really important that staff feel able to offer patients safe opportunities to talk about their lives and experiences.

Finding the language isn’t easy. The words often feel blunt and clumsy and confronting these things can be painful – it is easy to feel offended or worry about offending another person. Speaking of oppression or using words such as sexism or racism can make us feel guilty, or hurt, or find ourselves reacting defensively. This is particularly so when our training gives the expectation of being ‘expert’ and needing to know the answers or where the impact of our own personal experiences has not been considered as relevant to our training and work.

So, it may help to remember that there is no ‘good worker or bad worker’ rather to be mindful that the ways we understand the world and how we relate to others will have particular consequences. Most of us benefit from some form of privilege and at the same time many of us suffer from discrimination from one or more sources.

The idea behind the following exercise is to help you play with language and recognise its limitations and power. You are very likely to find that you already know quite a lot about the issues through your own life and observations.

Begin by familiarising yourself with the terms in the table on page 34. The left hand column contains descriptive terms that are frequently used by staff and others in positions of power but do not always communicate the process that contributes to that terminology. The column on the right begins to unpick these, often stereotyped, phrases and helps understanding and personalisation of that process.

To make this come alive, think of a woman patient that you know really well, and see if any of these words help you to describe her life, her inner world, important ways she is treated and effects on her mental health.

Look at the words you have used and try turning them into the kind of language you might use when talking to her. For example, instead of using the word ‘dominate’ you might say something like:

- ‘feeling you can’t be yourself’
- ‘not allowed to think for yourself/be yourself’
- ‘not allowed to get a word in edgeways’
- ‘being stopped from doing what you want to do’ or
- made to feel small.
### Social world

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominate</td>
<td>to have control over a place or a person</td>
</tr>
<tr>
<td>Ethnic minority group</td>
<td>a group of people differentiated from the rest of the community by racial origins or cultural background</td>
</tr>
<tr>
<td>Feminism</td>
<td>a social movement which seeks to achieve equality between the sexes</td>
</tr>
<tr>
<td>Gender inequality</td>
<td>when women and men do not have the same access to rewards and opportunities in society</td>
</tr>
<tr>
<td>Marginalised group</td>
<td>a group that is treated as if it is not important</td>
</tr>
<tr>
<td>Minority group</td>
<td>any small group in society that is different from the rest because of their race, religion or political beliefs, or a person who belongs to such a group</td>
</tr>
<tr>
<td>Power</td>
<td>ability to control people and events</td>
</tr>
<tr>
<td>Sex discrimination</td>
<td>unfair discrimination on the basis of sex, it occurs at different levels, from the individual to the institution, but all forms combine to preserve inequality</td>
</tr>
<tr>
<td>Social inequality</td>
<td>a lack of equality or fair treatment in the sharing of wealth or opportunities between different groups in society</td>
</tr>
<tr>
<td>Subordinate</td>
<td>to put someone or something into a less important position</td>
</tr>
</tbody>
</table>

### Inner world

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differential value</td>
<td>belief that some people have greater value than others</td>
</tr>
<tr>
<td>Gender identity</td>
<td>a sense of awareness, usually beginning in infancy, of being male or female.</td>
</tr>
<tr>
<td>Gender stereotypes</td>
<td>one-sided and exaggerated images of men and women which are commonly used in everyday life.</td>
</tr>
<tr>
<td>Prejudice</td>
<td>negative attitudes or beliefs towards women that have no evidence to support them</td>
</tr>
<tr>
<td>Stigmatise</td>
<td>treating someone or something unfairly by disapproving of them</td>
</tr>
</tbody>
</table>

### Behaviour

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>to use or treat someone or something wrongly or badly, especially in a way that is to your own advantage</td>
</tr>
<tr>
<td>Bully</td>
<td>to hurt or frighten someone who is smaller or less powerful than you, often forcing them to do something they do not want to do</td>
</tr>
<tr>
<td>Collaborate</td>
<td>to work with someone else for a special purpose</td>
</tr>
<tr>
<td>Discriminate</td>
<td>to treat a person or particular group of people differently, especially in a worse way from the way in which you treat other people, because of their skin colour, religion, sex, etc</td>
</tr>
</tbody>
</table>

Definitions from Cambridge Dictionaries Online & AskOxford.com
Staff care and clinical supervision

Working from an informed gender perspective offers staff hope, opportunities for creativity, and the rich reward of helping to make a difference to someone’s life. However, as a way of working it is more emotionally intense and demanding than keeping women and their difficulties at arm’s length. Working in acute mental health care is not easy, particularly so for ward based staff in women’s services.

Some of the issues that have been raised in relation to the supervision of nurses who work with women in secure care are highly relevant to staff working with women in acute services. It is important that the skills and commitment required to work in this way are properly acknowledged, and that staff receive the support and help they need.

Burnout, compassion fatigue, vicarious traumatisation and counter transference are all terms used to describe the stress of working in psychiatric services.

Staying Positive

Arguably the most challenging task in interpersonal mental health work is in retaining a positive perspective while being in almost continual contact with mental pain and confusion.

Walton, 2000 p. 85

It is evident that staff need safe opportunities to speak openly about the negative impact of the work. This will counteract isolation, restore connection, provide a reality check and normalise responses.

<table>
<thead>
<tr>
<th>Staff care and clinical supervision</th>
<th>Empower makes you more confident and makes you feel that you are in control of your life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entrap to cause someone to do something that they would not usually do, by unfair methods</td>
<td></td>
</tr>
<tr>
<td>Exclusion when someone or something is not allowed to take part in an activity or to enter a place</td>
<td></td>
</tr>
<tr>
<td>Marginalise to treat someone or something as if they are not important</td>
<td></td>
</tr>
<tr>
<td>Neglect to give not enough care or attention to people or things that are your responsibility</td>
<td></td>
</tr>
<tr>
<td>Oppress when people are governed in an unfair and cruel way and prevented from having opportunities and freedom</td>
<td></td>
</tr>
<tr>
<td>Sexism treating someone unfairly because of their sex</td>
<td></td>
</tr>
<tr>
<td>Violence behaviour involving physical force intended to hurt, damage, or kill</td>
<td></td>
</tr>
<tr>
<td>Effects on mental health</td>
<td></td>
</tr>
<tr>
<td>Entitled feel you have the right (no – it means to give someone the right)</td>
<td></td>
</tr>
<tr>
<td>Low self-esteem little belief and confidence in one’s own ability and value</td>
<td></td>
</tr>
<tr>
<td>Respect politeness, honour and care shown towards someone or something that is considered important</td>
<td></td>
</tr>
<tr>
<td>Shame an uncomfortable feeling of guilt or of being ashamed because of your own or someone else’s bad behaviour</td>
<td></td>
</tr>
</tbody>
</table>
Regular staff team reflective practice sessions provide opportunities for staff to talk about, and reflect on, their practices and style of work and to consider the implications of how and where staff divide their working time between face to face contact and office based duties.

Although the case for supervision in mental health services has been stated and re-stated many times, opportunities for supervision are often not taken up or provided. However, service commitment to providing gender informed care should both add weight to the case for supervision and help to give it a structure and rationale that makes sense to staff.

**Relevant Supervision**

We know nurses have limited time and for them to commit to any process of supervision it must be clinically meaningful, user friendly and relevant.

*Cleary & Freeman, 2006*

There are a range of supervision models to choose from; their suitability is likely to vary with the setting:

- one-to-one sessions with a senior member of staff, or a peer, and
- open or closed group supervision that is single discipline or multi-disciplinary, internal or external facilitator; rotating group member facilitation.

Practical matters are likely to be a factor determining choice though some difficulties can be anticipated and addressed such as availability of rooms, whether money has been allocated for an external facilitator and staffing rosters.

The purpose and benefits of clinical supervision in an informed gender service will vary with the model chosen, however, it has the potential to support the development of a learning community by enabling staff to see the relevance of their own lived experience of gender and other inequalities.

It will also be possible to create opportunities for staff to learn together and from each other, and across professional boundaries. The staff group can begin to name and constructively address issues arising from its own hierarchies and gendered dynamics, model the types of relationships known to be helpful to women patients i.e. safe and non judgemental, transparent exercise of power, respectful, valuing of personal experience, and to share the personal impact of the work, including the impact on their emotions, thoughts, bodies, and lives of working with traumatised and challenging women.

Working in this way will foster supportive interaction between staff and promote, cohesion, trust, self confidence, prevent burnout, and enable staff to find constructive ways of challenging each other and dealing with conflict.

Once decisions are made about the model or models of clinical supervision it is important to be clear about what it can and can’t deliver to staff working in a gender informed service. This should help staff understand the relevance of participating in supervision and provide a basis for reviewing its effectiveness. This is also an opportunity to remind staff that this is not the place where they will receive management supervision, which needs to take place elsewhere.
Currently many mental health services try to meet the needs of patients without addressing the underlying causes. This doesn’t work: the connections between life experiences (including inequalities), expressions of distress, treatment needs and responses is now well documented. Mental health staff are beginning to gain confidence in talking to patients about their lives and experiences in ways that will aid their recovery. It is hoped that this guidance provides further support in translating these ideas into practice. This is also one way for staff to re-claim or enhance the value and satisfaction of working in inpatient settings.

Informed gender practice is a crucial determinant of the quality of care for women using inpatient services. As such it contributes to the much larger task of developing practice that is informed by an inequalities perspective throughout mental health services.

7 Concluding points
Resources

British Columbia: Centre for Excellence for Women’s Health
www.bccewh.bc.ca/publications-resources/download_publications.htm
Good source of Canadian downloadable publications about women’s health and mental health.

Bristol Crisis Service for Women
Their publications can be ordered via this website.
www.users.zetnet.co.uk/bcsf/publications.htm

Eaves
Eaves is a London-based charity that provides high quality housing and support to vulnerable women. It also carries out research, advocacy and campaigning to prevent all forms of violence against women.
www.eaves4women.co.uk/

Fawcett Society
Fawcett campaigns for equality between women and men in the UK on pay, pensions, poverty, justice and politics. It’s a good source statistics and downloadable publications.
www.fawcett.org.uk/

Government Equalities Office
The Women and Equality Unit transferred to this website. It is a good source of information and statistics e.g. their new factsheet “Ethnic Minority Women in the UK”.
www.womenandequalityunit.gov.uk/index.htm

National Self Harm Network
Resources and Information for People who Self-injure for Health and Mental Health Professionals, Friends, Relatives and Advocates
www.nshn.co.uk/resources.html

Newnham Asian Women’s Project
Provides a range of services to meet the needs of Asian women and their children
www.nawp.org/

National Social Inclusion Programme
The National Social Inclusion Programme (NSIP) brings together the work of government departments and other organisations in a concerted effort to challenge attitudes, to enable people to fulfil their aspirations and to significantly improve opportunities and outcomes for people with mental health problems. The specific needs of women are addressed in some of its work.
www.socialinclusion.org.uk
PACE Promoting Lesbian and Gay Health and Wellbeing

PACE is London’s leading charity promoting the mental health and emotional wellbeing of the lesbian, gay, bisexual and transgender community.

www.pacehealth.org.uk

Pink Therapy

The UK’s largest independent therapy organisation working with gender and sexual minority clients. The organisation aims to promote high quality therapy and training services for people who are lesbian, gay, bisexual and transgender and others who identify as being sexual minorities.

www.pinktherapy.com/

Public Health Agency of Canada

Handbook on Sensitive Practice for Health Professionals: Lessons from Women Survivors of Childhood Sexual Abuse.

www.phac-aspc.gc.ca/ncfv-cniv/familyviolence/html/nfntsxsensie_e.html

Refugee Women’s Resource Project

RWRP aims to enable women seeking asylum in the UK to obtain protection and security, to maintain their dignity and to be treated with respect during the asylum process. It has useful material in its publications library.

www.asylumaid.org.uk/pages/the_projects_purpose.html

Rights of Women

Rights of Women is a women’s voluntary organisation committed to informing, educating and empowering women concerning their legal rights.

www.rightofwomen.org.uk

Sanctuary Model

Aims to teach individuals and organisations the necessary skills for creating and sustaining nonviolent lives and nonviolent systems and to keep believing in the possibilities of peace.

www.sanctuaryweb.com/

Sidran Institute: Traumatic Stress Education and Advocacy

This organisation aims to help people understand, manage and treat trauma and dissociation.

www.sidran.org/

Social Care Institute for Excellence SCIE

Brings together information, research and current good practice about particular areas of social care.

www.scie.org.uk/publications/practiceguides/practiceguide09/mentalhealth/index.asp
Star Wards
A project which works with mental health trusts to enhance mental health inpatients’ daily experiences and treatment outcomes. It aims to discover, celebrate, share, publicise and inspire excellence in acute care.
starwards.org.uk/

Virtual Ward
A place to share good practice between staff and people who use mental health services. The site is designed for all to access information about positive and innovative practice, to read supporting policy and to utilise the examples of training underpinning those examples. You will be able to adjust these to fit your local circumstances
www.virtualward.org.uk/

Women’s Aid
Women’s Aid is the key national charity working to end domestic violence against women and children. You can search the website for material that addresses mental health implications.
www.womensaid.org.uk

World Health Organisation: The Department of Gender, Women and Health
This department of the WHO aims to bring attention to the ways in which biological and social differences between women and men affect health and the steps needed to achieve health equity. Source of global information about women’s health/mental health as well as strategic issues such as gender mainstreaming.
www.who.int/gender/en/
References


Brent User Group (2006). Women into the mainstream: Survey of women using services to deal with mental health issues – or to deal with issues which affect their mental health – in Brent. Brent, Brent User Group.


National Institute for Mental Health in England (2004). Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health inpatient Settings


Acknowledgements

This guidance is produced as a collaborative work between Acute Inpatient Care and Gender Equality and Women's Mental Health Programmes, National Institute for Mental Health in England and Royal College of Nursing.

Steering group:

Jenifer Paul, Joint National lead, Gender Equality and Women's Mental Health
Karen Newbigging, Joint National Lead, Gender Equality and Women's Mental Health
Malcolm Rae, Joint National Lead, Acute Inpatient Care Programme
Yvonne Stoddart, Director, National Acute Mental Health Project

Consultation

The following groups were consulted and comments included from:

Gender Equality and Women's Mental Health Programme Board
Royal College of Nursing
Gender Equality and Women's Mental Health Service User Reference Group
Delivering Race Equality Programme
Regional Leads; Gender Equality and Women’s Mental Health Programme
Regional Leads; Acute Care Programme.
Endnotes

1 DH, 2002
2 DH, 2003a; DH, 2003b; Newbigging, 2006
3 Some of these can be tracked through the CSIP website www.csip.org.uk
4 Office of the Deputy Prime Minister, 2004
5 Itzin, 2005; CSIP, 2007; DH, 2003a
6 DH, 2005, 2007b
7 DH, 2007a; EOC, 2007
8 Good et al., 2005; MHF, 2006; Rosenfield & Pottick, 2005; Williams & Miller, 2008
9 DH, 2002; 2007a
10 DH, 2003a
12 Brent User Group, 2006; Williams et al, 2001
13 Deacon, 2006
14 Cann et al, 2001; Scott & Williams, 2004
15 Johnson et al, 2004
16 Barker & Buchanan-Barker, 2004
17 Elliott et al, 2005; Harris & Fallot, 2001
18 Commission for Equality & Human Rights, 2006
19 Barnes et al., 2006; Lloyd, 2007
20 www.brightplace.org.uk/starwardspub.html
21 Warne & McAndrew, 2007
22 O’Malley et al, 2000; Scheyett & McCarthy, 2006
23 Coatsworth-Puspoky et al, 2006
24 Padgett et al, 2006; Patzel, 2001
26 Jonikas et al, 2004
27 Sainsbury Centre for Mental Health, 2004
28 Jennings, 1994
29 George, 2005
32 CHRE, 2008; ‘Witness’ is a charity concerned with breaches of trust by health and care workers
33 RCP, 2007
34 Warner et al, 2004
35 Sainsbury Centre for Mental Health, 2004
36 Williams & Keating, 2000
37 Hayward et al, 2005
38 Williams et al, 2004
39 Deegan & Drake, 2006; Seale et al, 2005
40 CSIP, 2007
41 Caron & Bergeron, 1995; Harris, 1998; Watson et al, 1996;
42 Star Wards starwards.org.uk/
43 DRE Programme http://www.actiondre.org.uk/
44 Barn & Sidhu, 2002; Bhardwaj, 2001; Burr, 2002; Drennan & Joseph, 2005; Gilbert et al, 2004; Ziguras et al, 2003
45 Corhah, 2006 p.29
46 Hussain & Cochrane, 2004
47 Beibel et al, 2006; Nicholson et al., 2001
48 NICE, 2007
49 www.nspcc.org.uk/
50 Robinson & Scott, 2007
51 Owen et al, 2002
52 Howard et al, 2007
53 Healthcare Commission, 2007
54 Tischler et al, 2007
55 Ten- Have & Bijl, 1999; Wilson, 2001
56 O’Malley et al, 2000
57 King et al, 2003
58 Markoff et al, 2005
59 Oluwatayo & Friedman, 2005
60 Home Office, 2007
61 Mond et al, 2007
62 e.g. DH, 2005a; Sashidharan, 2003
63 DH, 2005a; Refugee Action, 2002; Refugee Women’s Resource Project, 2003
64 Hussain & Cochrane, 2004; Gilbert et al, 2004
65 HealthCare Commission, 2006; TenHave & Bijl, 1999
66 DH, 2007b
67 Bhardwaj, 2001
68 Hussain & Cochrane, 2004
69 Burr, 2002
70 Tribe, 2007
71 Rea, 2004
72 Alexander, 2004
73 Harris, 1994
74 Edge & Rogers, 2005; Newbigging & McKeown, 2007
76 McNair, 2003
77 DH, 2007a
78 HCC, 2007b p. 6
79 Owen & Khalil, 2007
80 Healthcare Commission, 2007b
81 Mental Welfare Commission for Scotland, 2005
82 DH, 2000
83 NHS Institute for Innovation and Improvement (NHS III), 2007
84 NHS III, 2007
85 NHS III, 2007
86 Women’s Resource Centre, 2007
87 Cutting & Henderson, 2002
88 Bills & Bloom, 2000; Bloom et al, 2003
89 DH, 20003a ; Smyth et al., 2006
90 Warshaw et al, 2003
91 Elliot et al, 2005
92 CSIP/NIMHE 2007b
93 Mayne, forthcoming
94 Johnson et al, 2004; Killaspy, 2000; Meiser-Stedman et al, 2006
95 Leeds Survivor Led Crisis Service www.lslcs.org.uk/
96 Keating, 2002
97 DH, 2004
98 Clarke, 2003; Williams & Watson 1991
99 Healthcare Commission, 2007b
100 Brown, 2004; Swenson, et al, 2001
101 Edge and Rogers, 2005
102 “harm-ed” is a good example www.harm-ed.co.uk
104 Agar et al, 2002; Humphreys, 2007; McCloskey & Grigsby, 2005
105 Matthey et al, 2004
106 Ramsay, 2007; Read et al, 2007
107 McNeish & Scott, 2007
108 The definitions given here are from the Cambridge Dictionaries Online & AskOxford.com
109 Arledge & Wolfson, 2001; Dennis & Akien, 2003
110 Aiyegbusi, 2004
A move from ‘what’s wrong with this woman?’ . . .

To ‘what happened to this woman?’