Women and secure settings

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST

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'IF THERE was a service in the community'; 'if we had the staff who could work with self-injury'; 'our service is for mental illness not personality disorder'. All too familiar accounts, heard in my time working as lead psychologist in high secure Women's Services at Ashworth, Rampton and others. Once in the secure mental health system, women are at risk of losing their liberty for between three and four times longer than their women peers in prison, and longer than their male peers (Aitken & Logan, 2004). As a feminist, how do I reconcile working within this system, when I'm the one holding the keys, metaphorically and literally?

A framework

Personal issues of difference have been a recurring feature of my life. However, I have not always had the resources to name or explain the issues in ways in which I felt I would be heard. Reading Kate Millett's (1977) *Sexual Politics* provided me with a nameable framework: feminism. It inspired me to go to university in 1983, to study psychology to better understand why discrimination occurred. Feminism gave me the framework to challenge social inequalities and discrimination, and to attempt to work and relate in anti-oppressive ways.

WEBLINKS

Women in Prison: *www.womeninprison.org.uk*
Equal Opportunities Commission: *www.eoc.org.uk*
Care Services Improvement Partnership Consultation: *www.csip.org.uk*
Women's policy team: *homeoffice.gov.uk*

But entering clinical training 10 years later, I was struck by the absence of reference to the social context of people's lives, whether in the understandings of their presenting distress or in the routes into (clinical psychology) services. There was little discussion of possible differences and similarities in the impact and meaning for women and men being referred to a particular service with a particular diagnoses, or in working with me as a woman. Nor was there space for me to reflect on my possible feelings and attitudes as a woman towards working with different women and men.

My final-year placement was in adolescent and adult forensic medium secure services. I became concerned that there might be one or two (young) women, often with histories of chronic abuse and domestic violence, on a ward of 14 men (some of whose offences were for sexual and physical violence against women). I questioned the physical and psychological or emotional safety of women patients being in both a numerical and political minority. I witnessed women being referred up the levels of secure care because of their self-injurious behaviour, and questioned how being behind a higher wall could positively impact on women's well being. I questioned whether assaults against members of care staff reflected re-traumatisation by the very hospital systems, which were supposed to provide therapeutic care and safety (see Jennings, 1994). Such experiences informed my decision to contribute to the development of more appropriate (psychological) services for women by working in 'closed' secure services.

Head above the parapet

As part of the recent national health and social care services reform agendas, equality and diversity is actively celebrated. Mission statements, legislative and policy directives, strategy and implementation initiatives abound. Gender and cultural sensitivity, competencies and standards are discourses commonly articulated. But this has not always been the case. Historically, putting and actioning women's and wider equality issues in organisations and professions has carried risks and been met with a range of forms of resistance (Holland, 1989, 1992; Sayal-Bennett, 1991). Reported experiences include being marginalised, subject to public humiliation with costs of personal distress, trauma and burnout, and blocked careers, as well as decisions to leave a profession or service are common. Not surprisingly, when issues around equality have been raised, a

majority of people have 'kept their heads down'.

For many feminists the key issues are that the role, meaning, and impact of social inequalities on many women's everyday lives has not been considered legitimate areas of concern for mainstream institutions – theorists, researchers and practitioners. At grass roots levels, women have always been organising for ourselves behind the scenes in practical ways: setting up of refuges, crisis houses, rape crisis lines, self help groups, women's therapy centres. The wealth of literature and shared experiences and activism over the decades produced by user groups, feminists and the women's movements have all too often remained outside of the mainstream institutions consciousness: from education to NHS organisations.

So how did I reconcile my feminist commitments with working in secure systems in which any contact with women is shaped both through general and specific forms of control? We are professionally positioned as 'experts' in the psychological domain and it is important to acknowledge that we are inherently part of such systems of control. We hold keys that can open and close down options, choices, and doors for women patients. We engage in psychological assessments of risk and need, assessment for therapy, and assessment of the usefulness (or the ability of any women to benefit from) such therapeutic work (Aitken & Noble, 2001). In response, colleagues and I have tried to build into our work 'an appreciation of the existence and impact of social and sexual inequalities' and power relations on women's lives (see Williams & Watson, 1994).

For example, in assessing women (pre-admission, on admission, or for therapy), I and colleagues questioned the relevance of a reliance on assessment tools which focus on personality or mental illness classifications but which ignore or minimise the possible impact of early and later trauma (physical, emotional and sexual abuse, and neglect) on women's presentations. We sought out tools, which reflected those aspects of women's lives, enabling us to question and reframe psychiatric diagnoses of borderline personality or severe mental illness. Rather than categorise women with schizophrenia, we could start to understand the presence of intrusive 'voices', thoughts, and visions as related to trauma and re-traumatisation by paying attention to the content and meaning of these experiences to a woman.

We aim neither to problematise women nor to position women as 'victims', but to understand women in their social contexts. The history of the psychiatrisation and psychologisation of women and minoritised social groups has focused on pathology and 'illness' models (Fernando *et al*., 1998; Ussher, 1991). Our approach has been to always include women's strengths and resources, and to build on and communicate women's perspectives in any encounter or in psychological reports.

Swimming against the tide

Although the recent Agenda for Change and Knowledge Skills Framework initiatives in the National Health Service focus on competencies rather than professional base, and the need to change ways of working for professional groups (e.g. New Ways of Working for Psychiatrists: NIMHE, 2006), change is still relatively slow at a local level. In my experience, gendered forensic and medicalised discourses are still particularly powerful tools in which potentially creative and innovative possibilities for developing services for women continue to be overridden.

Vivienne-Byrne's (2001) application of the concepts of 'safety' and 'certainty' to understand the tensions which might emerge when trying to move away from a medical and security driven model in secure forensic settings is useful. 'Safety' is understood as the provision 'of a sense of psychological or emotional containment' from a therapeutic perspective. In a forensic context, 'safety' often reflects 'physical containment': to protect the patient, staff, and public from dangerous behaviour. The concept of 'certainty' from an expert's position is understood as reflecting the knowledge 'about the condition to be treated and the means of doing this' (p.109).

For example, medico-legal discourses that link illness with acts (dangerousness to self or others including, where relevant, offending behaviour) still predominate. A solution is to create 'safe certainty' by drawing on evidence-based interventions which, in the world of the NHS, is paramount. Clinical effectiveness is still based on the outcomes of 'randomised control trials': a method suited for psychiatric diagnoses and medical/pharmacologically based interventions. Not surprisingly, the efficacy of neuroleptics in 'treating' schizophrenia is particularly promoted.

In secure settings, when 'illness' is contained or stabilised (i.e. safety established), then psychological interventions can be contemplated. Then it is cognitive behavioural approaches (randomised control trials) in particular which have emerged at the forefront of evidence-based psychological therapies. When adopting a woman-centred approach, one concern is that a (narrow) reliance on particular approaches or techniques risks requiring women to adjust to the social order of the institution or wider society. Some have argued this reproduces structures of domination and exploitation, in socialising women to tolerate the

WHO ARE THE WOMEN?

In 1997 the national listening panel exercises started in relation to women in secure settings. A strategy was published (Department of Health, 2002) for all women at risk of or identified with mental health and related needs. During the same period, the Fallon & Tilt inquiries, and commissioned research (e.g. Shaw *et al*., 1999; NHS Executive 1999) identified that too many men and women were held in too high a level of security.

The profiles of women in secure psychiatric and prison settings indicate histories of chronic sexual, physical and emotional abuse; instability of care relations; multiple contacts with statutory agencies (health, housing, and social services); and poverty associated with low income, non-paid employment and being lone parents (Parry-Crooke, 2000; Bostock, 1997). The charity Women in Secure Hospitals commissioned research which showed that relative to men, women were more likely to be detained under a civil section of the Mental Health Act, and to be spiralled up the system because of self-injury and/or aggressive acts against property and their carers (WISH, 1999). Further, women typically commit an isolated offence precipitated by a specific family or social situation (often linked to their abusive past), or have an index offence of arson with no intent to endanger others' lives (WISH, 1999; see also Gorsuch, 1998; Hemmingway *et al*., 1996).

oppression of the institution (Kendall, 2000). When psychological service provision is experienced as 'complying' with such evidence-based models, then the psychology service is at least tolerated and at most valued for being a 'team player' in adhering to models of safe certainty.

My experience across a range of secure psychiatric settings is that psychological therapies are often viewed by the wider institution as a form of therapy (like medication) on prescription. The experience of a woman is fragmented into discreet entities, e.g. self-esteem; assertiveness; anger; index offence; self-injury, rather than formulating the woman's presenting distress and risk in a more holistic way. Such approaches also, at times, reflect the skills and training of existing staff base or the availability of specific therapeutic or rehabilitation programmes, rather than the needs of the woman.

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The new women's unit at Rampton will provide a national high secure service for 50 women

Attempts to extend the range of therapies and therapeutic ways of working (including feminist or transculturally informed person-centred, psychodynamic, cognitive behavioural, cognitive analytic approaches, setting up of self-help groups, and bringing in community agencies which have a history of working with women survivors) can be threatening for existing professions and services. In part, this may reflect a move away from 'safe certainty' (knowledge of mainstream or familiar therapy approaches, traditional professions, and sense of control over internal employees) towards a position of 'unsafe uncertainty'. A move which can arouse anxiety about the anticipated increased risks to patients, staff, and the public, which then solidifies into forms of resistance against change.

This sense of 'unsafe uncertainty' is heightened by the articulation of gendered discourses. For example, women patients become constructed as having particularly complex needs, being particularly challenging, and especially vulnerable to overt forms of abuse (all of course relative to men). Women are also constructed as 'too fragile' to be allowed to risk trying out therapies which explore the emotional and relational aspects of being, even at a woman's request. In effect women are constructed as differently dangerous but more so than men – to services and to themselves. The consequence is that a culture of suppression of rage, anger, frustration, and fear is maintained, as is the communication of women's sense of vulnerability and powerlessness. Women are 'done to' rather than 'being with' (whether in staff-patient interactions or in relation to their own feelings).

I am not arguing that formalised psychological therapies are necessarily the solution to meeting or working with women's needs and risks. Rather, it is about opening up different possibilities of what could be considered therapeutic – treated with respect and as a human being, not being dependent on another to meet most basic care needs and to be acknowledged as having a positive contribution to make to life, to emotional and psychological containment as well as direction over the forms of meaningful activity, and therapeutic support and care.

Flux and transition

At the time of writing, all levels of secure services are in a period of flux. High secure services for women have been downsized. Ashworth Women's Services closed in Autumn 2003 and Broadmoor Women's Service will close in 2007. The

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number of beds at medium security for women is being increased, as well as the introduction of Enhanced Medium Secure Services (Edge, 2006). These reconfigurations also reflect the modernisation principles of the national health services: 'people should be kept in the least restrictive environment which could provide adequate care and treatment, and to be located as close to their home community as possible' (NSF Standard 5: Dept of Health, 1999). This was further supported by the integration of three English high secure hospitals into local NHS Trusts from 2000. This was an attempt to reduce the insularity and isolation of high secure services and to support the connection of high secure services to a community context (concept of pathways of care) and arose out of the Fallon (1999) and Tilt (2000) reports.

Possibilities for positive changes in women's experiences of inappropriate contact with psychiatric services are driven through women's mental health and related policy and guidelines directives (Dept of Health, 2002, 2003; Dept of Health/NIMHE 2006; Dept of Health/CSIP, 2006). But change is slow. We have internal interprofessional dynamics being played out as professions such as psychiatry, nursing, and social work expand their roles and ways of working. This means that the domain and ownership of psychological knowledge as the sole province of psychologists is increasingly contested. The risk is that women patients get forgotten as energies of professions are redirected to contest or claim legitimacy over the direction and content of patient care within particular settings.

Conclusion

In working in secure services, it felt safer for my colleagues and I to be or talk 'more revolutionary' outside of secure settings. Once physically working within the system we (or our activities) risked being interpreted as also differently dangerous. In these circumstances, we oscillated between conforming and reforming (but trying to hold a sense of integrity in any of our actions). For these reasons, we also worked outside the boundaries of our particular organisations, including action and support through independent networks such as NW Women working with Women (1998-2006) or in cross-organisational working.

I and a number of colleagues have reflected that much of the time we have borne witness to the experiences of women in the secure psychiatric system (see also Aitken and Arkwright, 2002). At the same time, we have tried to find spaces and allies to try to alert the system to our role in reproducing wider social injustices, and suggested that discourses around 'user-led', 'care' and 'collaborative multidisciplinary working' may not be the experience of all. Our responsibility as psychologists and therapists is to continue to question our own practices and work with a woman's experiences without closing her (options) down (Burstow, 1992).

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DISCUSS AND DEBATE

In April 2007, the Public Sector Duty on Gender Equality comes into force. This means that public sector service providers and employers will have to design employment and services with the different needs of women and men in mind and consider:

- What are the priority issues for women and men in the services we provide?
- Do women and men have different needs within some services?
- Are there some services which are more effectively delivered as women- or men-only?
- How prepared is psychology as an applied profession, and us as psychology practitioners, for the Public Sector Duty?

Have your say on these or other issues this article raises. E-mail 'Letters' on psychologist@bps.org.uk or contribute to our forum via www.thepsychologist.org.uk.