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Chapter Nine

Gender specific mental healthcare

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Introduction

It is perhaps a paradox of contemporary mental health provision, that the issues of gender-specific services and practice, is still largely unresolved. Given the emphasis that is placed on 'ensuring a positive experience of care and support' and 'protecting from avoidable harm and caring in a safe environment' taken from *No health without mental health* (HM Govt/DH 2011), then for the authors of this chapter, we will argue again, that more needs to be done to achieve in-patient services which are both safe and therapeutic for women. Ten years on, we have an opportunity to assess the extent to which services have achieved the aspiration of John Hutton in 2001 in announcing the strategy development (*into the mainstream*) for women to 'ensure that women are listened to and their views translated into real change….'

Our starting point is that acute in-patient services, despite the well-documented criticisms, remain a significant and expensive feature of our mental health provision. Our concern would be that little regard continues to be given to the specific needs of women; that national policy has been poorly implemented and that the barriers of implementation have been left unaddressed. The purpose of this chapter is to outline some of the policy that has driven the development of UK women-only acute in-patient provision, provide reflections on the continued difficulties, and suggest some ideas about future development. Let's turn briefly to what this chapter is not about. It is not an analysis of psychiatry and mental

illness; nor is it a look back at historical and social origins of 'women's madness', although there is much to warrant an understanding of this in order to arrive at a gendered analysis and critique relating to the provision of contemporary mental health care (For fuller accounts see Chesler 1997; Ussher 1997). We are also conscious that we have only touched on the specific social issues affecting women's experiences of mental health issues; and that we are white, middle-aged and have clinical backgrounds – our lens offers a limited view.

In the UK and beyond, policy is increasingly concerned with developing strong individuals, groups and communities where fairness and social justice equality and human rights are seen to be the underpinning principles of the social world. We see the rhetoric reflected in an abundance of social and health policy, legislation in the form of the Equality Act 2010 and associated public sector duties; and a social and political imperative to 'tackle' inequalities in health. This is a useful backdrop to current mental health strategy, as it is well established that social inequality leads to health inequality (Marmot 2010) and for people who use mental health services these inequalities can be further compounded by stigma and discrimination.

This is particularly relevant for women experiencing mental health services in two important ways that are the focus of this chapter. Firstly, women still experience inequalities in relation to earnings and income (GEO 2010) and secondly, women continue to be disproportionate survivors of violence and abuse. Gender inequality is regarded as both a cause and a consequence of violence and women and girls (WNC 2009). The evidence is compelling that these aspects of women's lives and past experiences have a direct impact on their mental health and well-being (see amongst others Itzin, 2006). In addition, women as part of the workforce, nursing as a largely female workforce, and the experience of

female employees also as potential survivors of gendered violence and abuse, needs to be considered as part of the needs of all women providing and receiving care (DH Taskforce 2010). We suggest that women-centred care takes these experiences into account when designing services and providing professional care. We believe, like others (see Williams et al 2001; Gallop 2009) that mental health nurses have a significant role in reaching a gendered understanding of nursing and promoting safe environments and compassionate responses to women receiving in-patient care. Initiatives to raise awareness amongst health professionals generally can only add to the urgency for mental health nurses to assert a professional understanding of the causes and consequences of violence against women; and prioritise responses which are informed and empowering.

This chapter will concentrate on mental health policy and practice initiatives, and asks the question: to what extent have things improved, if at all, for women since *into the mainstream?* When the consultation was launched in 2002, there was much hope that eventually a vision for women's services had been created, based on the views and preferences of many women and based on the evidence of women's experiences. For women working in the service, it was a time of renewed optimism, that the differences between men and women would be acknowledged, agreed and accommodated into the creation of a 'gender-sensitive' or 'gender-specific' framework for women.

The following implementation guidance *Mainstreaming Gender and Women's Mental Health* in 2003 made clear recommendations for reconfiguring services to provide safe and therapeutic spaces for women. This safety aspect was particularly important as there had been many reports of women being sexually harassed and assaulted in mixed sex environments. In 2006, the National Patient Safety Agency revealed that between

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November 2003 and September 2005 there were 122 incidents of sexual assault within mental health in-patient acute wards in the UK, 19 of which were rape cases. Of the 19 reports of alleged rape, in eight cases the alleged perpetrator was another patient and in 11 cases a member of staff. In recent years this evidence has been augmented by *With safety in mind* (2006) and the policy steer of eliminating mixed sex provision in wards – this goal is still a long way from being achieved (NMHDU 2010).

There has been a shift from the inpatient acute mental health ward as a place of treatment to a focus upon community care, with the development of crisis resolution and home treatment teams (Glover et al, 2006). Consequently, acute care is largely focused on crisis and higher risk patients, and staff are increasingly risk adverse. There have been a number of surveys to establish what inpatient, acute mental health services are like for service users. A survey by MIND in 2004, found that 53% of patients, both men and women, said the ward surroundings did not aid their recovery, and 31% stated their condition worsened (Mind, 2004). The Care Quality Commission conducted a survey in 2009 on service users' experiences of mixed sex, acute wards, and revealed that less than half (45%) stated they 'always' felt safe on the ward, while 39% 'sometimes' felt safe and 16% did not feel safe at all. For the users of services that are women, the traditional mixed inpatient, acute ward is particularly unsafe. Women's safety is a cause of concern for nursing staff, managers, psychiatrists, commissioners and campaigners alike. Many of the women admitted to these wards have experienced traumatic experiences including childhood sexual, physical and emotional abuse, all forms of domestic violence and sexual assault and rape. There have been many suggestions made to improve and maintain women's sexual safety in mixed-sex, acute, inpatient mental health services. These include the introduction of policies to ensure

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consistency in the management and recording of sexual assault cases reported (Lawn and McDonald, 2009). Ward layouts have been considered to ensure that women are safer and are given specific areas that are women-only (Subotsky 1991). Increased staffing levels are considered to bring about improvements in women's safety ensuring the presence of staff in all ward areas (Tonks 1991). The concern about the safety of women patients led to a commitment outlined in the NHS plan (DH 2000) to provide gender-specific or women-only services in every health authority proposed as achievable by 2004. The secretary of State, Patricia Hewitt, recently claimed on Women's Hour on Radio 4 (January 2010) that 99% of all mental health wards are single sex. However, women-only mental health provision has not been achieved in every health authority. The criteria used to define single-sex wards or women-only wards need clarification; this often means a corridor, a bay area, with day rooms and dining areas shared with male patients. It remains one of the key areas for development as highlighted by NMHDU (2010).

According to a study by Mezey (2005), the introduction of women-only acute wards has obviously made women less vulnerable to sexual assault by men. Although women were found to be subject to threats and abuse by other women, in this particular study (Mezey et al, 2005). There has been a development of several women-only projects for consisting of wards, hostels, crisis houses, contained units and services that provide an alternative to hospital admission. In the current economic climate, we are concerned about the impact of the cuts and economic downturn for women as both public sector employees and as users of services. This concern within the context of this chapter is that women tend to use mental health services more and therefore any cuts to services will disproportionately

impact on them and secondly, that women become more vulnerable to violence and abuse when they are less financially independent (TUC 2011).

Acute in-patient care for women

We argue that inpatient women-only wards are more able to provide a space which is both safe and therapeutic. However, staff need relevant education, training and supervision, particularly for the care and support of women with traumatic experiences, whether they work within mixed sex, or gender specific inpatient services. In this respect, *Informed Gender Practice* (2008) is an important resource to support acute in-patient wards develop their approach to providing women-centred care. It states that:

> "A high quality service will be one where everyone who contributes to the services: 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 and alert to and challenges the ways that gender and other inequalities undermine the safety and quality of services"

This aspiration is entirely compatible with the definition of 'quality': effectiveness, patient experience and safety embedded in future plans for an outcome-focused healthcare delivery (DH 2010). Very importantly, this best practice guidance posed a fundamental re-frame of a traditional (medical model) question of 'what is *wrong* with this woman?' to 'what has *happened* to this woman?'

This resource is also helpful in introducing practical ideas to support services identify inequalities and address the diversity needs of women.

Childhood sexual abuse and mental health

The prevalence of women in mental health services who have experienced childhood sexual abuse is well-documented: 7 to 30 per cent of girls are estimated to be having been abused, which is three times higher than rates among boys (DH 2002). There are strong associations between childhood sexual abuse and mental health problems in adult life (Mullen et al, 1993; Itzin et al, 2008). A study by Coid *et al* states child sexual abuse as being "the primary abusive experience associated with the psychopathological symptoms measured in adulthood" (Coid *et al*, 2003: 336).

Many problems such as eating disorders and a diagnosis[1] borderline personality disorder (BPD) are more frequently found among women with histories of sexual abuse (Spatoro 2004). Women who have been sexually abused in childhood are more likely to experience physical or sexual abuse as adults. Women with mental health problems, who have been sexually abused in childhood, have particular needs for care, treatment and support that must be addressed by mental health and other services (DH 2003).However, it is important to note that in a recent Delphi study, experts are in agreement that 'there is no single therapeutic approach that works best for every victim/survivor in this group' (Itzin et al 2010)

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[1] We will use the phrase 'a diagnosis of BPD' to indicate that we believe BPD to be an undesirable label, mostly used to describe women – the majority of whom have experience of violence and abuse – and would add our support to the movement which would apply a diagnostic category of PTSD, if any was required at all. See also the campaign to get this diagnosis removed from the DSM at http://www.cabl.co.uk/

In Section 8 of the Consultation Document, *Women's Mental Health: into the Mainstream* (DH 2002), the impact of child sexual, physical and emotional abuse, all forms of domestic violence and sexual assault and rape are stated. These are well established as significant factors in the development of mental ill health for women, clearly linking a history of child sexual abuse with higher rates in adult life of depressive symptoms, anxiety symptoms, substance abuse disorders, eating disorders and post-traumatic stress disorders (Silverman et al, 1996: Itzin 2006). It also considers how survivors of child sexual abuse can experience retraumatisation during treatment including close observation, restraint, seclusion and the administration of medication for example (Judd et. al, 2009).

The consultation document states that mental health professionals' awareness of violence/abuse issues is very limited. Staff often have little confidence in acknowledging and addressing child sexual abuse experiences and specific training should be made available to all health professionals to increase confidence and competence to 'ask the question' and to respond appropriately. There are some excellent resources available to use to support staff learning and development; see for example:; *Not Mad or Bad, but traumatized* DVD by Cisters (2007) and a course reader, from the DH Collaborative Pilot Project, *Meeting the needs of survivors of child sexual abuse-underpinned by routine enquiry in mental health assessments* (NMHDU 2010) .

A study of survivors of childhood sexual abuse found that survivors do not object to being asked about possible experiences of sexual abuse, and non survivors do not mind being asked the question. (Nelson 2001; Stafford 2006). The specific recommendations are unlikely to make an impact without significant changes in staff attitudes towards sexual

abuse. Training is a vital component of ongoing professional development in helping to explore, challenge and change staff attitudes.

Staff must be adequately trained to appropriately respond to the disclosure of violence and abuse and possess the required skills to ask relevant questions about these issues during the assessment process. Through training, staff should also be able to identify presentations seen in the daily life of wards related to a history of abuse, and explore their responses to these. Ideally training should be mandatory and supported by regular ongoing supervision. The very best practice would ensure that women service users are involved in designing, delivering and evaluating this training.

Gendered violence and mental health

Despite the policy and evidence over the last decade to raise awareness around women as survivors of abuse and violence, the issues of domestic violence and other forms of violence against women (VAWG) are not addressed consistently across in-patient setting (NMHDU 2010) This is not unique to mental health services – as it is a problem in all clinical settings. *Together we can end violence against women and girls: a strategy* (2009) highlighted many of the issues facing women survivors of domestic violence accessing services and the lack of appropriate response they receive. During the development of the cross-government strategy, it became increasingly clear in the focus groups that many women continue to experience poor attitudes from staff who display ignorance of the issues, pay little regard to the safety needs of women and lack empathy and understanding (WNC 2009). In the same study, the Women's National commission made a firm recommendation in *Still we Rise* that all frontline workers be trained about the causes and consequences of violence and abuse.

The evidence of poor health service responses prompted the establishment of a DH Taskforce. The resultant report: *Responding to violence against women and children – the role of the NHS* (2010) made 25 recommendations for comprehensive and integrated response by clinicians, service providers, commissioners, regulators and professional bodies/royal colleges. The first of these recommendations was to raise awareness. The report stopped short of advocating 'routine enquiry' in all health settings, but recommended its continued use within maternity and mental health services. We referred earlier to the CPA assessment making it compulsory to ask the following question: "*Have you experienced physical, sexual or emotional abuse at any time in your life?*" And to record whether it has been asked and an explanation to be documented if not. Of course, it goes without saying that the point of having this question is that it is asked by 'suitably trained' staff as recommended by NMHDU (2010); and that it does not become another 'tick-box' exercise as experienced by women who use services in relation to other areas of assessment.

Most of the experience and expertise for working with women survivors of domestic violence is in the voluntary sector – but there are some useful resources to support mental health professionals develop the knowledge and skills for 'safe enquiry' and referral onto specialist services; see for example: *Sane Responses*: *A Toolkit for Mental Health Professionals.* Understandably, the most useful response that can be made to a disclosure of domestic violence is one of respect and belief in a conversation that has been provided safely and with compassion and understanding (Humphreys 2009). The aspect of understanding is complex; women are not a homogeneous group and the diversity within different groups of women and between groups needs to be acknowledged. So for

example, services and practices must be sensitive to the specific needs of lesbian and gay women, women with disabilities, women across the age groups, women of faith amongst other issues. In relation to BME women, we would recommend that services access the wealth of resources published by specialist voluntary sector providers. In particular, Siddiqui and Patel (2010) have provided a useful critique of national policy and developed a 'hybrid' model of intervention specifically designed to promote a whole-systems approach. Importantly, they draw attention to the very different risks and dangers that services often unwittingly place BME women in. Specialist services for all groups of BME women to address gendered violence in its widest forms have to be supported and developed to comply with current legislation.

The current coalition government have made their commitment clear by producing a *Call to end violence against women and girls* (HM Govt 2011) In the *Action plan* a further commitment is made to the implementation of recommendations made in the Taskforce report (2010). In addition, we note that mental health commissioning guidance is highlighting the need to address the mental health impact of violence and abuse (Bennett et al 2011).

Reflections on education and training projects

Example: Model of care, Ward A

In our first example, a large Mental Health Trust in the Midlands developed a collaborative model of care for a new and first ever women-only ward within that service. The model of care was developed on the shared understanding of multi-disciplinary staff. A vision and set of principles was facilitated in order to develop a description of the purpose of the ward and set some criteria for referral to the ward. It was always anticipated that demand would be greater than the supply of beds; but that this would be an opportunity to establish a framework for future development at the same time outline best practices for caring for women on mixed sex wards.

The development of Ward A was aligned to national policy *Mainstreaming Gender and mental health* (2003) driven by the need to address privacy and dignity, and to ensure the safety of women in relation to the aforementioned vulnerability of women to sexual assault and violence experienced on mixed acute mental health inpatient wards. In addition, the NHS confederation Briefing (2008) had provided guidance to support the development of a national policy on abuse and violence. It is well-documented that a high proportion of women within mental health services are victims/survivors of all forms of emotional, physical, financial and sexual abuse and is incorporated as 'routine enquiry' and is supported in recent CPA documentation (DH 2008).

This model of care was based on pre-requisite standards for staffing and clarity around the patient group in terms of need and vulnerability. The following was used as immediate referral criteria, based on priority factors previously recommended within the literature for women-only provision (DH 2003): women who are pregnant; women from BME communities with cultural preference for single-sex ward; women with histories of abuse

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and violence (who state a preference to be on women-only ward) and women assessed as vulnerable with regard to sexual health behaviours.

The basis of the model of care were a number of core 'purposes' of the Ward A which were agreed and were suggested as a basis for future service evaluation[2]

- To provide a therapeutic and safe environment

- To provide a focused, holistic, positive and 'distinctly different'[3] experience of in-patient care

- To provide a meaningful choice for women

- To address issues of violence and abuse

- To address specific mental health and well-being needs

- To work collaboratively within a women-centred recovery-based approach

It set out to provide a specific philosophy of care which was therapeutic, set the parameters for the delivery of consistent and high standards of service, provide skilled care and effective systems of inter-professional working. The emphasis was on developing an ethos and skill-base for relational security, although it was anticipated at the time that this would need organisational investment and strong multi-disciplinary leadership. The model went onto articulate the women-centred aspects of holistic health including physical health with an emphasis on the specific reproductive, life cycle health needs.

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[2] The second author subsequently left working with the Trust and is unaware if any formal evaluation using these core purposes as criteria were developed

[3] Influenced by the sub-title of the Corston Report (2007)

Many of the staff taking part in the education and training projects were keen to adopt a woman-centred recovery based approach in their work with women. They wished to make a difference to the lives and help them make steps to improve their ways of relating to others, and to find and maintain safe and secure relationships. All the staff participating in the focus groups and training signed a consent form to enable the first author to write up discussions taking place and to publish the results; and the participants all gave informed consent. Time was taken during the training and workshops to ensure the views and reflections of the staff were recorded accurately. The author gained ethical approval to publish the paper from the Sub-Ethics Committee and final approval from the Clinical Director of the Mental Health Trust.

The focus groups were held monthly with a staff team from a women only ward in the South of England. They were a mixture of qualified and unqualified nursing staff. Within these groups, discussions took place relating to clinical practice in relation to work with women, such as culture and ethnicity, sexuality, women's specific mental health needs, and body image. It became apparent that this staff team did not receive training that addressed effective ways of meeting women's specific needs. For example, it was stated by some staff that some of the women service users disclosed painful experiences such as rape, and staff often did not know how to respond.

Women's spaces

Women's sexual expression was frequently discussed in the focus groups. It was very interesting – and often moving – how within the women only space of the ward, the

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experiences of the women patients' sexual relationships was freely discussed. It seemed that this was comfortable for the women patients and staff and there was much laughter and joy expressed. It seemed that in this space women were able to speak. Some women patients stated to the staff that they could not discuss their sexual feelings on mixed sex wards as they did not feel safe enough to do so.

In the focus groups, issues of the women's sexualized behavior when they were unwell, were also of great concern to many of the staff. Women from nearby mixed acute wards were frequently transferred to the women-only ward because their behaviour was considered as 'inappropriate', as the staff said. There were reports of how women would wander into male dormitories scantily dressed. They were often perceived as being 'flirtatious' and considered as highly vulnerable. Mentally ill women's sexuality seemed to be 'pathologised' as the staff taking part in the focus groups put it. The staff often felt helpless in these situations. They questioned what the most appropriate response would be to these women and it was generally considered that these women patients were being flirtatious and staff were often at a loss as to what to do. Women were often considered as 'uncontrollable' in their perceived eagerness for sex by some staff on the mixed sex wards. The issue of women's sexuality did not appear to be explored within any of the clinical areas, and the staff taking part in the focus groups expressed that it seemed that these issues were not addressed at all when the women were on mixed sex wards. Consequently, women with these 'issues' were referred to the women-only ward, as the staff in the focus groups stated: 'to decrease their desires'. However, in the women-only environment, the staff felt motivated to address these issues, and had the space to do so. In their view, they

needed more time spent in team meetings to explore these issues and more training to help them address these issues in the everyday running of the ward.

Experiences of gendered violence and abuse

A large majority of the women who were admitted on the women-only ward, as well as those transferred from mixed wards, had experienced sexual and physical abuse. From the first author's point of view, it seemed that 'flirtatious' behaviour on the part of women who had experienced sexual abuse, was often an attempt their work through the experience of abuse (we return to this issue on page 19).

The staff on the women only ward also stated that women who were in acute distress or who were perceived as manic were also frequently admitted. Consequently, 'at risk' women needing one-to-one observation, transferred from mixed sex acute wards, appeared to receive the most attention from staff. The other vulnerable women often got side lined, which was of great concern to the staff. They were not able to effectively deal with the issue of women's abuse. They were not given an adequate opportunity to explore this issue, and they frequently spent a large majority of time responding to women in crisis. The staff stated that there was a need for another unit that would serve to meet the needs of women in crisis who were seen as high risk and requiring intensive care and observation. Many of the women did disclose experiences of sexual abuse on the women-only ward and said they would not have done this if they were on mixed sex wards.

Body image

The issue of women's sense of their bodies and in relation to the experience of mental distress (Ussher 1997; Phillips 2006) is well documented. The staff team on the women only

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ward was aware of this and stated they would appreciate training in this subject area. They were aware that many of their women patients had experienced sexual abuse and domestic violence and they were interested in how these would affect a woman's sense of self and body. Discussions about female patients appearing to have complex and difficult relationships with their bodies were frequent in the focus groups.

The staff strongly stated that they would find training on eating difficulties very useful for their work with women. Interestingly, they reported that the female patients on the ward appeared to eat openly on the ward with other patients and often in large quantities. Many of the women would clearly become physically heavier during their stay on the ward. Obviously there are health concerns here, but it seemed that the women felt safe to take up space while on the ward. Often women feel uneasy about taking up space in the world. One of the discussions in the focus groups focused on how men often presume they can take up space and for women this is much more difficult! There was an acknowledgement that women were able to take up space on the women-only ward, and they were able to be 'themselves'. One staff member said the women could walk around, wash, sit on the sofa, and not worry about men being around for that particular time, when they were particularly in need of care and support.

Example: Mixed sex acute wards - workshops

Workshops for staff working within a variety of mental health mixed inpatient services were delivered over a period of four months, consisting of a one day programme that was repeated every week for ten weeks. The aim of the workshops was to encourage and enable

staff to work in a gender sensitive way and develop strategies for the sexual safety of women patients in their clinical areas.

The therapeutic relationship

The staff taking part in the workshops stressed the importance of maintaining boundaries with women patients who had experienced sexual abuse and clearly emphasised their wish to work therapeutically with them. But a number of factors prevented this. One issue preventing therapeutic work and a 'space' for women, were the demands on staff working in mixed sex wards. There were daily issues about the safety of all patients and dealing with high risk patients. There were also the responses of staff to women who had experienced sexual abuse. The staff expressed feelings of confusion and anger. As one participant stated 'I get so angry with the women who put themselves at risk. I do not know why they do this.' Women patients with sexual abuse histories were perceived as rather baffling and infuriating and appeared to consistently jeopardise the positive changes they made while on the wards. Staff stated that they felt hopeless, angry, and intruded upon by the women, and they had limited opportunity to explore these responses. There was an overall scarcity of training and supervision given to the staff, although one particular clinical area was an exception. As staff were frequently dealing with issues of risk, particularly physical threat in relation to the male patients, they stated that in their working lives they did not have an opportunity to discuss their responses to women patients. From their point of view, there was a need to focus on the women patients and their experiences, but they felt they did not have time to do so.

The feelings encountered by staff could actually bring them closer to the experiences of their women patients, but time is needed to think these issues through. Many women patients transfer their experiences of sexual abuse onto the staff that look after them. Transference is the repetition in the present of a relationship that was significant in the person's early life. Early relationships are 'lived out' in the transference (Laplanche and Pontalis 1988). This may be apparent in people who have experienced painful early lives such as sexual abuse, who may frequently transfer or project their feelings onto others as a way of getting rid of the anxiety it causes them. Women patients, who have experienced sexual abuse in childhood, may get rid of the painful memories, or unacceptable and disturbing thoughts associated with the abuse, and put these into the staff caring for them. The staff may then encounter uncomfortable feelings about their women patients. They may feel sexual attraction and feel confused about the 'sexualised' behaviour of their women patients. It is important for nurses to distinguish between the feelings that belong to them and those that belong to their patients.

It is vital that time is spent thinking about women patients and the ways in which their early experiences may affect their relationships with others. We believe this is more possible in women-only spaces, and women have reported that they are more likely to disclose abuse experiences in safe, women-only services. This may lead to the nurse being able to think more clearly and reinforce boundaries within the therapeutic relationship. The staff stated that their often troubling responses to their women patients prevented them in establishing good therapeutic boundaries. Unclear and inconsistent boundaries have been considered to decrease a sense of safety in many patients with a diagnosis of Borderline Personality Disorder (Geller & Srikameswaran 2006). When good therapeutic boundaries are

established, staff are less likely to feel overwhelmed and 'burnt out', and plans for the effective care of patients become clearer (NIMHE 2003; Langley and Klopper 2005).

There are many authors who have discussed the importance of supervision using a psychodynamic framework for understanding the experiences of patients (Evans and Franks 1997; Fagin 2001). This theoretical perspective has the potential to enable mental health practitioners to think about and provide meaning for the anxieties they often feel about patients, thus reducing the risk of thoughtless action. Staff are very unlikely to act upon difficult responses if these are articulated in a safe and meaningful way in a supervisory relationship. It is perhaps being given permission to say the unsayable and take hold of the reality of mental health practice. Staff could be encouraged to think about their own feelings that are provoked by working and caring for vulnerable women and to put these thoughts safely into words. What arose particularly in the workshops was the expressed feelings of hopelessness by staff, and the experience of observing women who do not appear to help themselves and repeat destructive relationships and patterns of behaviour. Perhaps articulating the reality of our feelings and responses to vulnerable women we care for is extremely important to their well-being.

Staff training

Staff taking part in the workshops expressed they often could not make sense of why the women were often putting themselves at risk and willingly repeating destructive behaviour and getting involved with men who might hurt them. One of the reasons why people often repeat early traumatic experiences is because these experiences are understandably reproduced or relived in adulthood in an attempt to overcome them. This is termed within a

psychodynamic framework as the 'compulsion to repeat' (Laplanche and Pontalis 1988: 78). Theoretical understandings incorporated into training, enable enhanced insight and understanding of how women who have experienced sexual abuse in early life, often repeat ways of relating inherent in these early experiences.

Thinking and finding out more about patients is daunting without good support. There are confusing messages in the world about women's bodies and it is worth thinking about them. Staff, and particularly male staff, may be concerned about stating their responses to women patients because of potentially being misunderstood or fearing disciplinary action. The document, *Sexual Boundary Issues in Psychiatric Settings* (RCP, 2007), emphasises that staff must be encouraged to recognise and acknowledge personal feelings that would actually help them to act appropriately and professionally with patients. It also states that healthcare workers can learn through training how to speak to patients in a gendered but unsexualised way. This is particularly important when working with women who appear to communicate in this way.

There needs to an emphasis upon 'being with' the women and the space found within women only services can enable this. Staff could focus on spending time with women during a shift, where there is not a sexualised discourse. There is space for positive engagement and reflection, and quality time being spent. Staff taking part in the workshops expressed that they needed space to think through and build up therapeutic relationships. Staff training is an effective way to enable staff to explore ways of keeping women safe, and it enables staff to spend some time reflecting upon and thinking about their work. Nurses seem to be caught up defensively in 'doing' things, (the vast amount of paperwork introduced in the last decade is one example). Training is particularly useful within clinical

areas on ward settings. Hardcastle (2000) has suggested that training could be incorporated structurally into practice and takes place within clinical areas so that it can be more accessible to nurses, which may be more cost effective. However, there are constraints within mental health clinical practice, despite the fact that the need for staff training is often articulated by service commissioners and practitioners. Often shortages of staff mean that team members cannot attend the training they need, and there are shortages of money available for staff training.

Conclusion

The staff taking part in the model of care development, focus groups and workshops discussed in this Chapter were highly motivated and dedicated nurses. They demonstrated willingness to engage with their women patients in a meaningful way. However, they expressed that they often did not know how to respond to women's specific experiences and subsequent health needs. This particular group of staff was not given the adequate training to prepare them adequately as mental health nurses to work effectively with women. They also stated that they needed more supervision, as informal support often took place between staff members during breaks or outside of work time. The staff stated that the focus groups and the workshops were very useful as it gave them the opportunity to stop and reflect upon their work. They also stated it provided an opportunity to praise themselves for their hard work in working with women.

There is an obvious need for effective policies, increased staff levels, improvements in ward layout and a consistent approach to recording and monitoring data relating to sexual

assault. Incidences of sexual assault may be decreased with these strategies in place. Women patients require acceptance, understanding, therapeutic care, and guidance on how to keep safe. They need to be taken seriously by staff caring for them regardless of the 'truth' of their perceptions of others. Psychodynamic insights can help mental health practitioners and professionals to understand why certain patients, particularly those with histories of sexual abuse, often relate to others in damaging ways. Staff may experience daunting and hopeless feelings about their patients and should be encouraged to speak truthfully about their reactions and responses and begin to make sense of them. Staff can put in place therapeutic boundaries that benefit both the staff member and the woman in their care. For this to occur, staff need support and acceptance from their managers, supervisors and colleagues. Nursing staff are well placed to fulfill some of lost aspects of many women patients' lives, particularly in the crucial area of the therapeutic relationship that deserves an important place in the daily running of mental health acute inpatient services.

Women patients do have particular needs. They need their mental health difficulties to be understood in light of their experiences and these include their roles within relationships and families and in relation to their ethnic and cultural backgrounds. It is also vital that staff respect and recognise women's expression of sexuality and their experiences of their bodies. Effective training with frequent and supportive supervision, create and safe and caring environment for staff and women to work together. This requires women to have access to a therapeutic space where physical and personal boundaries are not intruded upon or misinterpreted. Gender specific or women only mental health services can provide this space, particularly for women who are particularly vulnerable. Therapeutic space can

also be provided for women on mixed sex inpatient, acute wards, but this is more difficult when there are pressing concerns about risk and safety for all. Finally, but most importantly, the views of women themselves should be sought. We know that some women service users prefer to be on mixed sex wards and respond very positively to the presence of male staff and patients (Travers et al, 2006). Providing real 'choice' for women requires improved service–user involvement that directly impacts on service planning, delivery and evaluation.

It does not cost a vast amount of money to create a safe and therapeutic space for women. If there are very limited gender specific services that respond adequately to women's experiences of gendered violence and abuse, this must result in significant health care costs. Women with childhood sexual abuse histories are likely to repeatedly use A&E services and/or end up in the criminal justice system as they attempt to cope with their experiences. We would advocate the use of Crisis homes (see Howard et al, 2010 for an account of these services as viable alternatives to admission wards). They are cost-effective and have less impact on the family. We are aware that whilst this was a recommendation of *mainstreaming gender and women's mental health* – it has not been widely adopted – although this model potentially provides an alternative pathway which may be beneficial all round.

For organisations considering a whole-systems approach to developing specific mental health care for women, the Good Practice Checklist for Mental Health Trusts (NMHDU 2010) continues to be a useful framework. This is a self-assessment tool and considers the organisational context of all service provision, the values and principles of gender equality, specific women-centred delivery, workforce development and service monitoring. There is little formal evaluation of women- only services, despite the many recommendations about

the need to evaluate different models and pathways of care generally across mental health delivery. Given the rising costs of in-patient care and the desirability of increased community provision, it would seem timely to re-visit the recommendations made in *supporting into the mainstream: Commissioning women-only community day services* (2006).

The voluntary sector has for many years been the main provider of women- only services. They have the experience, the relationships and the expertise. For many women, mental health services are hard to access, stigmatizing and re-traumatising. However, we also know that the women's sector is under increasing pressure and actual threats of cuts and withdrawal of funding. We fear for the future of women-centred services as childhood sexual abuse and VAWG affect women more greatly – locally, nationally and globally, continue to be prevalent in our society. Investment opportunities are being reduced, yet the rhetoric is one of prevention. A healthy mental health landscape needs multiple providers within the economy, in order to give opportunity for all women of all backgrounds and experiences to access help when needed. We advocate the development of infant and child mental health – where services work to prevent and minimize the long-term effects of abuse and neglect on individuals and families. Gendered violence and abuse is widespread and the consequences to women's physical, mental health and well-being are supported by many sources of evidence. The need for equality, fairness and justice must underpin improved responsiveness to protecting and supporting the human rights of all women who come into contact with services. Future mental health services must reflect the continued pressure that campaigners seek to deliver services that are women-centred, safe and effective, and that issues of violence and abuse are tackled in line with national and

international legislation and best practices. It is imperative that clinical and strategic leaders commit to the human rights of women in receiving excellence in statutory and voluntary sector services.

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