Stepping out
The needs of women discharged from secure mental health services

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### Acronyms

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<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
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<td>CTO</td>
<td>Community Treatment Order</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>HSPH</td>
<td>High Secure Psychiatric Hospital</td>
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<td>LSUs</td>
<td>Low secure units</td>
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<td>MIME</td>
<td>Making Involvement Matter in Essex</td>
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<td>MSUs</td>
<td>Medium secure units</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>NMHDU</td>
<td>National Mental Health Development Unit</td>
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<td>OT</td>
<td>Occupational Therapist</td>
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<td>PCTs</td>
<td>Primary Care Trusts</td>
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<td>PD</td>
<td>Personality Disorder</td>
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<td>PIC</td>
<td>Partnerships in Care</td>
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Summary and key messages
The research was commissioned by Essex County Council’s Mental Health Commissioning Team as a small scale study to explore what is currently known about women’s needs as they are discharged from secure mental health services and the provision that is available to meet these needs. The aim of the study was to identify both the real and the ideal types of services that ensure women are able to lead independent and sustainable lives in the community. While local, the research will have national significance, and it is hoped that this will be one step towards enabling NHS and social care commissioning teams to plan with both insight and foresight for this particular group of women.

Setting the scene
There has only recently been recognition at governmental and hence policy levels that women have mental health needs that are distinct from their male peers and that they may therefore require different services which fulfill their particular needs. Many of the issues specific to women’s mental health were outlined in the consultation document ‘Into the Mainstream’ which details the gender differences in the ways in which women present with mental ill-health. There are gaps in knowledge in relation to almost every aspect of this complex subject; from the pathways that women actually take out of secure mental health services and the ways in which these could be eased (through effective service provision in the community for instance) to the best ways of designing gender-specific services.

The broader context which frames the discharge of women (and men) from secure mental health services has been the increasing emphasis on community treatment for psychiatric patients since the mid 1980s. This is also the period when many new ‘medium secure’ hospital places were created (Jamieson and Taylor, 2002; Steffen, Kösters, Becker, and Puschner, 2009). There has been a consequent change in the function of psychiatric hospitals towards providing short-term crisis interventions. Patients are therefore likely to experience several transitions from in-patient to out-patient status (Steffen et al., 2009).

The existing system for women moving on seems characterised by both a lack of uniformity in service provision and inadequate services (that for the most part fail to be holistic (Chaudhry and Pereira, 2009) as well as by differentiations in the patients that different sectors care for. Overall, it has been noted that services in England and Wales have often developed idiosyncratically, driven by local interests, rather than as part of a national strategy (Gow, Choo, Darjee, Gould, and Steele, 2010). Within this context, the complexities around understanding how best to plan specifically for women moving from secure mental health settings into the community are evident.

What’s already known about moving on?
Due to the lack of literature uncovered here that directly tackled the question guiding this review, (what are the needs of women discharged from secure mental health services?) the literature was interrogated critically for relevant themes. Some literature was found concerning the needs of women within secure services, including mental health units and prisons. Work has also been done on reconviction rates following discharge into communities and connected with this risk assessment work regarding reoffending following discharge. Other studies have examined the design of secure mental health services and geographers have considered socio-spatial injustices in community care models. Perhaps the most directly useful work was research (in the US) that discussed the reintegration of women leaving jail (Richie, Freudenberg, and Page, 2001; Richie, 2001); despite the obvious problems of extrapolating from this work, it nevertheless focused on women and their needs when leaving secure settings (albeit prison rather than mental health services).

What emerges from research and the broader literature is that women experience a series of ‘tangled pathways’. The literature on moving from secure services to other forms of services (medium/low security units – general psychiatric hospitals, hostels and community) indicates that there is not a simple process of discharge and neither are there standardised procedures that are followed. Rather there is often a certain amount of to-ing and fro-ing between units and services. The need for careful discharge planning has been highlighted by the only systematic meta-analysis of this subject (Steffen et al., 2009). This study comments upon the fragmented nature of services offered those who are discharged and reiterates the finding that transitions are often not successful. The difficulties of developing discharge protocols that are applicable to a
heterogeneous population are appreciated; and yet the authors comment with certainty that the implementation of discharge interventions:

‘...can contribute to reducing hospital stays and to improving patients’ adherence to aftercare as well as symptomatic impairment.’ (2009:8)

One of the few studies that considers gender differences following discharge (Maden et al., 2006) notes that women appear to have a lower risk of being reconvicted because they tend to less often have a history of previous convictions and more often one of self-harm. This provides the clearest indication that the journeys for women out of secure mental health services require different sorts of supportive interventions.

**Women stepping out**

Eight women from Brockfield House (a dedicated women’s medium secure service) took part in interviews with Making Involvement Matter in Essex. These interviews highlighted the significance of all aspects of the process of living in and leaving secure accommodation to eventually settling into the community. Women participants identified a range of positive aspects that this move might bring to their lives, but most were also very apprehensive about various aspects of the move, particularly when their previous experience had not been positive. The idea of the move understandably generated a range of strong emotions, from fear of the process and uncertainty about the future to much hope and excitement about being back in the community. Because everyone is different, women expressed different views in relation to their future accommodation and support needs. This demonstrated the importance of services being organised around the particular set of needs each women has, referred to as individual care planning. Despite these differences there were common themes:

1. **Securing accommodation that would meet each woman’s individual needs for:**
   - Safety (both a safe location and away from people or places that could be problematic)
   - Support
   - Reasonable living conditions
   - Not being isolated
   - Access to activities to occupy them.

2. **Transparent discussion and preparation before discharge, including information about:**
   - The likely accommodation options that would be available
   - How accommodation needs are assessed
   - Whether choices would be available
   - For women with children, whether the accommodation would be large enough for children to stay
   - How many moves from one place to another might be involved.

3. **Clear information before discharge about the support available in the community – who to call and when (including out of hours) for:**
   - Mental health support
   - Therapeutic support
   - Housing support
   - Opportunities for work (paid or unpaid), education and leisure facilities.

4. **Continuity of support before, during and after discharge, including for example:**
   - Building and developing independent living skills
   - Ongoing contact with a known professional
   - Opportunities before discharge to learn from women already discharged to the community about their experiences and coping strategies (if not possible in person then written or DVD material could be used)
   - Peer befriending following discharge
   - Assistance in maintaining existing community links and with developing new ones before discharge to help in reducing anxiety about discharge and to prevent isolation.
5. Regular opportunities after discharge to review progress (defined by the women as ‘monitoring’) and bring up any issues.

Overall, the message from these interviews was that an individualised coordinated package of care, together with information and support prior to and throughout the discharge process would heighten the chances of a successful return to the community. Continuity of care (i.e. the same practitioner and/or peer supporter) throughout the various stages of the discharge would assist with the transition process. Accommodation would need to provide a place of safety and security in a suitable location depending on specific needs in order to give individual women the best chance of success.

Women stepped out

A small number of women who had been discharged from secure settings and lived in the community talked about their experiences and views of the transition, what supported their re-integration and what hindered them. This included the type of accommodation; their relationships with family, professional staff and other people; employment, education and mainstream activities; space and personal belongings and choice and empowerment: what helps them to feel safe and how they manage the risks to their recovery, particularly when returning to communities associated with previous addictions.

- **Accommodation:** there is no single ideal model of accommodation that is “one size does not fit all” but supported housing can be a stepping stone to greater independence. Choice, involvement and empowerment were identified as important considerations in the transition from secure services to community. Self-contained apartments were the preferred model in supported housing, women wanted privacy and support from on-site staff and being amongst other people who have shared experience can help. Mixed sex environments were preferred but being the only female amongst a house full of men can be stressful and sharing bathrooms is unacceptable. There appeared to be a gap in the supply of supported housing that provided self-contained apartments with the flexibility to provide 24 hour support.

- **Family relationships:** support from families was important during the transition to the community but equally the links between individuals, their families and their communities needed to be maintained while women were in secure services. Programmes needed to be devised to enable women to spend time with their families and to undertake meaningful activities in the community, such as voluntary work, whilst still in secure services making integration into the community an easier experience.

- **Involvement with mental health professionals and others:** long term support from care workers was described as supportive to re-integration but there was no common experience in the type of support or where it was received from. Positive examples included being supported to exercise choice and being able to negotiate relationships. Support needed to be consistent, particularly in working through complex pathways, which can be destabilising, what Zeilig (2010) describes as the need to feel ‘held’ and helped towards empowerment and control. At the point of discharge, an individual may find herself facing the pressures any adult may face: finding a place to live; finding a job or tackling the benefits system; re-establishing family ties and returning to high risk places or situations. There was no consistency of approach to support during the transition between secure services and the community. Where a good transition was experienced it was deemed to be exceptional, “lucky” and “not my experience of other people”.

On the point of being discharged, some women felt considerable anxiety together with mixed feelings of excitement and expectations about how their lives might be different. The transitional process and the quality of the engagement between practitioner and women can have far reaching implications for how individuals settle into the community.

Women did not speak directly of ‘therapeutic interventions’ but there were references to on-going relationships with mental health staff and having somebody to talk to outside of family and friends. They mentioned:
Employment, education and mainstream activities: non-statutory services contributed to the expansion of links into the community, in employment, volunteering, education and in helping with housing tenancies. Employment and educational courses were key aspirations for the research participants and viewed as a gateway to financial independence and social integration.

Space and personal belongings: having space and personal belongings were all identified as important in women’s lives and helped them feel comfortable in the community. Belongings, artifacts, personal treasures and collected memorabilia were the outward expressions of style and taste and contribute to a sense of individuality.

Care pathways: one of the most significant threats to the ability of women to exercise choice and feel empowered was the lack of clarity and fragmented decision making that was characteristic of the progression through secure services and the transition into the community, contributing to delays and increasing anxiety.

The underlying problem that emerged for commissioning was that the pathways between secure services and the community were not sufficiently understood or developed between different agencies. A key message from the interviews was for health and social care commissioners to work together on care pathways through secure services into the community. The complexities of referral routes and funding streams for different types of accommodation need to be untangled.

Professionals and services: observations

Key issues identified by participants echoed those provided by the women including the following:

- **Women’s discharge from secure care**: women needed a clear pathway out of secure care. However, this was sometimes hindered by the late involvement of Community Mental Health Teams and inadequate follow up from Community Psychiatric Nurses.

- **Housing after hospital**: women and those supporting them found securing independent accommodation difficult as local councils and private landlords were often reluctant to accept women with, for example, a history of arson or women diagnosed with a mental illness. Moreover, perceptions of these women as unable to live independently often meant that they must prove to their local council that they are ready to reintegrate into the community.

- **The need for person centred planning and principles**: there is a growing need for these to be adopted by all mental health services. This would allow women to make choices concerning the care they receive through personal budgets. Thus, it is hoped that this would make women the ‘experts’ in their care encouraging independence.

- **Employment and education**: these were seen to empower women and provide them with a sense of belonging.

- **Finding appropriate accommodation**: Women who were unable to obtain accommodation were often forced back into hospital or ‘dumped’ into residential care for infinite periods. This could lead to increased feelings of powerlessness and vulnerability.

- **Mental health ghettos**: women who managed to secure accommodation were often housed in ‘mental health ghettos’ whereby they received hard to let properties in undesirable areas. Staff were concerned that these localities often had problems with drugs and crime which have had a negative impact on women’s recovery.

- **Residential care**: some women were unnecessarily discharged into residential care and not their own accommodation due to a Home Office expectation that women will progress from medium and low secure units as part of their pathway into the community. Thus, those women who entered residential care then became ineligible for housing meaning women were unable to secure accommodation or regain their independence.

- **Lack of integration between services**: women’s discharge from secure care was often hampered by a lack of integration between local authorities, housing services, mental health services, and children’s services. Thus, women’s sense of stability and support may be reduced at a time when they were at their most vulnerable.

The discharge process also concerned those working with women leaving secure settings. Key issues included:

- **Timing**: Different aspects of discharge needed to be planned into women’s care at different stages. Some favoured commencing planning almost immediately as a woman was admitted and settled into the secure service.
Who needs to be involved? Ideally, women themselves and the full range of agencies that have been and will be connected to discharge need to be involved in planning the process. However, agencies across sectors raised their concerns that there was insufficient and sometimes poor communication between individuals, agencies and the secure service. In the main, care coordinators have been tasked with finding move on accommodation. Advocacy services and other community based organisations were aware that sometimes statutory agencies were unable to meet women’s needs. However, they hoped that women could ‘fall back’ on them.

What resources are available for women stepping out?
In the current climate, participants described existing difficulties in terms of the funding available for women’s provision and the need to demonstrate value for money. Secure services are expensive and there is no question that most move-on accommodation and support will be cheaper. However, the provision of high support with accommodation is not cheap and services are under pressure to provide for users within existing (and possibly shrinking) budgets.

Interest was shown in how far and in what ways personal budgets will open up opportunities for women leaving secure services as it will give them more control over what, how and by whom support is provided.

Identifying women’s needs was possible, meeting them much more difficult.

Women only and/or a gender focus
There was a range of views about the need to address women’s needs as distinct from men’s, if and how this should happen, the difficulty of doing so for what, locally, is a very small number of individuals and in the absence of dedicated services, the importance of ensuring services and their staff were sensitive to gender. Those who believed that gender was a significant factor in planning women’s discharge from secure services, identified the following specific issues for them:

- Women can be more vulnerable and some services and professionals outside secure services find it difficult to work with a gender perspective.
- Women need to be given consideration in relation to appropriate employment packages and work placements which acknowledge their vulnerability.
- Women are often drawn to the caring professions where a criminal record hinders them and they need support to find access to suitable opportunities.
- Women need separate accommodation (e.g. flats with shared areas to allow them to choose whether to mix or not) so that they do not feel threatened.
- When moving into a new community women need to be educated in how to protect themselves.
- Young women, in particular, need staffed accommodation working within a recovery model rather than, e.g. being in foster care.
- Women are more likely to self harm and need appropriate support.
- Women with children need accommodation where children can visit and/or stay.

However, some said there are not enough women to warrant dedicated women-only provision and that seeking women only accommodation severely limits where women can be placed. All services need to be gender aware so that provision is designed to be appropriate to their needs as well as to men’s.

Meeting need through the person
Many professionals agreed that identifying a woman’s needs should place the woman at the centre. Hence, they emphasised the importance of early planning and developing processes which bring together relevant agencies through multi-disciplinary teams and CPA meetings. One person said in the context of considering women-only provision, ‘if I could commission relationships, I would do but I can’t. I can assure systems and processes are in place to support women’. It is hoped that personalisation of care will encourage independence by giving women a voice.

Meeting need through the budget
There have ongoing discussions in the commissioning of secure and move-on services about the relative merits of block or individual ‘bed’ buying. With the move towards personalisation and personalised budgets, the intention is that service users will have more say in their care, support and their options for living.
Meeting need through the availability of suitable accommodation and support

An increase in council housing stock is needed to help women in their discharge from leaving secure care. This would prevent women being given poor accommodation in hard to let areas. Where women live is a great stumbling block in the discharge process. Women need to be encouraged into independent living with the necessary support from their Community Psychiatric Nurse (CPN). However, women are often not followed up and there are unmet needs in relation to high level supported housing. There is a requirement for more individual flats with 12 hour support plus an out of hours telephone service which also allows women to remain on the housing register. Women should be given individual support within independent housing and a clear pathway out.

Women are often overwhelmed when released as they are so used to routines in secure services. This must be addressed before women leave secure care, i.e. pre-discharge wards containing individual rooms, bathrooms. Women aspire to have their own door key, however, this is not being addressed as they are often placed within residential care.

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| **Preparation for discharge** | Secure services and care coordinators need to ensure that discharge plans are considered as soon after a woman is admitted as deemed appropriate. Given the increasing emphasis on reducing the amount of time women spend in medium secure accommodation, this has become more urgent.  
Links between mental health services, housing services, local authorities, and children’s services need to be improved in order to create easier day-to-day management of women’s transition between services.  
Women’s discharge needs to be clearly planned when they enter the service allowing Community Mental Health Teams to be involved as early as possible.  
All disciplines and professions should come together to provide women with a smooth pathway out of secure care and to ensure they receive the right support and accommodation that they need. |
| **Accommodation** | Women’s move to the community would be enhanced by increased ‘transitional’ housing with 24 hour staffing for three to six months before moving to independent accommodation with lower levels of support.  
An increase in council stock and high support independent accommodation is needed to allow women to be discharged from secure care when they are ready, with the support they need.  
Accommodation needs to be safe (location and from people women wish to avoid) and easily accessible. This would link women to the local community, enhancing their capacity to maintain control over their own lives and facilitate their sense of connection to the community around them. |
| **Care and treatment** | There is a need to ensure and maintain continuity and consistency of care once women move from secure services, e.g. with CMHTs responsible for ‘monitoring’ how women are sustaining their lives.  
There is a need for an enhanced forensic community health provision which would alleviate pressure from CMHTs and ensure that these women receive appropriate support in relation to their histories and experience of secure services.  
Consideration may need to be given to the provision of psychological and other therapies during and beyond their transition to the community.  
Increased peer and other ‘local’ support could help women to reintegrate and ease pressure on other services. Voluntary sector agencies have been able to fill some of the gaps but said that signposting women was a key role they performed.  
Peer mentoring in the community may help women cope with the ongoing stress of every day life.  
The role of family and friends in providing support needs to be acknowledged and built on where appropriate for individual women both prior to and post-discharge from secure services.  
Support from services needs to be particularly extended to women with children where a programme of support is begun at the secure service and continued in the community.  
Consideration of what women might do once discharged could begin early on by bringing relevant professionals together to explore options. Although this would not be |
all women, making vocational services more available and accessible would help make the transition into employment much smoother. For women this would create a sense of belonging if they enter education/employment.

- Vocational services need to be targeted at and appropriate for women (especially young women) as well as men.
- Educational opportunities including retraining, employment and voluntary work will help women feel worthwhile.
- Practical help, e.g. with shopping and caring for children, will enable women to do what is ordinary.

**Staff**

- Agencies and providers of services need to be aware of the barriers women face in securing accommodation. This could be addressed through training, e.g. for housing providers. This may help to remove stereotypical attitudes that housing providers are perceived to have towards women with mental health difficulties.
- Funding needs to be provided for staff training in relation to women diagnosed with personality disorders, why women self-harm and how to support them.
- Local Authorities involved in personalised support could provide training to secure services staff in relation to personalised care and budgets. ‘Personalised budgets open many doors for women.’

**Social determinants**

- Public perceptions are difficult to change. However, clear pathways for women which make moving into the community smoother will enhance women’s experience and may impact on those around them.
- The impact of personalised budgets for women leaving secure settings needs to be monitored and evaluated.

Finally, the research undertaken here suggests that there is a need for continuing data collection and longer-term review of women’s experience of ‘stepping out’ to ensure that services are in place to meet their needs.
1. Introduction and Context

1.1 Background to the report

What are the needs of women discharged from secure mental health services and why was this question being asked? This section examines the background to the research, the literature review as well as the broader socio-political climate and context that framed this work.

- Local context

The East of England Specialist Commissioning Group commission secure mental health service has beds across Essex, Suffolk and Norfolk, Cambridgeshire, Hertfordshire and Bedfordshire. At the time of the research, there was a total of 32 beds for women (medium and low secure) in Brockfield House, South Essex, which is on the old Runwell Hospital site. Independent sector providers offered a range of medium and low secure services (St. Andrew’s Healthcare with 29 low secure spaces for women; Partnerships in Care (PiC) with mixed medium secure services). Essex County Council’s Mental Health Commissioning Team and NHS Commissioning Partners were concerned to scope and consider for the future, the availability and suitability of move-on accommodation for women from Brockfield House and women who have been placed outside the geographic area but wish/must return to the east of England. A principal concern was that women should be supported as necessary and that the services identified to support them are sustainable.

In 2007, the Department of Health commissioned four high support therapeutic community residential services for women with complex needs. The ethos which underpinned them is that some women, in the appropriate setting, will be able to sustain an independent life which is outside a secure service. However, in order to do so a number of fundamental structures and inputs need to be in place (report forthcoming 2012). It may be that women who are discharged from Runwell will have similar needs.

This research was commissioned as a small scale study in order to explore what is currently known about women’s needs as they are discharged from secure mental health services and the provision that is available to meet these needs. The aim of the study was to identify both the real and the ideal types of services that ensure women are able to lead independent and sustainable lives in the community. It is hoped that this will be one step towards enabling NHS and social care commissioning teams to plan with both insight and foresight for this particular group of women.

- Socio-political climate

Gender specific service differentiation in mental health is in its infancy (DoH, 2002, 2003). There has only recently been recognition at governmental and hence policy levels that women have mental health needs that are distinct from their male peers and that they may therefore require different services which fulfil their particular needs. However, gender differences in psychopathology and the resultant treatment of patients have been discussed for many decades by both practitioners and academics (Bartlett and Hassell, 2001) and it is this debate that has subsequently informed policy makers and those planning services for women with mental health problems. Many of the issues specific to women’s mental health were outlined in the consultation document ‘Into the Mainstream’¹ which details the gender differences in the ways in which women present with mental health problems.

ill-health. The differing ‘roots and contexts’ (Newbigging and Abel, 2006) of women’s distress are gradually being established. However, despite the growing awareness that women require specific provision within mental health services and the advances that have been made in recognising women’s special needs (NMHDU, 2010) there is little systematic evidence available on the services that are most therapeutic for women either within mental health settings or those which may aid the reintegration of women on their discharge into the community (these gaps are documented in more detail below). There are, therefore, lacunae in knowledge in relation to almost every aspect of this complex subject; from the pathways that women actually take out of secure mental health services and the ways in which these could be eased (through effective service provision in the community for instance) to the best ways of designing gender-specific services. Above all, there is little understanding about what women themselves perceive to be their needs.

It should also be noted that the broader context which frames the discharge of women (and men) from secure mental health services has been the increasing emphasis on community treatment for psychiatric patients since the mid 1980s. This is also the period when many new ‘medium secure’ hospital places were created (Jamieson and Taylor, 2002; Steffen, Kösters, Becker, and Puschner, 2009). There has been a consequent change in the function of psychiatric hospitals towards providing short-term crisis interventions. Patients are therefore likely to experience several transitions from in-patient to out-patient status (Steffen et al., 2009). As has been observed:

‘Deinstitutionalisation moved the focus of psychiatric care away from hospital institutions to community settings. Mental health services are no longer driven by a policy of illness containment, although detention and coercion retain legislative and cultural legitimacy, because the conceptual and practical focus of caring for people in the 1990s is built around journeys to(wards) ordinary ‘independent’ living.’ p.201 (Pinfold, 2000)

Given that a decade ago it was stated that the focus in mental health care was upon journeys towards independent life, it is curious that there appears to be so little research on these transitions.

Part of the political background to mental health care includes the impact of market forces within the NHS and in particular the significant provision of psychiatric intensive care units and low secure units by the independent/private sector (Page and Dix, 2007). The differences between independent/private and NHS units have been noted (Chaudhry and Pereira, 2009) and the difficulties for patients admitted to out of area facilities (which occurs more commonly within private units):

‘This appears to go against the standards outlined for people with severe mental illness, which is to ensure that service users are placed as close to home as possible.’ (Chaudhry and Pereira, 2009)

NHS low secure units (LSUs) reported having significantly more occupational therapy (OT) and social worker input in their units compared to the private sector, however neither NHS or private units were found to be adhering to basic National Standards (DoH, 2002) (Chaudhry and Pereira, 2009). In addition, the routes for patients into either independent or NHS units have been found to be quite different. Patients in the independent sector are less likely to have been referred directly from the criminal justice system or from high security hospitals (Lelliot, Audini, and Duffett, 2001), as is iterated by Chaudhry and Pereira:

‘Significantly more NHS patients were identified as having substance misuse issues, challenging behaviour and forensic history compared to private patients.’ (2009:22)
The existing system seems characterised by both a lack of uniformity in service provision and inadequate services (that for the most part fail to be holistic) (Chaudhry and Pereira, 2009) as well as by differentiations in the patients that different sectors care for. Overall, it has been noted that services in England and Wales have often developed idiosyncratically, driven by local interests, rather than as part of a national strategy (Gow, Choo, Darjee, Gould, and Steele, 2010). Within this context, the complexities around understanding how best to plan specifically for women moving from secure mental health settings into the community are evident.

The 2009 report My life in safe hands?, an evaluation of women’s medium secure services (Parry-Crooke and Stafford), said that women service users and professionals agreed that the paucity of move-on accommodation was a major barrier to women’s recovery and timely discharge. The report noted that ‘in January 2009, only 12 of the 27 services provided a rehabilitation ward and just over half (14) had access to low secure services’. Services acknowledged the importance of community forensic teams which worked with others in the community to increase understanding of gender sensitive services. Staff in one service said

‘the lack of low secure or other step-down accommodation meant women had to be well enough to go straight into the community. In order to effect successful move-on, they had negotiated with commissioners for women to have trial periods thus requiring payment for two beds during this time. The rationale was to ensure women received sufficient support from the women’s service and should the move not be successful, they had somewhere to return to.’

The forthcoming evaluation report on four pilot high support residential services for women with complex needs (Parry-Crooke 2012) describes the work entailed in developing as smooth a pathway as possible from secure services to more independent living. Close links and clear lines of responsibility including care coordination have facilitated referral and assessment processes which enable women to move at a pace appropriate to their needs, usually involving day and overnight visits before final decisions are taken.

1.2 Methods of research

This report is based on a collaborative exercise with four strands of work including:

- a literature review
- discussions with women looking towards ‘stepping out’ of secure environments.
- interviews with women who have ‘stepped out’
- interviews and a workshop with agencies and services concerned with women and their lives on leaving secure services

The research was overseen by a Steering Group, comprising representatives of the local forensic unit; SEPT and Anglia Ruskin University Research Department; regional Specialist Commissioning Group; Supporting People service (County Council) and health and local government commissioners. The Steering Group was formed to develop a wider programme of work related to the discharge of women from secure services and was able to provide a reference point for discussions as the course of this study unfolded, meeting monthly over a 12 month period. Each method of data collection and analysis is described below.
<table>
<thead>
<tr>
<th>Activities</th>
<th>Description</th>
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<tr>
<td><strong>Proposals for the research</strong></td>
<td>The Steering Group developed a plan to support the delivery of the project. This set out the deliverables, core activities and timeline for the work.</td>
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<tr>
<td><strong>Literature review</strong></td>
<td>An extensive literature search was conducted which involved on-line searching within databases and websites as well as library catalogues and using the old-fashioned method of perusing library shelves. The sources used are detailed below as are the search terms that were used. An endnote library (consisting of 126 references) was gradually built up and the literature has subsequently been analysed to establish definitions and themes as a means of addressing the research question. A thematic approach was adopted due to the striking lack of literature with direct relevance. Search of databases: Web of science / Web of Knowledge Psychinfo Pubmed Ovid Library catalogues: King’s College libraries – Franklin-Wilkins and Maughan King’s Fund library Websites: <a href="http://www.therapeuticcommunities.org">www.therapeuticcommunities.org</a> <a href="http://www.dh.gov.uk">www.dh.gov.uk</a> <a href="http://www.dh.gov.uk/publications">www.dh.gov.uk/publications</a> <a href="http://www.mind.org.uk">www.mind.org.uk</a> <a href="http://www.mentalhealth.org.uk">www.mentalhealth.org.uk</a> <a href="http://www.dhcarenetworks.org.uk">www.dhcarenetworks.org.uk</a> Search terms (using Boolean search): Women Low secure unit Discharge OR release Therapeutic communities Secure units Reintegration Medium secure units Pathways Most frequently cited journals: The British Journal of Psychiatry Journal of Forensic Psychiatry and Psychology Journal of Psychiatric and Mental Health Nursing Journal of Psychiatric Intensive Care Feminist Review</td>
</tr>
<tr>
<td><strong>Interviews with women 'stepping out'</strong></td>
<td>This aspect of the research was carried out by service user and academic researchers from Making Involvement Matter in Essex (MIME). MIME is a three-year project established by the Essex health and social care mental health commissioners to extend the involvement of service users and carers in commissioning decisions. The particular focus here was the women who have been detained in secure services and concentrated on looking at their service needs following discharge. Eight women from Brockfield House (medium and low secure services for women) took part in interviews. These explored previous experiences of accommodation and support in the community, before asking about the sort of accommodation and support, from the women’s perspective, that would best meet their needs when they are discharged from secure services.</td>
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| Interviews with women ‘stepped out’ | This aspect of the research involved two sets of semi-structured interviews with five women who had left a medium secure service (Robinson 2011).

The first interview set out to explore women’s residential history; choice accommodation and support; and their social and physical environment. This included length of stay in current accommodation, views about living there, like what sort of room they had and whether there was shared space in the house. In addition, women were asked about:

- Where they had lived before
- Their preferred choice about where they might live
- Why they had made their choice and what happened if no choice was offered
- What help they were given to move
- Where they would like to live in the future if this was different from the present
- What was enjoyable and what was difficult about where they lived
- What support was available to help with settling in

After the first interview participants were provided with a disposable camera and asked to take photographs over a period of a week to provide a visual means for them to describe and discuss their current living situation. There were few guidelines offered, other than the photographs should not include people, for ethical reasons, and that individuals were invited to take photographs that represented things that were important to them about where they now lived. When the photography was completed, cameras were collected, images developed and returned to the women with the wallet of pictures unopened. The woman was able to look at the pictures and then proceed with the second interview which was in the form of open dialogue led by the women talking about their pictures. Although some of the women needed more time to complete their photography, all took part and bar one, who had photographs taken of herself with her birthday cake, they strictly adhered to the agreement that photographs of other people were not to be included, to the extent that individuals went to extraordinary lengths to take shots of public places, without people present within them. |

| Interviews with agencies and services | Approximately 30 individuals representing a range of services were purposively selected and invited to take part in interviews. They came from a range of organisations which have a role to play in provision for women leaving secure services and included:

- commissioners of services;
- secure services;
- accommodation providers;
- advocacy services;
- PCTs;
- CMHT care coordinators.

Eighteen people took part and responded to questions on a variety of topics including:

- contact with women in secure services;
- care planning and care pathways; |
- moving on from secure services to the community;
- ideal and real opportunities for women;
- provision, gaps, access and barriers.

The data from these discussions was analysed using Framework (Ritchie and Lewis 2003) which allows for within and across case analysis as well as in depth description from individuals. The preliminary findings, along with a summary of the literature review, formed the basis of a workshop in October 2010.

| Workshop with agencies and services | More than 20 representatives of key agencies attended a workshop hosted by Essex County Council’s Mental Health Commissioning Team. The workshop comprised of presentations and facilitated small group discussions which provided a further set of data on understanding women’s movement through the secure system; planning for appropriate care pathways/moving on; and priorities leading to recommendations. |
2. Terms used in relation to women, secure services and their move on

2.1 Women

‘Women’ generally refers to females who are over the age of 18 years. At first sight, this is a relatively unproblematic term. The emphasis on women is however important due to the relative absence of understanding about the vagaries of mental health service provision for women. The conditions and tensions within most women’s lives are qualitatively different to those experienced by men and these certainly have an impact upon their mental health and their needs within mental health service provision. For instance, women are much more likely to experience domestic abuse and violence and in turn this is likely to have a negative influence on their mental health. Equally, women are more likely to have suffered sexual abuse as a child (most studies suggest that women are three times more likely to have been abused than men). Further to this, research has indicated that 50% of women who see a psychiatrist report experience of sexual abuse as children (Kotecha, 2008). The complexity of issues surrounding this shocking statistic are compounded by research which has shown that women who are survivors of childhood abuse and who experience chronic physical ill health as a result of this, are likely to be diagnosed as having ‘psychosomatic’ symptoms, or as ‘attention seekers’.

One of the most compelling statistics when considering the need for gender sensitive service provision showed that within secure psychiatric settings:

‘Up to 60% of women in the UK mental health service population have been sexually abused in their lifetimes.’ (Newbigging and Abel, 2006)

Those working with women and their mental health needs are still arguing that the impact of social inequalities and the ways in which these influence the levels of distress and illness that women present with are not considered legitimate areas of concern for mainstream institutions – theorists, researchers, practitioners (Aitken, 2006). These are areas that are explored further below (sections 4.2, 4.3).

There has been some examination of gender differences in the onset of depression in connection with role differences. One study found a strong association between the sense of responsibility innate to a woman’s role and subsequent rates of depression (Nazroo et al, 1997). The influence of social factors upon women’s mental health is evident:

‘These results support the hypothesis that gender differences in rates of depression in the general population are, to a considerable extent, a consequence of role differences’ (Nazroo et al, 1997 – from Abstract).

Similarly, childbirth including the hormonal changes that affect a woman’s body as well as the generally greater burden of caring for a new baby and later for children that is the responsibility of most women, can have long term consequences for a woman’s mental health. Overall, it is worth

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2 The GLDVP (Greater London Domestic Violence Project) began work on mental health early in 2003 having identified both a strong link between women’s experiences of domestic violence and mental distress and huge gaps in services for these women. As the Department of Health report Into the Mainstream confirms, women’s experiences of violence and abuse frequently lead to mental distress.

3 As noted in Women’s Mental Health: Into the Mainstream, Strategic Development of Mental Health Care for Women DH (2002) Consultation Paper.

4 Information from MIND factsheet on women and mental health.

5 There is a body of work on perinatal mental health which is not possible to examine within the remit of this paper, but which nevertheless provides some useful insights into the mental health needs of women at this crucially vulnerable period. For example: Currid, T.J. (2004) Improving perinatal mental health care in Nursing Standard 19:33 pp40-43; among many other such studies.
noting that prevalence data estimating the number of women compared with men with significant psychiatric disorder or ‘psychological symptoms’ have:

‘...consistently found women to have higher rates in the UK and other Western countries.’

Further, statistical research has shown that two-thirds of people using mental health services are women (noted by Kotecha: 2008 p.59). Despite these compelling statistics, it is only relatively recently that researchers and clinicians have become aware of the importance of gender differences and their potential effect on aetiology and treatment in a range of mental health problems.

It has been posited that women’s over-representation in mental health statistics is not exclusively due to socio-economic or physiological factors. It may also be a result of discriminatory practices which are embedded within 21st century psychiatry (which after all emerged as a domain dominated by white Western men towards the end of the 19th century). This has led, some have argued, to men being regarded as the epitome of mental health which has therefore slowed the progression of scientific research into the mental health of women. It has also been proposed that women who do not conform to widely held stereotypes of what it means to be ‘female’ or ‘feminine’ are more likely to find themselves diagnosed with mental health problems. Feminists and critical thinkers have long argued that gendered attitudes and assumptions are implicated in the disadvantaged structural, social and material conditions in which women find themselves in relation to men (Aitken and Heenan, 2004). These conditions have clear and long-term implications for women’s mental health and by association for the services that women with mental health problems have historically received. It has further been posited that even therapeutic and rehabilitative services have been developed to meet white western male needs and do not meet women’s needs (Aitken and Heenan, 2004).

It is important to recognise that whilst women might be over-represented in mental health statistics, they remain a minority population within the secure services (Blattner and Dolan, 2009; Long, Fulton, and Hollin, 2008; Newbigging and Abel, 2006). This minority status may also have consequences for the treatment that women received, making it easier to overlook their specialised needs both within services and as they are released into the community. Although women are a minority in secure services:

‘The annual rate of male admissions to the secure specialist services was 5.6 times that for females.’ p.275 (Coid, Kahtan, Gault, and Jarman, 2000)
‘Women constitute about 15% of these populations (people in special hospitals and regional secure units).’ p.68 (Aitken and Noble, 2001)

This is a population that is steadily increasing (Long et al., 2008) and it has also been found (Aitken and Heenan, 2004; Aitken and Logan, 2004) that once in these secure settings, women stay longer than men and for up to four times longer than women in prison.

As has already been noted (above p.2), the women who find themselves within secure mental health settings tend to be different (and not merely in physiological terms) from their male counterparts.

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8 If this is true for the population of women at large, then it is especially relevant for women from BME backgrounds who (as is discussed below) have mental health issues which are mostly invisible to the services / service providers that are responsible for attempting to meet their needs.
Research has demonstrated that women in secure psychiatric facilities are a group with special needs (Coid et al., 2000). Women suffer from higher rates of depression than men and also present with post traumatic stress disorder and eating disorders more than their male counterparts (Newbigging and Abel, 2006). Women are also more likely to self-harm than men (Maden, Skapinakis, Lewis, Scott, and Jamieson, 2006). Clearly, the population of women within mental health services represent a distinct group (this is discussed below 4.3 ‘profiling women in secure services’).

The Care Services Improvement Partnership (CSIP) in their work on Women’s Mental Health stated that:

‘The key message to deliver is that women require equal treatment but not necessarily the same treatment.’ (From CSIP website).

Different and therefore equal remains a pertinent adage for women’s mental health.

2.2 Secure mental health services

“Mental health secure services provide treatment for people with mental health disorders that mean that they are at significant risk of harming themselves or others. Many of these patients will be detained under the Mental Health Act 1983.” (From the Department of Health website).

This is a broad definition that belies the nuances in provision which exist across the country within various secure settings. These can be divided into ‘high secure units, special hospitals or high secure psychiatric hospitals (HSPH)’, ‘medium secure units’ and ‘low secure units (LSUs)’, the latter organised into two main categories of unit including the LSU and ‘psychiatric intensive care units (PICU)’ (Pereira, Dawson, and Sarsam, 2006b). Each of these facilities has developed to fulfill particular roles. However, (from the literature available) it seems that in some cases there is not as much clarity about the functions of different settings and equally the profile of patients that they may be treating as might be expected given that these services are located in different geographical areas and represent different treatment settings. Thus, a low secure unit might be defined in terms of it not being a medium secure unit rather than according to its individual characteristics. Similarly, it was difficult to ascertain whether patients (and which groups of patients) were likely to follow a linear pathway as they are discharged, for example, whether they progress from high secure units to medium secure units to LSUs and then into the community and in which cases patients were discharged directly from high secure units (for example) into the community. These pathways are discussed in more detail below. This sense of confusion is echoed by Kennedy (2002) who notes:

‘There is a wide variation between services, e.g. in the level of physical security in medium secure units. Published needs assessments all illustrate a considerable degree of inappropriate placement within the overall system….partly due to the varied pattern of provision across the country.’ (2002:433).

For the purposes of this review, a working definition for each of these terms is offered as these emerged from the literature that has been interrogated.
**High secure units / special hospitals / high secure psychiatric hospitals (HSPH):**
These are terms which appeared to be used interchangeably within the literature. In general, they refer to high security psychiatric facilities where people with mental disorders are placed who are considered to pose a high risk of harm to others, they include special hospitals such as Rampton, Broadmoor and Ashworth (Jamieson and Taylor, 2002). They are inevitably places with an emphasis on high levels of physical security both within the hospitals and without; in order to minimise the risk of absconding and dangerous behaviour. It has been observed that there are few data on the characteristics of females in special hospitals (Coid et al., 2000). Patients from high secure units deemed suitable for discharge are usually transferred to lower levels of security prior to discharge into the community (Blattner and Dolan, 2009).

**Medium secure units:**
These are facilities for the placement of patients who are unsuitable for care within general psychiatric services and who require specialist and / or secure care, but not at a level provided by a high security hospital (Lelliott et al., 2001). The creation of medium secure units is best understood against the background (outlined above p.2) of an increasing emphasis on community treatment for psychiatric patients (Jamieson and Taylor, 2002). They are described in government documents as a ‘key’ element of the forensic mental health system and an important part of the integrated care pathway for patients who need care and treatment within a secure environment (Department of Health, 2007). It has further been stated that the development of MSUs has been ‘largely responsible’ for the emergence of forensic psychiatry as an increasingly influential discipline (Coid et al, 2001). However, it seems to remain the case, as was noted by Jamieson and Taylor (2002:404) that although medium secure provision is a popular concept in the UK, it is one that has had little refinement. MSUs have developed unevenly across the country and vary in their resources and ability to deliver services (Coid, Kahtan, Gault, Cook, and Jarman, 2001). This contributes to the relatively amorphous or ‘unrefined’ status they seem to occupy. The lack of coordination in their development has been criticised:

‘Uncoordinated development led to under-provision despite high demand. Certain regions prioritised offender patients and did not support local psychiatric services.’ (Coid et al, 2001).

There are approximately 60 such units in England provided by the NHS, each of them varying in size, in design and in environmental and security standards (DoH, 2009); this variation in medium secure units was also noted in research conducted by Lelliott et al (2001):

‘The settings ranged from highly staffed units with ‘air-lock’ entrances, to lower staffed facilities which were unlocked.’ (2001:62).

Similarly, it has been observed that the needs of patients within these environments also varies and that some units specialise in meeting the needs of specific groups of patients, whilst others provide for a wide range of need (DoH, 2009). Again this has been noted in research:

“Medium secure psychiatric units were intended to meet the needs of three main groups: those who would otherwise be housed in over-crowded high-security hospitals; those admitted through the courts; and ‘difficult to manage’ patients cared for by general psychiatric services.” (Lelliott et al., 2001)

This is a grouping of patients that is so wide it is almost meaningless.
Despite these variations and lack of certainty which make it difficult to pinpoint what exactly an MSU is and for whom it provides care, there are some guidelines about the physical environments and standards for MSUs including some specific to dedicated women’s units (Department of Health, 2009). It is appreciated that the environment provided by medium secure mental health services is a crucial element in the delivery of therapeutic outcomes for patients, their safety and the safety of the wider community (DoH, 2009).

It has been posited that plans exist for a large increase in medium-secure beds over the next five years (Long et al., 2008); and that despite this there remains a reliance on the independent sector to provide beds in single-gender units for women. The numbers of such units and their provision for women is succinctly outlined by Parry-Crooke and Stafford (2009):

‘By January 2009, there were 27 dedicated women only medium secure services (nine independent and 18 NHS)....There was at least one service in each health region of the country; with six in the North West and only one in the South West. Of the 27 services, 19 had a gender specific care pathway with either a women only rehabilitation or pre-discharge ward, or a women only low secure or step down service. Four of the 27 services were women only sites with five on mixed sites but with no regular mixed activities. Seventeen were on sites where some activities were mixed.” (Parry-Crooke and Stafford, 2009)

This report provides some of the clearest available outlines of the characteristics of medium secure units and specifically of the services that they provide for women.

‘Low Secure Services’:
Low secure units (LSUs) and psychiatric intensive care units (PICUs):

Low secure mental health services have been a developing feature of psychiatric care for the past 25 years (Pereira, Dawson, and Sarsam, 2006a). The ‘low secure service’ (described by Pereira et al, 2006a as at the cutting edge of psychiatry) comprises both psychiatric intensive care units (PICUs) and low secure units. It should, however, be noted that psychiatric intensive care units can also be found in medium secure units (Dolan and Lawson, 2001) – further evidence of the often confusing blurring of boundaries within these services.

Low secure services are designed to provide care for patients deemed unmanageable on open or general psychiatric wards. This also echoes the function of medium secure units.

The definitions employed by Pereira et al (2006b) in their national survey seem the clearest:

- LSU: a unit providing ongoing care and rehabilitation, usually within conditions of security for mentally disordered patients who exhibit behavioural disturbance. Patients may have a mixture of offending and non-offending behaviours. The unit is not a medium secure unit.
- PICU: the provision of intensive multidisciplinary treatment and care by trained staff for severe or consistent disturbance exhibited by mentally disordered patients, over a time-limited period, usually within conditions of security. (Pereira et al., 2006b) p.14

Psychiatric Intensive care units (PICUs) provide intensive care for patients (who are already compulsorily detained usually in secure conditions) for short periods of time who are in an acutely disturbed phase of a serious mental disorder (Pereira and Clinton, 2002). In contrast LSUs deliver
intensive, comprehensive, multidisciplinary treatment and care on a longer term basis. The nature of many LSUs is that they are the setting from which patients with complex risk issues are successfully discharged into the community (Laidlaw, 2008). For this reason they are intermittently in the media spotlight.

In Pereira et al’s (2006) national survey of low secure services, they identified a total of 307 units comprising 170 PICU housing 1,242 patients and 137 LSUs treating 1,583 patients. The overwhelming majority of PICU provision was found to be within the NHS (90%) whereas slightly more LSUs were provided outside the NHS (28% were independent). It has subsequently been noted that these figures will have risen significantly since this research (Page and Dix, 2007). For some time there has been concern about ‘out of area treatments’ for mentally ill patients (Brindle, April 14th 2010) (also noted above, section 1 p.2) and particular disquiet about those who are placed in out of county LSUs for long periods of time:

‘For many years critics may have levelled the view that difficult patients have been located in PICU / secure placements a long way from their home area.....The all too often destructive nature of enduring mental illnesses means that people in longer term LSU out of county care commonly have no-one to advocate for them.’ (Page and Dix, 2007) p.82

In Essex, PICUs are not commissioned by the Specialist Commissioning Group and are thus seen as outside the secure services provision.
3. What does the literature say about moving on?

Due to the lack of literature uncovered that directly tackled the question guiding this review, (what are the needs of women discharged from secure mental health services?) the literature was interrogated critically for relevant themes. Some literature (research papers and government reports) was found concerning the needs of women within secure services, including mental health units and prisons. Work has also been done on reconviction rates following discharge into communities and connected with this risk assessment work regarding reoffending following discharge. Other studies have examined the design of secure mental health services and geographers have considered socio-spatial injustices in community care models. Perhaps the most directly useful work was research (in the US) that discussed the reintegration of women leaving jail (Richie, Freudenberg, and Page, 2001; Richie, 2001); despite the obvious problems of extrapolating from this work, it nevertheless focused on women and their needs when leaving secure settings (albeit jail rather than mental health services). The most relevant themes from all these studies, and others, are detailed below.

3.1 Design of studies

It is important to note that the information and results obtained depend on the design and focus of a study, the types of questions asked and the methodologies used. Studies can be limited by cross-sectional rather than longitudinal design and by using retrospective data. In addition, there are complex ethical issues that determine the sort of research that it is possible to conduct with any group of people who are in (or moving out of) secure mental health services and are therefore a vulnerable group. In the literature reviewed there was some study of women in prisons and secure hospitals (Aitken, 2006; Aitken and Heenan, 2004; Aitken and Logan, 2004; Bartlett and Hassell, 2001; Parry-Crooke, Oliver, and Newton, 2000; Parry-Crooke and Stafford, 2009), and interest in the policies surrounding women’s services in mental health units was evident following the DH report ‘Into the Mainstream’ (2002). Despite this flurry of concern there has been very little consideration of pathways out of units and routes to reintegration for women emerging from these institutions. The work that has been done on ‘pathways of care’ and ‘discharge routes’ has tended to focus on patients in general rather than women (Blattner and Dolan, 2009; Brown and Fahy, 2009; Coid, Hickey, Kahtan, Zhang, and Yang, 2007; Davies, Clarke, Hollin, and Duggan, 2007; Steffen et al., 2009). Further, the focus in these studies of discharge has tended to be on reconvictions and readmissions (Coid et al., 2007; Jamieson and Taylor, 2002), rather than patient centred work (on men or women) exploring their needs and experiences. There are therefore many unexplored areas that require research and careful attention should be paid to study design.

3.2 Admitting women as a category

As has been repeatedly noted, there has only been relatively recent acknowledgement (at least in the literature reviewed) that women’s mental health deserves particular attention. The first government report on the subject ‘Into the Mainstream’ (Department of Health, 2002) described in some detail the mental health needs of women and a later (companion) report ‘Mainstreaming Gender and Women’s mental health’ (Department of Health, 2003) was a first attempt at setting out the steps necessary for meeting their distinct needs. However, both these studies concentrate upon the diverse reasons guiding women’s entry into secure services and their experiences within such settings. A later report (Newbigging and Abel, 2006), also for the Department of Health, examines the need for and role of women only community day services. These are important reports that document the need for multi-level approaches, women-only services and sensitivity to the underlying reasons for women’s mental health problems. Most recently, further work has been completed assessing developments in gender specific provision in mental health services
Department of Health (2010) in which it is noted that high secure services for women have been concentrated at Rampton and that there has been some development of new gender-specific services in medium and low secure units (albeit patchy and unsystematic) (2010:5).

However, little or no work has been done examining the processes of discharge for women and women’s needs once they have emerged from secure settings into the community. There has been some significant work on mental health that places women at its centre, this includes ‘Good Girls: surviving the secure system’ (Parry-Crooke et al., 2000) and ‘My life: in safe hands?’ (Parry-Crooke and Stafford, 2009) although unique studies of women’s needs as articulated by themselves, these also focus on women within secure mental services. The work of Bartlett (Bartlett and Hassell, 2001; Hassell and Bartlett, 2001; Mezey, Hassell, and Bartlett, 2005) is similarly ‘women centric’. It has been crucial in alerting us to the vulnerability that women experience in mixed gender units as well as the intimidation that they may experience in single sex units and the clinical challenges that women in secure facilities may present that are different from men. However, the remit of the studies was not about examining women’s needs as they emerged from these settings. In contrast, there has been some work done on women released from prisons (Chapman, 2002; Dodge, 2001; Richie, 2001; Visher and Travis, 2003) which has identified the need for suitable and safe accommodation, support on release, reintegration into family and community, and employment. These are areas that are considered below.

3.3 Profiling women in secure mental health services

Research conducted by Bartlett and Hassell (2001) provides an outline of the reasons that women may be admitted to secure services:

‘Women are often admitted to secure services because of damage to property, self-harm or aggression towards hospital staff….Female patients in Broadmoor Hospital had a forensic history of assault (79.3%), arson (47.1%), theft (37%) and murder (21%). The same group of women exhibited self harming behaviours, including self injury (84%), alcohol misuse (38%), drug misuse (37%), eating disorders (17%) and sexual disinhibition (17%).’ (2001:304).

These findings are replicated (in general terms) by other studies. Bartlett and Hassell (2001:303) eloquently note that the relative absence of serious convictions among women in high secure care indicates that women are considered differently from men. Consequently their pathways into such settings are quite different and their subsequent discharge needs are also likely to be different. Moreover, the diversity of reasons for being admitted to secure mental health services are likely to require diverse and individually fashioned discharge protocols. Research has also demonstrated that once they are admitted to the secure mental health system, women are at risk of losing their liberty for between three and four times longer than women in prison or their male peers (Aitken, 2006) (as mentioned above 3.1 ‘women’). This contrasts with the small numbers of women in any type of secure setting (whether criminal justice or mental health) and with the high numbers of women that are seen in general psychiatric hospitals (Bartlett and Hassell, 2001).

Women typically admitted to high and medium secure units are more likely to receive a primary diagnosis of personality disorder (PD) than men, especially border line PD; and to be more likely than men to be charged with or convicted of arson (Coid et al., 2000)9. Coid et al’s analysis (2000) revealed three subgroups of women with PD as their primary psychopathology. The prevalence of this diagnosis is confirmed by Aitken and Logan (2004) who note:

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9 This is in contrast to men who were found (J. Coid et al., 2000)p.290 to be more likely to have previous convictions for major violence (including previous homicide, attempted murder, grievous bodily harm) and unsurprisingly to have committed more sexual offences.
‘Sixty-two percent of women in HSH and 42 percent of women in prison with a history of violent behaviour receive this diagnosis (borderline personality disorder)’ (264:2004).

Equally Long et al (2008:306) and Maden et al (2006) confirm that most of the women in the medium secure unit they were studying had a dual diagnosis of PD (mainly borderline PD) and mental illness. The extent to which women with these disorders are adequately cared for within mental health facilities has been questioned. This group may benefit most from attention to their interpersonal interactions and from ‘relational’ security rather than physical security (Aitken and Heenan, 2004; Aitken and Logan, 2004; Bartlett and Hassell, 2001). The concept of ‘relational security is discussed in some detail below.

Women homicide offenders are more likely to be admitted to medium secure services than men; it is proposed that this may reflect:

‘...women’s tendency to commit their offences in different circumstances and with different victims’ p.293 (Coid et al., 2000)

If these various patient subgroups require different therapeutic regimes and levels of inpatient security (Long et al., 2008) then it can reasonably be surmised that they are also likely to have different needs when they are discharged into the community. In particular, diagnoses of PD require specialised and ongoing treatment. This is complicated by the lack of research that has been conducted on personality disorders of all types (cf: The Royal College of Psychiatrists on-line information).

3.4 Context
Here, ‘context’ refers to the circumstances (structurally, environmentally and personally) that have repeatedly been found to underlie the reasons that women may suffer from mental health problems and / or have forensic histories. (Some of these points are noted above 3.1 ‘Women’).

It is clear from the literature reviewed that the underlying reasons that women may be incarcerated (whether in secure services or other settings such as prisons) have to be fully understood. It is logical that if pathways out are to be disentangled, the routes into such services must firstly be unraveled. Similarly, the contexts from which women enter secure mental health services may not have greatly altered by the time they come to be discharged. This has been considered in relation to women who are discharged from prisons (see references under 4.2, above). In these studies, women are described as having to confront the same abusive relationships and deprived communities and suffering from unchanged (or heightened) mental health problems with the additional stigma of having spent time in prison / secure institutions:

‘A review of the literature suggests that most of the women who are released from jail or prison are likely to return to the same disenfranchised neighbourhoods and difficult conditions without having received any services to address their underlying problems.’ (Richie, 2001) p.370

Although this quote relates to a different population (US women discharged from prison) there are likely to be parallels for UK women discharged from secure mental health services. The need to address these contextual issues has been recognised in a recent government report and it seems that general awareness of these has been raised (Department of Health, 2010). However, the extent to which extant underlying and ‘contextual’ issues continue to define women’s needs when they are discharged has not been fully explored.
Research on women and mental health (and women in prisons) repeatedly uncovers childhood abuse and extensive adult intimate violence (Aitken, 2006; Bartlett and Hassell, 2001; Coid et al., 2000; Coleman and Guildford, 2001; DoH, 2002; Richie, 2001) as having a profound impact on women and therefore their experiences in mental health facilities (and prisons). As has been succinctly summarised:

‘Women face an increased prevalence of social risk factors for mental ill health: they are more likely than men to be victims of physical and sexual abuse as children, and domestic violence as teenagers and adults’ (Long et al, 2008) p 305

There is likely to be an ongoing need for support for women living with these abusive pasts upon discharge. Whilst it seems that some advances have been made through programmes such as improving access to psychological therapies (IAPT) and the creation by some Trusts of whole-system therapeutic environments (Department of Health, 2010) these are not necessarily targeted specifically at women who have been discharged from mental health services.

In general terms, it is widely acknowledged that women are poorer and experience greater deprivation, have less social and political power and have less access to health, education and employment than men (WHO 2002). These pervasive structural inequalities when combined with mental health problems and the institutionalisation that may be a feature of having spent long periods of time in secure settings are likely to make reintegration into community settings especially difficult for women. Work about women released into community settings from US prisons (Richie, 2001) highlights their lack of educational opportunities which may result in a heavy reliance on family members with only episodic support from community based agencies, as factors that combine to exacerbate women’s difficulties on re-entering communities.

3.5 Care received within secure services

Although the focus of this review is on the care needs of women when they are discharged from secure services, it seems relevant to consider the work that has been done on services for women within mental health facilities. This is because it is within these contexts that most work has been done (and where there has been a concentration of funding). In addition, it may be surmised that there is likely to be some continuation in the needs of women as they journey towards independent or ‘normal’ lives in the community. Finally, if the care within secure psychiatric settings is inadequate it is possible that discharge may be a lengthier and more problematic procedure leading to women yo-yoing between secure settings and their communities.

It should be recognised that there are manifold complexities involved with the delivery of mental health care services. Mental illness itself remains enigmatic (and this is particularly true of diagnoses such as personality disorder), influenced by neuro-chemistry and human relationships which combine to complicate the delivery of mental health services (Page and Dix, 2007). Moreover, judging the efficacy of services is equally complex as outcome measures are likely to be limited in their true accuracy and value (Page and Dix, 2007:80). Nevertheless, in recent years there has been consensus around the benefits of therapeutic activities within secure units for all patients (Chaudhry and Pereira, 2009). The importance of a therapeutic environment including areas such as a garden, access to a gym, art rooms is noted. When specifying environmental design principles, there has been an emphasis upon ensuring that there are spaces created for these activities as well as quiet rooms (Department of Health 2009). In addition, the importance of Extra Care Areas (ECAs) within medium secure settings for women, as an alternative to seclusion have recently been discussed (Long, Silaule, and Collier, 2010). Therefore, the physical design of units has a bearing upon the
services provided to patients and also upon how patients (and women in particular) experience their time within these facilities.

However, crucially the availability of trained staff (as well as the recruitment and retention of staff) facilitate patients’ ability to access these areas (Beer et al., 2005). Thus the lack of Occupational Therapists (for example) results in limited ability for patients to engage in therapeutic activities. The emphasis upon holistic services for mental health patients in secure settings necessitates the input of a multi-disciplinary group of professionals. However, it seems that just as there are not enough OTs, neither are there adequate numbers of social workers or psychologists (Chaudhry and Pereira, 2009). In addition, the need for staff to be properly educated so that they are able to care for difficult patients is fundamental to the care that is given; so for example it has been found that forensic nurses responses to self harmers have sometimes worsened patients symptoms and that those who had received education in self-harm showed greater empathy (Dickinson, Wright, and Harrison, 2009). The management of self harm (generally an out-working of women’s mental distress rather than men’s) is topical and one that NICE have been focusing on (Department of Health, 2010).

There is no systematic evidence available that focuses on the efficacy of one service model above another for women (Newbigging et al, 2006); even the recent evaluation of an Extra Care Area (Long et al, 2010:44) stresses the need for further research on service user benefit. One study outlines the development of a ‘best practice’ service for women in a medium secure setting (Long et al, 2008) and despite their avowed inability to make ‘bold proclamations’ about what works best for women (2008:315), there are useful indications (and tentative suggestions) concerning the best care regimes for women. The emphasis in this study was upon the development of gender sensitive therapeutic services with an awareness of the needs for staff training. The strategy was centred upon:

1) the establishment of a supportive ward milieu to maintain a communal commitment to change,
2) group work as part of an intensive treatment programme,
3) individual support and treatment as appropriate’ (2008:306).

Above all, the emphasis here on relational security (discussed in more detail below) and consistent focus on women’s strengths and resources – rather than their frailties chimes with feminist approaches (Aitken, 2006; Aitken and Noble, 2001). This has been further underlined in work on ‘New Therapeutically Enhanced Medium Secure Services for Women’ (Green, 2006) that are characterised by:

‘...increased relational security, which is achieved not just by greater numbers of staff but crucially by the skills of staff and the quality of therapeutic relationships.’

The report by Newbigging et al (2006) also stresses that women sensitive provision is best characterised by an ability for women to make choices about the staff and the care and treatment provided to them, access to staff who give women time to talk, women only spaces within the physical environment and an understanding of women’s distress in the context of their whole lives. The few studies that have asked women about what they want (Parry-Crooke et al., 2000; Parry-Crooke and Stafford, 2009) demonstrate their need for appropriate talking therapies, more opportunities for trips outside the setting as preparation for moving into the community, wards which were more homely, changes in staff attitudes to women and greater respect for them.
3.6 Tangled pathways
The ‘Tilt Report’ (DH 2000) recommendations for upgrading facilities and reducing the number of patients in high secure hospitals led to an accelerated discharge programme for men and women. While welcoming the development of dedicated services, including those for women, higher levels of rehabilitation and assertive outreach, concerns were raised about the consequences of these changes for some groups of patients who would no longer need a secure service but would require a high level of support (Davies and Abbott 2006). However, they note the following:

‘The very welcome development of forensic rehabilitation medium secure services and the discharge from high security hospitals of patients who no longer require these services is, however, likely to create a further bottleneck between forensic rehabilitation and local services.’ (2006:353).

In addition to these concerns, the procedures surrounding discharge into the community appear to be quite complex. It seems possible that the ways in which women are discharged from secure services may have some impact upon their subsequent needs in the community and these are therefore worth considering.

The literature on moving from secure services to other forms of services (medium / low security units – general psychiatric hospitals, hostels and community) indicates that there is not a simple process of discharge and neither are there standardised procedures that are followed. Rather there is often a certain amount of to-ing and fro-ing between units and services. Some of the reasons for this are described by Kennedy (2002):

‘Guidelines for moving a patient to lower levels of security and eventually to community care are much more difficult to operationalise. It cannot be presumed that all patients will automatically progress within defined periods of time....Reasonable clinical criteria include evidence that dispositional, situational and mental illness factors relevant to the risk of violent behaviour are understood and are reduced by treatment, and that changes indicating risk could be monitored and managed at a lower level of security.’ (2002:440).

This is worth quoting at some length because it goes some way towards explaining the plethora of factors that are considered before / as patients move through the secure mental health system. Given that risk assessment scales are inexact tools and that their relevance for assessing women’s mental health has been called into question (Aitken, 2006) and that what constitutes good mental health is a variable concept it is not surprising that many people fail to return to community life on any permanent basis. As was reported in one study:

‘... nearly one fifth of this discharge cohort failed to return to the community...’(Jamieson and Taylor, 2002)

This same study suggested that medium secure provision has an insignificant long-term role for progressing high security patients (2002:404) and that simple concepts of community or institutional care are outmoded:

‘Some people living in hospitals appeared to have been spending much of their days outside those hospitals in the wider community, whereas patients in some of the hostel placements (designated community placements) appeared to be more supervised and observed than those in some hospitals.’ (2002:405).
This deftly highlights some of the complications when considering discharge from these settings which provide such differing levels of access to the community and provide such different levels of care. Given the difficulties around collecting data on discharged cohorts, it is unsurprising that data on long-term outcomes of patients released from psychiatric services are limited (Steffen et al., 2009). However, without reliable data on this, the ability to ameliorate or change discharge procedures is hampered. The research by Steffen et al (2009) followed up all admissions to a medium secure unit (Arnold Lodge) for a period of 20 years, of these a minority, were discharged to the community – including either a home or a hostel. As the authors state in their discussion:

‘...after discharge outcome for patients was poor, with a mortality rate that was six times that which one might expect; that almost half of those discharged had at least one reconviction; that almost two thirds were re-admitted within 5 years after discharge; and that their capacity to obtain and retain gainful employment was very limited.’ (2009:73).

These findings echo those of Davies et al (2007) who found that after discharge, the outcome for patients was poor and that almost two-thirds were readmitted within five years. This research clearly indicates that routes out of secure mental health settings can be torturous and are often unsuccessful, if success is measured by an individual’s ability to maintain an independent life in the community. However, these studies are limited by the lack of comparable information about discharge from other medium secure units. And for the purposes of this literature review, there was no differentiation by gender. Work by Blattner and Dolan (2009) on the movement of high security patients into a medium secure unit, similarly fails to consider women and stresses the need for further large scale studies on this subject.

The web of complexity surrounding successful discharge procedures has been further highlighted by research examining the reconviction rates of patients discharged from the same medium secure unit as was studied by Steffen et al (Arnold Lodge) (Sahota, Davies, Duggan, and Clarke, 2009). This study found that contrary to expectations, patients discharged to specialised community forensic services had a shorter time to reconviction. Although it is inadvisable to generalise from a single study, this work indicates that specialised services in themselves may not resolve issues around rates of reconviction or ease pathways into the community. It is also important to consider the communities into which patients are discharged. For instance, if people have been subject to out of area treatment, then they are either discharged into unfamiliar communities or they move back ‘home’ and are therefore at some distance from the support of the mental health services from which they were discharged (Jones, 2009). In either case, the need for secure mental health services to be well connected with the surrounding community is clear (Pinfold, 2000). In this way, some real continuity of care between psychiatric services and the community might be achieved.

Brown and Fahy (2009) examined male patients in medium secure units subject to section 37/41. A close scrutiny of a relatively defined population is one way of beginning to untangle some of the overlapping factors that affect discharge into the community. This study is not of direct relevance (female patients were excluded as their numbers were so small). However, the finding that:

‘Both forensic and general psychiatry service development should include plans for the development of community-supported hostel placements in order to ensure efficient pathways out of care.’ (2009:276)

is certainly generalisable. To some extent, the expansion of medium secure units was aimed at providing more appropriate pathways out of high security hospitals and prisons into the community (Brown and Fahy, 2009), however without adequate community based mental health services (both general and forensic) discharge procedures are likely to remain complicated. In addition the
importance of early review after discharge has been stressed (Royal College of Psychiatrists, 2000) as 40% of post-discharge suicides occur before the first follow-up appointment (Kennedy, 2002). Discharge then, can pose real dangers for patients (although for the most part studies have concentrated on the dangers that discharged patients present for the community).

The need for careful discharge planning has been highlighted by the only systematic meta-analysis of this subject (Steffen et al., 2009). This study comments upon the fragmented nature of services offered to those who are discharged and reiterates the finding that transitions are often not successful. The difficulties of developing discharge protocols that are applicable to a heterogeneous population are appreciated; and yet the authors comment with certainty that the implementation of discharge interventions:

‘...can contribute to reducing hospital stays and to improving patients’ adherence to aftercare as well as symptomatic impairment.’ (2009:8).

One of the few studies that considers gender differences following discharge (Maden et al., 2006) note that women appear to have a lower risk of being reconvicted because they tend to less often have a history of previous convictions and more often one of self-harm. This provides the clearest indication that the journeys for women out of secure mental health services require different sorts of supportive interventions.

Little mention has been made in the literature examined of the psychological aspects of discharge for individuals who may be very fearful about re-entering the community for a number of reasons. They may be returning to difficult personal lives, women may have to confront their responsibilities as mothers again or face situations in which they are separated from their children, they may also be unable to work. These are all factors diminishing (particularly women’s) chances to integrate successfully on discharge. As has been noted about women in another context (emerging from US jails):

‘Women need more comprehensive services and economic conditions need to change for them to successfully reengage with community life’. (Richie:2001)

Future issues that may affect the experience of discharge for patients as well as discharge procedures include the introduction of ‘personal budgets’ which seek to give people more choice and control and are intended to provide

‘The flexibility of being able to organise support around one’s own life rather than having to adapt one’s life around support is central to personalisation’. (Spandler and Vick, 2006:112)

The shift away from ‘one size fits all’ support services and towards personalisation has been welcomed in the field of mental health as supporting the concept of ‘recovery’, where people learn to live well despite the continuing or long-term presence of a mental health issue. Personalised approaches require thinking about care and support services in a whole new way, seeing a person as an individual with their own strengths, aspirations, hopes and fears and allowing them to make the choices about the types of supports they require in order to live an ordinary life.

Many local authorities use a model of self-directed support which starts with a self-assessment and is followed by the allocation of a personal budget, with the person themselves and their family leading the decision making. Access to a personalized budget has undoubtedly had a positive impact for some people (ADASS 2011) and being in control of managing one’s own support services has
been identified as contributing to mental wellbeing (MIND, 2009a). There have also been some reports of a negative impact of having a personal budget in the ‘stress, upset and confusion’ caused by inadvertent misuse of funds and problems with employing and managing personal assistants (The National Audit office IPSOS MORI 2011). However, a personal budget can come in different forms and be managed in different ways. It can be a direct payment in cash, so that an individual can employ their own staff and directly purchase what they need, or a notional budget where someone else (for example an individual, agency, trust or provider) can do this on their behalf.

A Personal Budget may be funded solely from a local authority or from a combination of sources such as the Independent Living Fund or Supporting People under the ‘Right to Control’ programme which is currently being piloted and evaluated in seven local authorities, one of which is Essex. The ‘Right to Control’ enables people to combine the support they receive from six different sources covering employment, housing and community care and decide how best to spend their funding to meet different needs.

The NHS can also allocate a notional personal health budget, which, with changes in legislation, may in the future also come as a cash payment. However people choose to manage their personal budget, the idea is that they are encouraged to put together a support plan to meet the personal outcomes they want in their lives, and have maximum control over how the plan is put into action.

This may at first seem daunting for mentally fragile people who have spent extended periods of time in secure institutions and need to re-learn many of the practical aspects about how to manage ‘normal’ life again. The flexibility and freedoms that personal budgets offer, however, could provide real solutions to meeting some of the current gaps in services, for example, by arranging personal support outside of the more rigid hours set by providers, a difficulty identified for a number of supported housing schemes. Personalisation also has the potential to meet the needs of women being discharged from inpatient units in a unique and different way from current mainstream services that have often been designed around the needs of the majority male population in secure mental health services.

3.7 Relationships and relational security

Although these are distinct areas, the concept of ‘relational security’ seems to have arisen from an understanding of the crucial importance of relationships to the lives of most people, and especially to women (Aitken and Noble, 2001, Aitken, 2006).

Indeed a growing body of research (Department of Health, 2002, 2003, 2010) suggests that for women in secure psychiatric facilities there should be more emphasis on relational security and less importance placed on physical security:

‘Relational security is by far the most important element in the maintenance of therapeutic progress of patients.’ (Kennedy, 2002:442).

For Aitken (who coined the term ‘relational security’) this is a concept that centres upon the development of good interpersonal and professional relationships between patients and carers. The need for staff to alter their attitudes to women and show them greater respect was stressed by the women interviewed by Parry-Crooke et al (2000). The locus of power is therefore shifted away from ‘professionals’ (medical staff, OTs, social workers etc) and relocated (however marginally) with women who are being ‘treated’. The relational approach thus concentrates upon women’s strengths and abilities rather than their weaknesses. It is likely that relational security continues to be of the utmost importance on discharge in terms of continuity of care from regular psychiatrists / CPNs /
social workers. Richie (2001) discusses the critical nature of mentoring and peer support for women on discharge from prisons – a concept that is possibly applicable to other groups of women.

More recently, the Department of Health has offered definitions including:

‘Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care.’

‘Relational security is not simply about having a ‘good relationship’ with a patient. Safe and effective relationships between staff and patients must be professional, therapeutic and purposeful, with understood limits. Limits enable staff to maintain their professional integrity and say ‘no’ when boundaries are being tested.’ (DH 2010)

Understanding the importance of relationships with former and current partners, family members and children is also crucial to the success of women’s reintegration into the community. The extent to which these relationships are functional may determine the likelihood of individuals being able to return to independent life. Working with women when they are discharged to strengthen their relationships or move away from abusive patterns may be one way of aiding their reintegration. Similarly facilitating contact with children and estranged family members is important (Richie, 2001).

3.8 Theoretical perspectives

There is a marked lack of theory underpinning the development of services for women. Theories are analytical tools for understanding, explaining, and making predictions about a given subject matter. Without adequate theorising it is hard to formulate models that are enduring and as a result the development of services is based upon constant fire-fighting rather than valid or reliable data and concepts emerging from this which can be translated into rational frameworks. It has been noted that theorising about the psychosocial needs of women has been based on western male-derived practice (Aitken and Heenan, 2004) and that this needs to be redressed. Feminist thought, in a general sense, has been applied to the position of women in secure mental health services, but there is scope for extending this with reference to specific feminist theoretical perspectives (whether post-modern or Marxist for example). The use of theory is of pragmatic importance. Theory can aid the holistic and appropriate development of services for women in the community (for example the concept of ‘relational care’ could be expanded with reference to symbolic interactionism perhaps). Moreover, the difficulties encountered by staff working with abused women were found to be heightened by the lack of theoretical frameworks for interpreting why women with mental illness are exposed to abuse (Bengtsson-Tops, Saveman, and Tops, 2009).

Useful theoretical approaches that might be applied to the needs of women as they are discharged from psychiatric settings include: feminist epistemologies, Foucauldian perspectives on power/control and ways of thinking about structural inequalities and how these relate to individual lives through critical theory and symbolic interactionism (Mead). It is also likely that social psychological theories may provide useful insights into the needs of women in this context.
4. What did women say about their experience of moving on?

The literature review provides a comprehensive tour through what is known about secure services and identifies gaps in that knowledge. One of the crucial ways of filling the gaps was to ask women who were considering moving on and women who had already been through the process. The following sections provide summaries of the data collected from interviews with women about their experiences.

4.1 Brockfield House: women talking about ‘stepping out’

This aspect of the study was carried out by service users and academic researchers from Making Involvement Matter in Essex (MIME). MIME is a three-year project established by the Essex health and social care mental health commissioners to extend the involvement of service users and carers in commissioning decisions. This research formed part of a larger programme designed to give a voice to women service users with the aim of ensuring that services are tailored to their needs. The particular focus of the study was with women who have been detained in secure services.

Eight women from Brockfield House took part in interviews. The interviews explored previous experiences of accommodation and support in the community, before asking about the sort of accommodation and support, from the women’s perspective, that would best meet their needs when they are discharged from secure services.

The study highlighted the significance of all aspects of the process of living in and leaving secure accommodation to eventually settling into the community. Women participants identified a range of positive aspects that this move might bring to their lives, but most were also very apprehensive about various aspects of the move, particularly when their previous experience had not been positive. The idea of the move understandably generated a range of strong emotions, from fear of the process and uncertainty about the future to much hope and excitement about being back in the community. Because everyone is different, everyone expressed different needs and views in relation to future accommodation and support needs. This demonstrated the importance of services being organised around the particular set of needs each woman has, referred to as individual care planning. Despite these differences there were common themes, and the main ones are summarised below.

Securing accommodation that would meet each woman’s individual needs for:
- Safety (both a safe location and away from people or places that could be problematic)
- Support
- Reasonable living conditions
- Not being isolated
- Access to activities to occupy them.

Transparent discussion and preparation before discharge, including information about:
- The likely accommodation options that would be available
- How accommodation needs are assessed
- Whether choices would be available
- For women with children, whether the accommodation would be large enough for children to stay
- How many moves from one place to another might be involved.
Clear information before discharge about the support available in the community – who to call and when (including out of hours) for:

- Mental health support
- Therapeutic support
- Housing support
- Opportunities for work (paid or unpaid), education and leisure facilities.

Continuity of support before, during and after discharge, including for example:

- Building and developing independent living skills
- Ongoing contact with a known professional
- Opportunities before discharge to learn from women already discharged to the community about their experiences and coping strategies (if not possible in person then written or DVD material could be used)
- Peer befriending following discharge
- Assistance in maintaining existing community links and with developing new ones before discharge to help in reducing anxiety about discharge and to prevent isolation.

Regular opportunities after discharge to review progress (defined by the women as ‘monitoring’) and bring up any issues.

Overall, the message from the study was that an individualised coordinated package of care, together with information and support prior to and throughout the discharge process would heighten the chances of a successful return to the community. Continuity of care (i.e. the same practitioner and/or peer supporter) throughout the various stages of the discharge would assist with the transition process. Accommodation would need to provide a place of safety and security in a suitable location depending on specific needs in order to give individual women the best chance of success.

4.2 Women stepped out: what supports and what hinders them?

“Sometimes I’ve been inside [high secure] for weeks on end, not gone outside at all.”

This was a study of the experiences of a small number of women who have been discharged from mental health, secure services and are currently living in the community. The primary concern was to consider what supports them and what hinders them and how this might inform the commissioning of accommodation and social care support.

Semi-structured interviews were conducted with five women who had been discharged from secure services and were living in different models of accommodation in the community. In addition, the women were given disposable cameras to take pictures of their lived environment, as a means of
gaining a different insight into their view of the world and these were discussed in a follow up interview.

The women identified what helps them make the transition from mental health secure services, what supports them to re-integrate into the community and what hinders them. This includes the type of accommodation; their relationships with family, professional staff and other people; employment, education and mainstream activities; space and personal belongings and choice and empowerment: what helps them to feel safe and how they manage the risks to their recovery, particularly when returning to communities associated with previous addictions. The study also identified the need for better data collection and monitoring of outcomes for women once they have left mental health secure services; and the need for more joined up commissioning across health and social care pathways. The common themes identified are summarised below:

- **Accommodation**: the findings from this study appear to support other research which demonstrates that there is no single ideal model of accommodation, that is “one size does not fit all” (Lee 2009; O’Malley, 2005; Whitley 2008; Grant 2010; Nelson 2007) but that supported housing can be a stepping stone to greater independence. Choice, involvement and empowerment were identified as important considerations in the transition from secure services to community accommodation and could have far reaching implications for how settled women feel in the long term.

Self-contained apartments are the preferred model in supported housing, people want privacy and support from on-site staff. Being amongst other people who have shared experience can help. Mixed sex environments were preferred but being the only female amongst a house full of men can be stressful and sharing bathrooms is unacceptable. Other tenants caused distress when they were unwell or behaved anti-socially by, for example taking food, borrowing money or in their association with other people. Women moving into supported housing from secure services need 24 hour staffing cover in order to feel safe and secure.

These findings support other research (Nelson et al, 2006/2008; Grant 2010 Whitley, 2008; O’Malley, 2005) concerning choice and empowerment and the benefits of supported housing. There appeared to be a gap in the supply of supported housing that provides self-contained apartments with the flexibility to provide 24 hour support.

- **Family relationships**: support from families is important during the transition from secure services to the community but equally the links between individuals, their families and their communities needed to be maintained while women are in secure services, wherever possible. Ideally, programmes should be devised to enable women to spend time with their families and to undertake meaningful activities in the community, such as voluntary work, whilst they are still in secure services; this would make integration back into the community an easier experience.

- **Involvement with mental health professionals and others**: long term involvement of care workers was described as supportive to women’s re-integration in the community but there was no common experience in the type of support or where it was received from. Positive examples included being supported to exercise choice and being able to negotiate relationships, for one person this included negotiating how family and others might respond to self-harming behaviour. Support needs to be consistent, particularly in working through complex pathways, which can be destabilising, what Zeilig (2010) describes as the need to feel ‘held’ and helped towards empowerment and control.
This should be seen within the context of individuals having spent years living with restricted liberties, institutionalised and what has been described by Parry-Crooke and Stafford (2009) as being “treated like children”. At the point of discharge, an individual may find herself confronted with the responsibilities of an independent adult and with some of the most difficult pressures any adult may face: finding a place to live; finding a job or tackling the benefits system; re-establishing family ties and returning to high risk places or situations. This research found that there was no consistency of approach to support during the transition between secure services and the community. Where a particularly good transitional process was experienced it was deemed to be exceptional, “lucky” and “not my experience of other people”.

On the point of being discharged from secure services, some women felt considerable anxiety together with mixed feelings of excitement and expectations about how their lives might be different. The transitional process and the quality of the engagement between practitioner and patient can have far reaching implications for how individuals might settle into the community. This research supports Pinfold’s study (2000) which said that women discharged for secure services tend to have smaller social networks than those of the general public and that their networks were dominated by relationships with relatives and professionals. It revealed complex dynamics and tensions between seeking connections to the community and desiring autonomy, linked to the experience of stigma and discrimination. Much energy was spent on avoiding people who were associated with past histories of substance abuse or people who would draw attention by their ‘oddness’ and association to mental illness. At the same time these women were attempting to break into established networks, after having been ‘removed’ from the community for what may have been many years. This supports the view that it is important to support ‘inpatients’ connectivity to the world outside of secure services, through activities such as voluntary work.

Whilst research participants did not speak directly of ‘therapeutic interventions’, there were a number of references to on-going relationships with mental health staff and having somebody to talk to outside of family and friends. Further research is needed on the benefits and mechanisms for maintaining continuity with therapeutic interventions once individuals have been discharged from secure services.

- **Employment, education and mainstream activities:** non-statutory services contributed to the expansion of linkages into the community, particularly in employment, volunteering, education and in helping with housing tenancies. Employment and educational courses were key aspirations for the research participants and viewed as a gateway to financial independence and social integration.

- **Space and personal belongings:** The women in this research used their photographs to highlight the importance of physical and public space such as gardens and parks, enabled them to be amongst people as a fully active citizen but at the same time, maintaining an anonymous presence if wished. As for most people, personal belongings, artifacts, the personal treasures and collected memorabilia are outward expressions of style and taste that contributes to a sense of individuality. They are also important aspects of creating a personal environment for the women who took part in this research and featured in everybody’s photographs.
• Care pathways: one of the most significant threats to the ability of women to exercise choice and feel empowered was the lack of clarity and fragmented decision making that was characteristic of the progression through secure services and the transition into the community, contributing to delays and increasing anxiety for individuals. This supports findings by Parry-Crooke (2000; 2009) and Zeilig (2010).

The underlying problem that emerged for commissioning was that the pathways between secure services and the community are not sufficiently understood or developed between different agencies. Added to this, there is insufficient information about the actual demand and need for different types of accommodation and long term outcomes for women once they have been discharged from secure services. The focus over the past decade has been on recidivism, as described, for example, by Coid (2007), Beer (2005), Maden (2006) and Visher (2003) which is primarily concerned with men who are a higher risk to the public even though, when adjusted for incidents of self-harming behaviour, the rates of relapse are similar for both men and women.

A key message from the interviews with these women was for health and social care commissioners to work together on care pathways through secure services into the community. The complexities of referral routes and funding streams for different types of accommodation need to be untangled. These may include specialist, tertiary, secondary and community services, including residential care, supported housing and the use of personal budgets. The ultimate aim is to support women within their own private tenancies wherever possible, in order to sustain their recovery in the community.

“That’s a photo of my front door. Just I suppose it signifies my flat and how great it is to have my own place.”
5. What did professionals and services say about moving on?

Eighteen representatives from a range of organisations including commissioners of services; medium secure services; accommodation providers; advocacy services; PCTs and CMHTs in Essex took part in individual discussions. These focused on a range of topics including their contact with women in secure services; care planning for women and care pathways; moving on from secure services to the community; ideal and real opportunities for this group of women; as well as existing provision, gaps, and access and barriers to services for women leaving local secure mental health services or returning to their home area from secure services located around the country. Following individual interviews, participants and others (approximately 30 people) were invited to a workshop to discuss how to take forward the concerns of women. This section presents the key issues identified by professionals and their views on what may help or hinder women’s successful ‘stepping out’ into the local community.

Key issues identified by participants included the following:

- **Women’s discharge from secure care**: most agreed that women needed a clear pathway out of secure care. However, this was sometimes hindered by the late involvement of Community Mental Health Teams and inadequate follow up from Community Psychiatric Nurses.
- **Housing after hospital**: women and those supporting them found securing independent accommodation difficult as local councils and private landlords were often reluctant to accept women with, for example, a history of arson or women diagnosed with a mental illness. Moreover, perceptions of these women as unable to live independently often meant that they must prove to their local council that they are ready to reintegrate into the community.
- **The need for person centred planning and principles**: there is a growing need for these to be adopted by all mental health services. This would place women at the centre of their care and allow them to make choices concerning the care they receive through personal budgets. Thus, it is hoped that this would make women the ‘experts’ in their care encouraging independence and empowerment.
- **Employment and education**: these were seen to empower women and provide them with a sense of belonging. However, vocational services needed to be pitched at women as well as men to aid the transition into employment.
- **Finding appropriate accommodation**: Women who were unable to obtain accommodation were often forced back into hospital or ‘dumped’ into residential care for infinite periods. This could lead to increased feelings of powerlessness and vulnerability.
- **Mental health ghettos**: women who managed to secure accommodation were often housed in ‘mental health ghettos’ whereby they received hard to let properties in undesirable areas. Moreover, staff were concerned that these localities often had problems with drugs and crime which tended to have a negative impact on women’s recovery and integration back into the community.
- **Residential care**: some women were unnecessarily being discharged into residential care and not their own accommodation due to a Home Office expectation that women will progress from medium and low secure units into residential care as part of their pathway into the community. Thus, those women who entered residential care then became ineligible for housing meaning women were unable to secure accommodation or regain their independence.
- **Lack of integration between services**: women’s discharge from secure care was often hampered by a lack of integration between local authorities, housing services, mental health services, and children’s services. Thus, women’s sense of stability and support may be reduced at a time when they were at their most vulnerable.
5.1 Existing accommodation options for women leaving secure settings

According to participants here, accommodation does exist that women could access so there is not a ‘bottle-neck’ situation here to be addressed. However, a key concern was that much of this was inappropriate provision (which, for example, will not take women with histories of arson or provide adequate levels of support) added to which there are further difficulties associated with placing women where there may be little public understanding of them. A bottle-neck may still develop with women moving through the relatively new medium secure service at Brockfield House into the community. Further concerns related to specific options included:

<table>
<thead>
<tr>
<th>Type of accommodation</th>
<th>Provision and views from participants</th>
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<tbody>
<tr>
<td>Secure mental health services</td>
<td>Brockfield House has 32 medium and low secure beds for women. St. Andrew’s Health Care provides an Enhanced Low Secure (High Dependency) Unit for 13 women, a Low Secure Rehabilitation Unit for 16 women which encourages independence through management of risk and increasing levels of responsibility, and an Intensive Rehabilitation service for six women in flatlets which enable them to live semi independently and to demonstrate their ability to maintain progress through the care pathway towards non secure living. These services are not exclusively for women in Essex or returning to the county. However, even where low secure services exist, this was not always deemed appropriate for women stepping out. For some women, the linear pathway is seen to be unnecessary and they can, with suitable accommodation and support, move to independent living including high support services.</td>
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<tr>
<td>High support accommodation</td>
<td>Supply of high support accommodation was considered to be limited. One high support service was provided by NACRO. It offers 24 hour staff to a 16 bedroomed, mixed sex, shared house. NACRO has developed a model of referral and assessment which aims to ensure communication across agencies via a joint referral panel. Other services included supported accommodation from Granta Housing (with a range of flats and shared housing). Many participants agreed that despite small numbers of women, high level supported housing would work well as a next stage from an MSU. However, a key issue for them and providers was that 24 hour staffing was rare and might become increasingly difficult to provide. For some agencies there was also a lack of clarity about the provision of formal ‘therapeutic’ services, e.g. counselling. Residential care has been in high demand especially by the Home Office which often expects women to go from secure to residential. However, this is not always necessary or appropriate and may result in bed blocking. Questions were raised about how far this option helps women to get used to being back in the community and the view was that it should be used for no more than six months. This option can prevent women from being on the housing list and receiving local authority accommodation. If women are moving from ‘hospital’, it should signal that they do not need residential care.</td>
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<tr>
<td>Women-only accommodation</td>
<td>The perception was that there is very little women-only accommodation. Hostels are frequently mixed sex with very few women residents. For women who are vulnerable, hostels are unlikely to provide appropriate support or physical and relational security.</td>
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<td>Mixed sex accommodation with range of support</td>
<td>In addition to very scarce provision for women only, participants were aware that there were few special supported housing schemes. Those financed through Supporting People are not funded to provide counselling/other therapeutic interventions. This has left a gap for women in need of higher levels of support.</td>
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<td><strong>Independent accommodation with floating support</strong></td>
<td>Limited accommodation is available via housing schemes but these may only offer floating and not on-site support. For women leaving an MSU, this was considered to be an inadequate level of input for most.</td>
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<tr>
<td><strong>Local authority housing</strong></td>
<td>Although women were encouraged to bid for housing, some suggested that the council may refuse accommodation due to a history of arson or questions about the state of the woman’s mental health and whether she is ready to leave secure care. In order to leave secure care a woman must provide evidence that she can live in the community, for example, ‘they can prove they have done x, y, and z’. Some described women being housed in a ‘mental health ghetto’ in ‘hard to let’ areas with tower blocks, problems with drugs and a high population of disadvantaged people. This may make women more vulnerable than they already feel and cause problems with women reintegrating into the community. Being a parent may also delay a woman’s discharge as she has to be assessed by the Children’s Service.</td>
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<tr>
<td><strong>Private sector landlords</strong></td>
<td>Landlords were thought to be unlikely to offer any support and indeed would not want to know or know how to deal with a crisis. Women are more likely to commit arson. This makes getting a woman out of hospital much more difficult as landlords and other forms of housing are reluctant to take them. ‘Some of these private landlords would rather take a murderer’ even though there may not be any evidence to suggest that a woman is more likely to be reconvicted of arson. Private landlords were perceived as being concerned with keeping their property undamaged and creating a steady income.</td>
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<tr>
<td><strong>Return to family home</strong></td>
<td>This was considered an option for some women although there were concerns that issues in the family home had not always been identified and a woman could be returning to an inappropriate environment.</td>
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### 5.2 Views of the discharge process for women

All those who participated in interviews and workshop discussions agreed that the key to successful move on from secure services was early and well-coordinated planning. Taking into account concerns about the lack of appropriate accommodation, most argued that even that could be partly compensated for by referral, assessment and discharge processes which focused on the individual woman and meeting her needs. Workshop participants suggested that although there are pockets of good practice, there is no clear pathway for women being discharged from secure services. Aside from concerns about accommodation and costs, two overriding factors were likely to help or hinder what could be achieved by the woman and those working to support her – timing and who was involved in the process.

#### Timing:

When is the right time to begin planning for discharge? Different aspects of discharge needed to be planned into women’s care at different stages. Some favoured commencing planning almost immediately as a woman was admitted and settled into the secure service. Interviewees and workshop participants identified the following issues related to discharge preparation:

- A few months are never enough. One social landlord, offering accommodation to those with mental health needs, described how they worked with the secure service on the basis of meeting need and not timelines.
The social landlord is a special supported housing organisation and, where a referral has been made, asks to be invited to the woman’s CPA meeting to find out why she is being referred, subsequently arranging an informal visit with the care coordinator. If the referral is accepted, three to four visits are arranged before a panel meeting takes place to agree if the move will go ahead or not. Women can choose to mix with men or not as they are provided with individual flats. However, this agency no longer provides a sleeping in service and was concerned that the level of support would be too low. There may not be continuing therapeutic care from other parts of the community and thus, the transition from secure service would be too great a step for some people.

- Care coordinators were perceived as unwilling to get involved as a result of heavy caseloads and demands on their time/travel.
- Planning was rarely coordinated across services/professionals. However, there are examples of changing practice.

Although NACRO take few people from secure services (approx. 10% of residents), their 16-bed, 24 hour high support house has piloted a new Joint Referral Panel as a result of concerns over the timing and process. All specialist services are involved in the Panel and share information; where there are concerns about a resident, the Panel will review their situation.

- Community team members needed to attend CPA meetings at the secure service at least six months in advance in order to get to know the women concerned and to support transfer and hand over to other services.
- MSUs had no forensic outreach which would enable people to move through the pathway more quickly.
- Women who have been out of area have experienced more difficulties especially related to resolving funding.
- Non-statutory support, e.g. advocacy services, were often only contacted one month prior to discharge. However, they could meet with women before leaving the service and then arrange befriending and help to signpost them with good local knowledge.
- Women become very frustrated but many agreed that the referral and discharge take a long time and from forensic services this can be additionally slow.

**Who needs to be involved?**

Ideally, women themselves and the full range of agencies that have been and will be connected to discharge, need to be involved in planning the process. However, agencies across sectors raised their concerns that there was insufficient and sometimes poor communication between individuals, agencies and the secure service. Participants described wanting to see improved liaison between the Local Authority, Mental Health Services and Forensic Services and that the secure services needed to request more from the local authority than just residential care. In the main, care coordinators have been tasked with finding move on accommodation. In addition, Community Mental Health Teams needed to be involved with women as early as possible to help this.

Advocacy services and other community based organisations were aware that sometimes statutory agencies were unable to meet women’s needs. However, they hoped that women could ‘fall back’ on them.

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One voluntary sector support service had developed its own pathway approach to working with service users. Within this goals are set, formal and informal meetings are held, there is a planned reduction in support and links to other sources are developed. However, there was a concern that provision did not always exist. Hence the importance of both early involvement and close working with the local mental health trust to prevent users falling through the net, was highlighted.

A forensic advocacy service is involved in working with women from the Brockfield House pre-discharge unit and supporting them pre and through discharge. One of the key contradictions for this agency was that where a woman was discharged and her section lifted, they could no longer provide ongoing support. With no Community Treatment Order (CTO), the best they could offer was to signpost the woman to other community based support providers. Their concern was that, in the absence of the CTO and given the size of CPN caseloads, these women would lack continuity of support and not be followed up.

Suggestions were offered to improve the current process:

- Streamlined approach with a directory of services and a pathway diagram which would help identify a woman’s need and see what appropriate provision is available.
- Developing peer-support for women who do not want to be in contact with services. This would give them both an ally and a link to other networks.

**What resources are available for women stepping out?**

In the current climate, participants described existing difficulties in terms of the funding available for women’s provision and the need to demonstrate value for money. Secure services are expensive and there is no question that most move-on accommodation and support will be cheaper. However, the provision of high support with accommodation is not cheap and services are under pressure to provide for users within existing (and possibly shrinking) budgets.

Interest was shown in how far and in what ways personal budgets will open up opportunities for women leaving secure services as it will give them more control over what, how and by whom support is provided. Whilst it has been reported that uptake among people with mental health issues has been slow and concerns have been raised about increased bureaucracy, (Community Care, August 2011) the evaluation of outcomes for other people with complex mental health needs in Essex will help us to understand how best to support women who may have been in secure care for some time and are likely to experience greater difficulties in managing both the resources and freedoms that personalisation offers.

**5.3 What are women’s needs and how are these being met?**

Discussions focused around whether or not women have specific and different needs to men. In addition, how these individual needs can be met, in light of budgets and budget constraints and the availability of suitable options for women to ‘step out’, were all discussed. The picture was not promising and the following sections demonstrate that most of those involved in this research recognised the acute difficulties faced by women and those supporting them in managing their move from secure settings.

**Women only and/or a gender focus**

There was a range of views about the need to address women’s needs as distinct from men’s, if and how this should happen, the difficulty of doing so for what, locally, is a very small number of individuals and in the absence of dedicated services, the importance of ensuring services and their staff were sensitive to gender.
Those who believed that gender was a significant factor in planning women’s discharge from secure services, identified the following specific issues for them:

- Women can be more vulnerable and some services and professionals outside secure services find it difficult to work with a gender perspective, they may stigmatise women who need to be reintegrated into the mainstream.
- Women need to be given consideration in relation to appropriate employment packages and work placements which acknowledge their vulnerability and their often low sense of self worth.
- Women are often drawn to the caring professions where a criminal record hinders them and they need support to find access to suitable opportunities.
- Women need separate accommodation (e.g. flats with shared areas to allow them to choose whether to mix or not) so that they do not feel threatened.
- When moving into a new community women need to be educated in how to protect themselves. They are often at risk of becoming involved in abusive relationships.
- Young women, in particular, need staffed accommodation working within a recovery model rather than, e.g. being in foster care.
- Women are more likely to self harm and need appropriate support.
- Women with children need accommodation where children can visit and/or stay and where mothers can care for them appropriately.

Some participants said that they were uncertain that women needed anything different to men. Others, however, acknowledged the differences but noted the following:

- There are not enough women to warrant dedicated women-only provision.
- Seeking women only accommodation severely limits where women can be placed, e.g. it may be at some distance from their children/preferred area.
- All services need to be gender aware so that provision is designed to be appropriate to their needs as well as to men’s.

**Meeting need through the person**

Many professionals agreed that identifying a woman’s needs should place the woman at the centre. Hence, they emphasised the importance of early planning and developing processes which bring together relevant agencies through multi-disciplinary teams and CPA meetings. The nature of a woman’s relationships with representatives of the range of agencies was also key to a successful transition, as one person said in the context of considering women-only provision, ‘if I could commission relationships, I would do but I can’t. I can assure systems and processes are in place to support women’.

Workshop participants suggested that person centred planning and principles be adopted by the local authority and in all mental health services. Women would then be able to direct their own support needs. Personalisation of care will encourage independence by giving women a voice.
Meeting need through the budget
There have ongoing discussions in the commissioning of secure and move-on services about the relative merits of block or individual ‘bed’ buying. With the move towards personalisation and personalised Budgets, the intention is that service users will have more say in their care, support and their options for living. There is a growing need for direct budgets and personalised care.

Meeting need through the availability of suitable accommodation and support
An increase in council housing stock is needed to help women in their discharge from leaving secure care. This would prevent women being given poor accommodation in hard to let areas. Where women live is a great stumbling block in the discharge process. Some women may be ready to leave secure care but are unable to secure accommodation due to their mental health and criminal history and so may be forced into residential care. This may turn into a life sentence for many women who are never released. Women need to be encouraged into independent living with the necessary support from their Community Psychiatric Nurse (CPN). However, women are often not followed up by their CPN.

There are unmet needs in relation to high level supported housing. For example, there is a requirement for more individual flats with 12 hour support plus an out of hours telephone service which also allows women to remain on the housing register. But there must also be a pathway out of this. Women cannot be simply shifted into residential care.

Women should be given a high level of individual support within independent housing and be provided with a clear pathway out of this. This will improve women’s self esteem and empower them.

Women are often overwhelmed when released as they are so used to routines within secure services. This must be addressed before women leave secure care, i.e. pre-discharge wards containing individual rooms, bathrooms, etc. Women aspire for their own door key, however, this is not being addressed as women are so often unceremoniously placed within residential care.

5.4 Other types of support women need on stepping out: in an ideal world?
A wide range of additional support needs were identified by statutory and voluntary agencies which included the following:

- Provision of therapy/therapeutic activities in the community
- Increased forensic mental health community teams to support women on discharge
- Practical support setting up bank accounts, dealing with finance and bill paying
- Training, skills development and support with employment
6. Conclusions and recommendations

The four research components which make up this report have identified the needs of women moving on from secure services to more independent living; the factors which may help or hinder that stepping out process and some of the concerns which need to be addressed if their transition is to be successful in the future. Agencies and service provider interview participants were asked to summarise their thoughts on the ‘ideal’ stepping out scenario for women leaving secure services. There remained some difference of view about whether the single most important issue was the ‘real’ availability of accommodation or whether the key problem were the difficulties of accessing this and providing support to women. However, the views of professional and the views of women were, in the main, in agreement and are reflected here as a set of recommendations.

<table>
<thead>
<tr>
<th>Area for change</th>
<th>Specific recommendations</th>
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<tr>
<td>Preparation for discharge</td>
<td>Secure services and care coordinators need to ensure that discharge plans are considered as soon after a woman is admitted as deemed appropriate. Given the increasing emphasis on reducing the amount of time women spend in medium secure accommodation, this has become more urgent. Links between mental health services, housing services, local authorities, and children’s services need to be improved in order to create easier day- to-day management of women’s transition between services. Women’s discharge needs to be clearly planned when they enter the service allowing Community Mental Health Teams to be involved as early as possible. All disciplines and professions should come together to provide women with a smooth pathway out of secure care and to ensure they receive the right support and accommodation that they need.</td>
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<tr>
<td>Accommodation</td>
<td>Women’s move to the community would be enhanced by increased ‘transitional’ housing with 24 hour staffing for three to six months before moving to independent accommodation with lower levels of support. An increase in council stock and high support independent accommodation is needed to allow women to be discharged from secure care when they are ready, with the support they need. Accommodation needs to be safe (location and from people women wish to avoid) and easily accessible. This would link women to the local community, enhancing their capacity to maintain control over their own lives and facilitate their sense of connection to the community around them.</td>
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<tr>
<td>Care and treatment</td>
<td>There is a need to ensure and maintain continuity and consistency of care once women move from secure services, e.g. with CMHTs responsible for ‘monitoring’ how women are sustaining their lives. There is a need for an enhanced forensic community health provision which would alleviate pressure from CMHTs and ensure that these women receive appropriate support in relation to their histories and experience of secure services. Consideration may need to be given to the provision of psychological and other therapies during and beyond their transition to the community.</td>
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<tr>
<td>Other support</td>
<td>Increased peer and other ‘local’ support could help women to reintegrate and ease pressure on other services. Voluntary sector agencies have been able to fill some of the gaps but said that signposting women was a key role they performed. Peer mentoring in the community may help women cope with the ongoing stress of everyday life. The role of family and friends in providing support needs to be acknowledged and built on where appropriate for individual women both prior to and post-discharge from secure services. Support from services needs to be particularly extended to women with children where a programme of support is begun at the secure service and continued in the community. Consideration of what women might do once discharged could begin early on by bringing relevant professionals together to explore options. Although this would not be appropriate for all women, making vocational services more available and accessible would help make the transition into employment much smoother. For women this would create a sense of belonging if they enter education/employment. Vocational services need to be targeted at and appropriate for women (especially young</td>
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women) as well as men.
- Educational opportunities including retraining, employment and voluntary work will help women feel worthwhile.
- Practical help, e.g. with shopping and caring for children, will enable women to do what is ordinary.

Staff
- Agencies and providers of services need to be aware of the barriers women face in securing accommodation. This could be addressed through training, e.g. for housing providers. This may help to remove stereotypical attitudes that housing providers are perceived to have towards women with mental health difficulties.
- Funding needs to be provided for staff training in relation to women diagnosed with personality disorders, why women self-harm and how to support them.
- Local Authorities involved in personalised support could provide training to secure services staff in relation to personalised care and budgets. ‘Personalised budgets open many doors for women.’

Social determinants
- Public perceptions are difficult to change. However, clear pathways for women which make moving into the community smoother will enhance women’s experience and may impact on those around them.
- The impact of personalised budgets for women leaving secure settings needs to be monitored and evaluated.

Finally, the research undertaken here suggests that there is a need for continuing data collection and longer-term review of women’s experience of ‘stepping out’ to ensure that services are in place to meet their needs.
Appendices:

Appendix 1: References
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Community Care August 2011


Appendix 2: Topic guide for agencies and professionals

Discharge from secure mental health services into the community

Background

- Essex County Council Mental Health Joint Commissioning Team is concerned to scope and consider for the future, the availability and suitability of move-on accommodation for women from Runwell hospital MSU and women who have been placed outside the geographic area but wish/must return to the east of England. Concerned that women are supported as necessary and that services identified to support them are sustainable.
- In 2007, the Department of Health commissioned four pilot high support therapeutic community residential services for women with complex needs which are being evaluated as part of a pilot two year period. The ethos which underpins them is that some women in the appropriate setting will be able to sustain an independent life and one which is outside a secure service.
- It may be that women who are discharged from Runwell will have similar needs.
- Asking for your help with consultation among professionals and others involved in women’s care into understanding ways in which care pathways for women are ‘successful’ or otherwise.
- Understanding essential to any consideration of move-on care and the identification of gaps in current provision offers opportunity to determine what is needed and how it can be provided.
- Confidential discussion, digest of findings, presentation at meeting on Friday October 15th 2010.

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Section 1: Your agency/service and your role

The agency/service

- Aims/objectives of the service
- Philosophical approach of the service
- Meeting the needs of women leaving secure services
- What important for women’s recovery and why
- How is/not provided

Agency/service experience of women from secure services

- Frequency and type of contact
- Role in their discharge to community
- Obligations to women
- Familiarity with Gender Equality Duty

Your role

- Professional background
- Contact with secure services for women
- Role in relation to commissioning/service provision/discharge/further accommodation/support

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Section 2: Women’s contact with agency/service

Women’s contact with agency/service

- Do women in need have access to the service
- What are the specific needs of the women/realistic in terms of what can be provided
- Effectiveness of referral/assessment/discharge process (from secure)
- Admissions and discharge rates/average length of stay and waiting lists
Models of care and service delivery (for community residential, housing and day care providers)

Which models influence what happens within the service?
- Staff confidence to listen to women talk about their past lives
- Differentiated care and why is it important
- How are women’s needs identified? Is approach effective?
- How does the service meet the specific needs of women in terms of self harm/surviving sexual abuse or other abuse/specific index offences e.g. fire setting/violence
- Range/Content of policies/help or hinder practice
- Range care/ support provided for women from MSUs
- Range/frequency of treatment/therapy/activities/facilities
- Access to/use of educational and vocational opportunities
- Access to/use/views of psychological therapy
- Access to/use/vies of creative and complimentary therapies
- Access to/use of physical healthcare facilities
- Experiences/practicalities of service provision/daily living

Care Planning Process and Care Pathways

When/ how does it take place
- Level of involvement of staff/team members/service users
- Review Process-level/range of involvement from staff/team members/service users
- Role of different professionals/multi-disciplinary teams
- Women’s pathways towards independent living?
- Would you consider the care planning process to be effective/holistic? Why?
- Care Programme Approach:
  - Taking account of: women’s experiences of violence/abuse/child sexual abuse
  - Does it ensure care/safety/recovery
  - Prevention of re-traumatisation/victimisation within the service

Section 3: Moving on from medium secure services

Ideal move-on
- Design
- Single or mixed sex
- Content
- Relationship to services
- What sustain women/work/activities/other
- How be provided?
- Funding; timing

Real moving on
- Concept of rehabilitation/what this means/how it is practiced
- Ideal post-MSU placement?
- What available? Low secure, supported housing, other
- Appropriateness? Suitability of move on accommodation
- Access and availability
- Contact with out-reach community services
- Resettlement where and how?
- Support for underlying social problems e.g. poverty, housing, benefit entitlements
- Support given/required
- Early intervention approach in terms of a speedy post discharge review
In the community

Concept of the community
how accessible is this to women?
What programmes/services are in place to promote social inclusion/integration? What are the levels of integration?
Liaison and Collaboration-Joint working with the community and other agencies
Procedures/support to facilitate and promote healthy relationships between service users and staff/their family