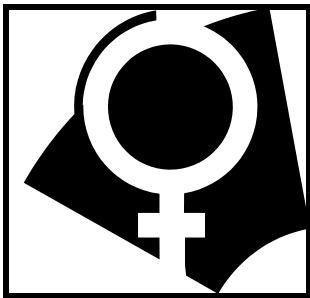


# **Increasing Safety and Gender Sensitivity in mixed sex psychiatric units**

**Gathering Information about clinical mental health service initiatives**

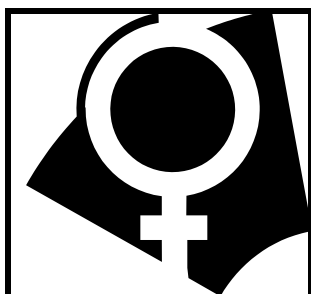


**A report by the Victorian Women and Mental Health Network, 2009**

# **Increasing Safety and Gender Sensitivity in mixed sex psychiatric units**

**Gathering Information about clinical  
mental health service initiatives**

**Project report**



**Victorian Women and Mental Health Network**

## **Acknowledgements**

The Victorian Women and Mental Health Network would like to acknowledge the contributions of all those who participated in this information gathering project and the production of this report.

In particular, we would like to acknowledge the nurse unit managers, consumer consultants and women's mental health consultants who generously shared their knowledge and experiences in order to promote the cross fertilisation of ideas relating to gender sensitive practice within adult acute inpatient units.

We also wish to thank the staff of the Department of Human Services Mental Health and Drugs Division for their support in facilitating the gathering of information for this project.

The VWMHN would like to acknowledge the recent action taken by MHDD to promote safety within acute inpatient units and also to recognise the achievements of many area mental health services who have initiated significant changes to increase gender sensitive practice. We look forward to continuing to work with mental health services at all levels in promoting services that are responsive to women consumers' needs

Finally, we are extremely grateful to the Mental Health Council of Australia and the Australian Government Department of Health and Aging for providing the funding to enable this project to be undertaken.

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## **Acronyms and Abbreviations**

CC	Consumer Consultant
IPU	Inpatient unit
MHDD	Mental Health and Drugs Division, Department of Human Services
NTBS	Nowhere to be safe : women's experiences of mixed sex psychiatric wards
NUM	Nurse Unit Manager
PDRSS	Psychiatric Disability Rehabilitation Support Service
SECU	Secure Extended Care Unit
WMHC	Women's Mental Health Consultant
VMIAC	Victorian Mental Illness Awareness Council
VWMHN	Victorian Women and Mental Health Network

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**Every attempt has been made to ensure the accuracy of the information contained in this report at the time of printing however the VWMHN accepts no responsibility for omissions or inclusions which may no longer be accurate as a result of subsequent developments within particular inpatient units.**

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## **Executive Summary**

This report of the 'Gathering Information' project continues the work of the Victorian Women and Mental Health Network (VWMHN) undertaken during 2006-2008 to raise awareness of women's experience of mixed sex psychiatric wards and to highlight the need for mental health services to develop gender sensitive responses which ensure safe treatment environments.

Previous consultations undertaken by the VWMHN have focussed on women consumers. The 'Gathering Information' project has provided the opportunity to explore the experience of area mental health service staff working in adult acute inpatient units, in particular, in relation to developing initiatives to address safety and gender sensitivity.

A Steering Committee was established to oversee the project and the information was gathered via key stakeholder interviews with 43 mental health service staff from 26 inpatient units, including nurse managers, consumer consultants and women's mental health consultants.

The overall findings of the project are as follows :

1. Clinical mental health staff identify significant safety concerns for women consumers receiving treatment in mixed sex inpatient units.
2. The action priorities identified by mental health service providers to address these safety concerns have much in common with those previously suggested by women consumers.
3. There is evidence of increased awareness of gender sensitivity with a diverse range of gender sensitive initiatives being implemented or planned within some services to address identified safety concerns.
4. The provision of women's corridors in sixteen adult acute units has significantly increased gender sensitivity while still enabling responsiveness to the general demand for acute admissions.
5. Further action is required in other areas to ensure that there is a consistent level of gender sensitive service provision throughout the state.
6. Further action is also required by the Department of Human Services Mental Health and Drugs Division to ensure the sustainability of positive developments in gender sensitive service provision through the adequate resourcing of area mental health services.
7. Recent initiatives to increase safety and gender sensitivity in acute inpatient units appear to have relevance for other parts of the mental health system, for example, community care units, secure extended care units and potentially residential drug and alcohol services.

## Recommendations

1. DHS Mental Health and Drugs Division take appropriate action to ensure that :

- (i) A policy of providing choice of single sex treatment environments is incorporated into the design guidelines for adult acute inpatient units. (As recommended by DHS Gender Sensitivity and Safety in Adult Acute inpatient units report, 2008)
- (ii) New adult acute inpatient units currently being built or planned, including units at the Northern and Dandenong Hospitals provide a separate women's area comprising an adequate number of designated female rooms, a women's lounge and outdoor recreation space.
- (iii) Women's corridors are established in the adult acute inpatient units where this provision is yet to be introduced.
- (iv) A research study is undertaken to explore the impact of ward design on patient safety and gender sensitivity, the findings of which will guide services in the construction of new units and the redevelopment of existing units.

2. DHS Mental Health and Drugs Division explore options to restore funding for women's mental health consultants in order to bring all areas into line with the three areas where such positions continue to operate.

3. DHS Mental Health and Drugs Division provide funding for a state wide women's mental health coordinator position to support women's mental health consultants and area service based women's portfolio positions to initiate and sustain gender sensitive practice within area mental health services.

4. Area mental health services identify staff positions to undertake women's portfolio responsibilities, including the establishment of multidisciplinary women's mental health interest groups to promote gender sensitive practice at the local level.

5. Area mental health services utilise the inclusion of gender sensitivity and safety in Mental Health and Drugs Division annual provisions, to apply for design work for minor renovations that will continue to increase gender separation / safety in wards.

**Top 10 changes to increase Safety and Gender Sensitivity in inpatient units identified by nurse unit managers and consumer consultants**

1. Separate facilities within inpatient units - women's corridors / lounges / outdoor spaces
2. Staff education and training re gender sensitivity
3. Development of policies that promote gender sensitive practice
4. Lockable bedroom doors
5. Separate female and male areas in high dependency units
6. Gender specific group programs
7. Development of Patient Codes of Conduct
8. Provision of trauma informed care
9. Establishment of staff positions that focus on increasing gender sensitivity
10. Increased staff presence / communication between staff and consumers

**Top 10 changes to increase Safety and Gender Sensitivity in inpatient units identified by women consumers**

1. Locate bedrooms in separate women's and men's corridors
  2. Separate women's lounges, outdoor areas and family visitor areas
  3. Lockable bedroom and bathroom doors
  4. Separate women's and men's bathroom facilities in high dependency and low dependency units
  5. Introduce Patient Codes of Conduct which clarify unacceptable behaviour
  6. Earlier intervention by staff to protect women and prevent escalating patient conflict
  7. Better staff support for women who experience harassment
  8. Staff to be aware of patients' previous experiences of trauma
  9. To be treated by female staff where possible, particularly at night
  10. More opportunities for communication and therapeutic contact with staff
- (Nowhere to be Safe report, 2008)

## Introduction

In May 2008, the VWMHN released the report *Nowhere to be Safe: Women's experiences of mixed sex psychiatric wards.*(NTBS) This report documents the experiences of 140 women consumers who had participated in a project organized by the Network involving questionnaires and focus groups for women to speak about their inpatient experiences. An alarming 61% of the women who responded to the questionnaire reported experiencing harassment or abuse during hospital admissions to mixed sex psychiatric wards. Concerns raised by women related primarily to the behaviour of male patients and included witnessing verbal and physical aggression, receiving unwelcome sexual advances, male patients entering women's bedrooms and threatened or actual assault including sexual assault. This report highlighted the need to increase gender sensitivity and documented the changes identified by women consumers that are needed to increase patient safety.

The promotion of gender sensitive practice has also occurred as a result of work undertaken within state government departments and other mental health organisations. In June, 2008 the DHS Mental Health and Drugs Division (MHDD) released the final report of the Gender Sensitivity and Safety in Adult Acute Inpatient Units Project (DHS, 2008b). Findings include the identification of key policy gaps relating to gender sensitivity and safety and recognition of the need for Mental Health and Drugs Division and service level leadership to ensure sustainable implementation of policy. Recommendations included producing guidelines for promoting sexual safety and for responding to allegations of sexual assault on inpatient units, adopting a policy of providing choice for patients to be treated in single sex environments, improving gender sensitivity in current bed-based environments through existing annual provision processes and developing key performance indicators which include gender issues.

During 2008, the Victorian Mental Illness Awareness Council (VMIAC) also undertook a project focussing on women's safety, the results of which will be documented in the report *Unsafe in a Sanctuary* shortly to be released. In developing this report, VMIAC undertook consultations with 49 women consumers from six country areas and four metropolitan regions about their inpatient experiences. These consultations confirmed VWMHN's earlier findings that women frequently feel unsafe in mixed wards and would prefer to be treated in more separate environments.

In mid 2007, as part of the MHDD gender sensitivity project, one-off Environmental Improvement Grants of \$20,000 were provided to 25 Victorian area mental health services to make inpatient environmental alterations to enhance safety and contribute to a sense of security among female patients. This grant process increased awareness of gender sensitivity and safety issues within these services and prompted significant developments in the provision of gender sensitive practice within inpatient units.

In mid 2008, the VWMHN received funding through the Mental Health Council of Australia to undertake a project which would gather and share information about these gender sensitive developments thereby contributing to the current dialogue regarding the provision of gender sensitive responses within mental health services.

### **Who is this report for?**

The information collected in this report is aimed at any one who has a role or interest in promoting gender sensitive practice in mental health services, in particular within acute inpatient environments. It aims to create awareness of the significant work that is already being undertaken in this field and in doing so to promote cross fertilisation of ideas, generate further initiatives and identify future priorities. It is hoped that it will be useful to all who play a part in creating client-centred and recovery-promoting inpatient treatment environments including nurse unit managers, nurse educators and other nursing staff, area managers, clinical directors, allied health staff and consumer consultants.

### **How was the information gathered?**

The information contained in this report was collected via telephone interviews with 43 mental health service providers comprising 24 nurse unit managers, 11 consumer consultants, a carer consultant, three women's mental health consultants, a nurse educator, a clinical coordinator, a senior nurse and a quality manager.

The report is organised into two parts. The first half contains information about current gender sensitive developments supported by quotes from participants about their 'hands on' experiences in implementing these initiatives. The second half discusses some of the key issues identified by mental health staff which confront services as they attempt to incorporate gender sensitive changes into practice.

## **Increased awareness of gender sensitive practice in mental health services**

### **Nurse Unit Managers**

Information gathered from nurse unit managers and other mental health staff revealed an increased awareness and widespread interest in the development of gender-sensitive practice in inpatient units.

A majority of staff consulted (96%) were aware of the Gender Sensitivity and Safety in Adult Acute Inpatient Units project undertaken by DHS in 2007, particularly the Environmental Upgrade Grant component of the project. This increased awareness is reflected in the comment of one nurse unit manager who noted -

*'Gender-sensitive practice has become part of our day-to-day decision making... there's been a culture shift over the last twelve months prompted by the gender upgrade grant and the gender-sensitive audit that was undertaken across the organisation.'*

### **Consumer Consultants**

A majority of consumer consultants (92%) were also familiar with the Gender Sensitivity and Safety in Adult Acute Inpatient Units project although many were unaware that the final project report had been released.

Most had been consulted about the use of the gender focussed environmental upgrade grant with the level of consultation ranging from participating as a full member of the ongoing working groups established to oversee the utilisation of the funds to attending a one-off meeting with the nurse unit manager with whom final decision making rested.

In one service where both a male and female consumer consultant are employed, only the male CC had been consulted in relation to utilising the grant. Consumer consultants from two services noted that their suggestions had not been accepted in the final utilisation of the grant money.

In some areas consumer advisory groups or councils had also been consulted but this also varied from service to service. Consumer consultation about how the grant should be utilised also included speaking with current women inpatients in a number of units.

## **Lack of safety in inpatient units**

Contact with nurse unit managers and consumer consultants working in mixed psychiatric wards revealed that these staff clearly identify significant safety concerns associated with inpatient environments for :

- Women consumers
- Vulnerable male patients
- Staff

Safety issues for lesbian and homosexual consumers and patients with gender identity issues were also highlighted by one informant.

### **Safety Issues for women consumers**

There was general confirmation from both nurse unit managers and consumer consultants of the potential for women consumers' to be exposed to harassment / aggression and risk of sexual assault by male patients within mixed sex wards.

- *'During our consultation about how to use the gender upgrade grant, women identified that there was nowhere on the ward where they could be safe...their priority was to be safe in their bedrooms.'* (NUM)
- *'Women's main concerns are witnessing aggressive behaviour of other patients and patients wandering into rooms while relaxing or changing.'* (NUM)
- *'I recall when single sex wards were made mixed sex, staff were only told about the benefits...the negative repercussions in terms of how to make sure patients were protected were not acknowledged. Women, especially young women are definitely at risk from predatory behaviour...whether it's part of male patients' illness or their personality.'* (NUM)
- *'Male patients can have a 'pack mentality'...their behaviour can include loud verbal abuse directed at other patients as well as staff...such behaviour can have distressing effects on women with past trauma history and older patients.'* (NUM)
- *'The mixed ward arrangement is hard on staff...even though we monitor patients hourly at night...when people are unwell they can become promiscuous...it's hard for staff to protect them.'* (NUM)
- *'Aggression on the ward is the most important issue... some of the eating disorder patients have felt threatened and uneasy about the level of aggression displayed on the acute ward....most aggression is perpetrated by males so this is a gender issue'* (CC)

### **Risk of sexual assault – part of lack of safety in inpatient units**

- *'We all know what happens on inpatient wards, that a number of women are unsafe...you don't come onto an inpatient ward expecting to be assaulted...it appals me that this still happens.'* (CC)
- *'Many incidents aren't disclosed at the time largely because women feel they won't be believed – as the nurse unit manager, I may only hear about them some weeks later.'* (NUM)
- *'Both women and men have shocking experiences in acute units...it is not necessarily harassment by other consumers but also by staff...both male and female staff can be sexually inappropriate at times.'* (CC)

### **Lack of Safety for Vulnerable Males**

- *'Some male patients are going through similar things... women can be disinhibited and approach male patients.'* (NUM)
- *'Guys feel unsafe too...sometimes this relates to sexual orientation.'* (CC)
- *'Many males also have a trauma history...we need to also think carefully about their admissions, for example, to seclusion.'* (NUM)

### **Safety Issues for Staff**

- *'There is an increased level of male clients displaying aggressive behaviour often related to illicit substance use – we are aware of the fear that this trend can generate for vulnerable women patients as well as staff.'* (NUM)
- *'Harassment of staff is also an issue...patients make inappropriate comments when they are disinhibited...we try to link them with male staff and provide staff with supervision / debriefing.'* (NUM)

## **Initiatives to address safety and gender sensitivity in mixed sex psychiatric units**

Contact with mental health staff revealed that a wide range of gender sensitive initiatives have been implemented or are planned to address these safety concerns. A small number of services had been implementing these practices for a number of years however many have occurred as a direct response to the DHS environmental upgrade grant in 2007. It is positive that many of these initiatives correspond to suggestions included in the Women's Top 10 changes to increase safety detailed in the NTBS report.

The following list details the variety of initiatives reported by nurse unit managers, consumer consultants and women's mental health consultants that have been implemented or are planned to increase safety and gender sensitivity in adult acute inpatient units :

- Women's corridors
- Lockable bedroom and bathroom doors
- Sensory motion detectors / Nurse call buttons
- Women's lounges
- Women's outdoor recreation spaces
- Family visiting areas
- Separate facilities in high dependency units
- Gender sensitive seclusion practices
- Access to female contact nurse
- Gender specific group programs
- Patient orientation / questionnaires incorporating gender sensitivity
- Gender audits of ward environments
- Policies to promote gender-sensitive practice
- Incorporation of gender-sensitive practice principles in core training for mental health staff
- Establishment of women's portfolio positions
- Formation of women's mental health interest groups

## **Women's Corridors**

Women's corridors have been implemented in 16 out of 26 wards (62%) indicating a significant commitment by services to increasing women sensitive responsiveness.

Two of these were established at the time when the wards were first built or were being redeveloped. The remaining 14 units have established women's corridors by adapting their current physical environment.

Within these units, women's corridors are generally designated for female patients however if there is additional demand for male beds, men who are assessed as 'low risk' and unlikely to engage in predatory behaviour may be allocated a room in these corridors, usually in one of the rooms nearest the nursing station to facilitate monitoring.

Several wards have been utilising this approach for a number of years however a majority of gender specific corridors have been established within the last twelve months within the constraints of existing ward designs.

In some units where the design features a number of corridors radiating out from the nurse station, the separation has occurred by designating particular corridors as either female or male and has been relatively straightforward.

Some other units feature a horseshoe design resulting in a long circular corridor with limited visibility. Gender separation has been achieved in one such ward through the construction of a door at the halfway point of the horseshoe with one half designated as the female side and the other male. This door was originally only locked at night but is now kept permanently locked to maintain privacy and safety.

Strategically located doors have also been constructed or are planned in two other units to create a greater degree of separation of the women's corridors in these wards.

## **Staff Experience of Women's Corridors**

Nurse unit managers of wards where women's corridors have been established unanimously identified that this initiative has significantly improved inpatient conditions for women while still enabling responsiveness to the general demand for acute admissions.

*'This use of space (women's corridor) requires some movement of consumers to different rooms but this can be dealt with sensitively through good staff / consumer communication – we don't see this as juggling but as being mindful about creating the environment that will best respond to consumers' needs.'*  
(NUM)

*'It's important to be able to provide choice of a more separate area for vulnerable women.'* (NUM)

*'Some level of separation on the ward is appropriate, for example, a female sleeping area especially for vulnerable women...some men are over familiar, not in control of their own behaviour...there are some incidents between men and women.'* (NUM)

*'We need to keep patients segregated...this is important for the safety and comfort of the women, a number of whom also experience disinhibition. Staff are becoming more aware of how to juggle rooms and move patients about so gender and safety issues can be responded to.'* (NUM)

*'We've got better at separating the male and female patients.'* (NUM)

### **Nurse unit managers concerns about 'women preferred' corridors**

While expressing overall positive views, some staff identified limitations to patient safety with the current level of implementation of gender specific corridors in inpatient units.

*'These measures don't completely address safety issues for women because there are no doors at the entrance to these corridors so men can walk into them... but their presence there attracts attention and prompts staff to check men's reasons for being there so women are less at risk.'* (NUM)

Lockable doors at the entrance to the women's corridors are in fact planned at two units and would appear to be supported by a number of nurse unit managers.

*'I would support a lockable door between female and male wings – these gender sensitive developments have been a long time coming...folks are so unwell, we've got to be able to protect them.'* (NUM)

Although a majority of the units are forced to place 'low risk' males in the women's corridors when demand for male beds exceeds the number of designated beds, this practice is seen as far from ideal by some staff.

*'I acknowledge incidents occur...we can't get rid of all the risks because we're forced to place males in the female corridor when there are males who require admission...I am not in agreement with this...I believe if there was greater co-operation between areas, gender needs could be managed so that wards did not have to place men in women's corridors – there is not currently this level of cooperation.'* (NUM)

One male nurse unit manager expressed the view that separate corridors aren't 'good' for women because they don't reflect a 'normal' environment. Another male nurse unit manager expressed support for separate corridors in mixed

wards but not gender specific wards because *'often females diffuse things'*. These attitudes were mirrored in the comments of a male consumer consultant who noted – *'Women have to deal with men in the outside world so having to deal with males in mixed wards could be good for women...I also feel it's beneficial for males to have women in the wards.'* (CC)

These comments raise the issue of whether it is appropriate or good practice to rely on women who are acutely unwell to perform the function of subduing male behaviour. They clearly represent a minority opinion with a much more common view being typified by the comment - *'Staff are aware that women don't want to be with strange men when they are vulnerable and unwell.'* (NUM) This more commonly held view is consistent with findings from VWMHN consultations with women consumers and clearly challenges the assertion that *'there is, as yet, no clear evidence that women prefer single-sex environments,'* (DHS, 2008b, p6)

### **Women consumers' experience of women's corridors**

Feedback obtained by staff indicates women consumers are also very supportive of this initiative.

*'Women's feedback about having access to a separate corridor is very positive - they feel much safer. Most of the female population is fearful and vulnerable... a majority have a history of abuse and are frightened by the male patients ...being able to get away to their specific area is reassuring and comforting. Relatives, especially partners are also reassured by the separate women's corridor...as a relative, I know I would be.'* (NUM)

*'Women have reported the separate corridors are much better. Men also think this arrangement is better. The nurses' office is the dividing line between the two wings...if anyone strays into the other area it's immediately obvious.'* (NUM)

*'Women report that being located in a separate corridor they feel they are able to provide support for each other and keep each other safe from males who are being inappropriate.'* (NUM)

*'Feedback from women via our consumer consultant is that women are very happy with the new arrangement.'* (NUM)

*'Our ward environment is better for women as a result of the gender door...staff are thinking more about where people are placed so that the separation of females and males is becoming almost routine.'* (CC)

Support for women's corridors was also identified from consumer consultants in areas where these are yet to be established.

*'Separate men's and women's corridors would be preferable. The expectation would be that patients would only need to be in their gender specific corridor. This would help to prevent issues of sexual harassment about which have been concerns for a long time. It's been recognised that the de-segregation of the*

*wards hasn't worked and there's been talk of addressing the concern...the challenge is how to do this given great demand for beds.'* (CC)

*'Patients should have access to choice of single sex or mixed ward environments that provide separate female / male wings that can provide patients with some options and balance.'* (CC)

### **Mixed Gender Corridors**

Ten wards (38%) continue to operate mixed gender corridors resulting in male and female patients being allocated bedrooms in close proximity within the same corridor. In wards where not all rooms have their own ensembles, this practice can result in some male and female patients having to share bathroom facilities. In addition to not being consistent with women's identified safety and privacy preferences, such shared provisions increase women's potential exposure to harassment and abuse. They also increase the potential for women who have experienced past physical or sexual abuse trauma to experience retriggering of this trauma. Such retriggering may take the form of flashbacks which may be minimised or misinterpreted as 'delusions' linked with the experience of mental illness. Given that an estimated 70% of women inpatients have histories of physical or sexual abuse.(Goodman et al, 2001), it is suggested that the continued provision of mixed sex corridors in inpatient units is a practice which fails to respond sufficiently to the specific needs of women consumers.

### **Key Learnings**

- Building of new wards or redevelopment of existing wards provides an opportunity to establish women's corridors within IPUs.
- Creative use of space allows for the establishment of women's corridors within a variety of existing IPU designs.
- Implementation of gender specific corridors significantly increases safety and amenity for women inpatients without reducing the capacity of units to respond to demand for acute admissions.
- Women's safety would be further enhanced by the location of a lockable door at the entrance to women's corridors. Doors from other parts of the ward which open onto the women's corridor also need to be locked to preserve safety.
- Evidence from staff suggests that having to allocate rooms in women's corridors to male patients is not consistent with good practice. Alternative approaches utilising increased cooperation between multiple units within the same service or neighbouring mental health services should be explored as an alternative to this practice.

### **Models of Good Practice**

- Gender Sensitive area – IPU 1, Maroondah Hospital
- Women only wing with door at entrance (planned) – E Ward, Casey Hospital
- Women’s corridor - Sunshine Adult Acute Psychiatric Unit, Sunshine Hospital
- Women’s wing – Broadmeadows Inpatient Unit, Broadmeadows Hospital
- Use of ‘gender door’ - to create gender-specific areas – Peninsula Mental Health Services (adult acute unit)

## **Lockable Bedroom Doors**

Women consumers have consistently identified the need to be able to lock themselves in their bedrooms at night in order to feel safe. Seventeen wards (65%) already offer this provision while a further five are planning to respond to this expressed need by seeking to utilise their environmental upgrade grant to install locks on bedroom doors. This initiative has been met by delays in a number of areas with the result that, at the time of writing, there is a lack of consistency across the state in terms of this provision. Such delays in utilising the grant prompted one consumer consultant to comment – *‘There needs to be transparency and accountability within mental health services to ensure that monies allocated for purposes of improving gender sensitivity in inpatient units are utilised for this purpose.’* (CC)

Only one NUM identified not being in favour of lockable bedroom doors. Within this service, patients can ask to have their bedrooms locked from the outside but cannot secure themselves from the inside. One consumer consultant described a similar provision in her area – *‘Women are able to ask staff to lock them in their bedroom and can let themselves out from the inside....women have always been able to do this but recent discussions have resulted in more women taking advantage of this.’*

Another consumer consultant commented – *‘if I were a patient on the ward, I’d be very concerned...privacy is a real issue...people can come and go... personal items go missing - not feeling safe in my own room...older women patients feel particularly uncomfortable when there are younger aggressive males...I’m totally in agreement with locks on bedroom doors.’*

One unit is also planning to install peepholes in women’s bedroom doors so that if women become aware that an incident is occurring they can ascertain what is happening before opening their door and exiting their room.

## **Provision to secure personal property**

Women consumers have frequently expressed concerns about the lack of safety for their personal belongings when they are not in their rooms. One service is planning to address this issue by trialling a lockable cupboard in one of their bedrooms however this room which will not be gender specific. Another service plans to provide lockable cabinets in all rooms located in the women’s corridor.

## **Lockable Bathrooms**

Twenty wards (77%) provide bathrooms with lockable doors utilising mechanisms which allow staff to override the locks and gain access if required. In relation to privacy associated with bathroom use, it is important to note that while many wards have mostly single rooms with ensuites, in some wards the facilities available to patients who are admitted to shared rooms require the use of bathrooms which are shared by both men and women. Such shared arrangements are identified as a source of lack of safety by women consumers and are clearly inadequate.

## **Nurse Call Buttons**

Previous feedback from women consumers has been that their sense of safety within inpatient units would be greatly enhanced by the provision of nurse call buttons which would enable them to call for staff assistance in case of emergency.

Ten units were identified as having this provision and while patients in another unit are able to request personal alarms if they are feeling unsafe. In one service the nurse call buttons are located in both patient bedrooms and bathrooms however staff recently became aware that not all patients realised they had access to them. Information about them is now provided as part of patient orientation. Contrary to concerns expressed by some service providers, staff experience within the wards where nurse call buttons are provided is that patients do not misuse these alarms.

## **Sensory Motion Detectors**

Only one ward was identified as having installed sensory motion detectors in all bedrooms. These are activated at night and alert staff if patients leave their rooms. This provision is also available in the HDU sections of a small number of other wards. Sensory motion detectors support staff to monitor patient movement and to prevent inappropriate access to other patients' rooms thereby promoting safety and privacy at times women have identified as feeling particularly vulnerable.

## **Key Learnings**

- A majority of NUM working in wards where lockable bedroom and bathroom doors are now provided have found these provisions are manageable and increase women's sense of safety and privacy.
- Nurse call buttons and / or sensory motion detectors are provisions which also promote safe inpatient environments.

### **Models of Good Practice**

Nurse call buttons – P Block, Monash Medical Centre

Sensory motion detectors – Werribee Mercy Mental Health Program

## **Women's Lounges**

*'Women shouldn't have to leave the TV room because they're being harassed.'* (CC)

The Department of Human Services report 'Tailoring services to meet the needs of women' (1997) suggests that wards need to provide smaller alternative recreation spaces to the main day room in order to provide consumers with choice. However information obtained during the Listening Events project indicated that women's experience is that male patients displaying predatory behaviour will often follow them from one common area to another. The provision of women specific lounges in IPUs is an initiative which addresses this issue and promotes increased safety, privacy and improved amenity for female consumers.

Eleven units (42%) have established women's lounges with separate recreational spaces for women planned in a further six wards.

In a number of units these spaces were identified by designating existing lounge areas located in the newly created women's corridors as women specific. Others were developed in areas which had previously been used as interview rooms and in one unit the women's lounge that is planned will continue to be used for this function and will only be available to women part-time.

In establishing their women's lounges at least three services committed to significant structural work involving the removal of a wall between two smaller rooms to create a larger area. Another service has established a sensory / therapeutic room for women containing sensory equipment and a massage chair. In some units, women's lounges are used as a family area and for family meetings as well as a venue for women specific group activities.

The rooms that were transformed into women's lounges generally received a fresh coat of paint, new comfortable furniture and a variety of entertainments including television, DVDs, books, magazines, games and children's toys. Sensory equipment to promote self soothing is also provided in some areas. One unit provides pamper products - a massage mat, oils and foot massager - and continues to add items such as quilts and pillows created through the ward craft programs and a relaxation DVD developed during the digital photography program.

### **Staff experience of women's lounges**

*'Staff have observed that the women's lounge is well used for a variety of purposes ...women feel very comfortable in the space, particularly women who are feeling anxious. It has provided private space for families to meet and private space for nurses and consumers to talk which has enhanced the potential for the therapeutic relationship.'* (NUM)

*We're trialling a designated 'Ladies Lounge' – a small recreation space opposite the nurses' station...the ladies are loving it... staff are able to direct women who*

*have children visiting to this space...male patients need to be educated about need for it.'* (NUM)

*'The women's quiet area is somewhere to get away from difficult males who pester them. It's used by women when children are visiting and also promotes therapeutic contact between staff and consumers so may be used for one-to-one contact.'* (NUM)

*'Before we developed our Women's Lounge, women weren't using the space...now they are... from observation they appear relaxed and safe in this space.'* (NUM)

### **Consumers' experience of women's lounges**

*'Women consumers are very happy about having access to the separate recreational space – they feel comfortable and safe.'* (CC)

*'There has been some reaction to the establishment of the women's lounge by male members of the Community Advisory Group who have suggested that a male lounge is needed. This prompted discussion within the group about why there is a need for a women only recreation area and acknowledgement of women's privacy and safety concerns.'* (CC)

### **Key Learnings**

- Women's lounges can play an important part in helping women to feel safe and more relaxed in inpatient settings as well as providing a space where supportive contact between other female patients and therapeutic relationships with staff can be promoted.
- The potential dual use of women's lounges as areas where their children can visit them has been highlighted however this does not resolve the question of where children may safely visit their fathers or male relatives. It is suggested that a preferable option is for separate space to be allocated for a family area on each ward.

### **Models of Good Practice – Women's Lounges**

- Alexander Bayne Centre - Bendigo Health
- Butterfly Room - Ward 5, Mildura Base Hospital
- P Block - Monash Medical Centre

## Women's Outside Recreation Areas

In utilising their grant, a number of units identified the creation of a specific outside recreation space for women patients as a priority. These courtyards tended to be accessed via the women's lounge areas within wards.

*'We're planning a female courtyard opening off the women's corridor which will provide a refuge from the noise of the ward. It will contain outside furniture and be fenced off from the general outside area so women feel secure.'* (NUM)

Delays in completion of structural work required to secure these areas have impacted on women's access to these provisions.

*'We decided to create a women's outdoor area because women had identified this as a need in the past. The garden furniture has been purchased but we're still awaiting the building of a fence to separate the area from rest of courtyard.'* (NUM)

Staff concerns about security may also limit women's access to gender-specific outdoor areas. *'Initially the women's garden was operative only when nurses made it available. Women had to ask to have the door unlocked because some nurses had concerns about how secure it was. Because there is no electronic surveillance there was the idea that there had to be a nurse there all the time if women are using it...Now the garden courtyard is freely available to use with the door left unlocked in day light hours and no extra supervision required. Initial concerns have been overcome with experience as staff have become comfortable with patients using the garden.'* (WMHC)

### Key Learnings

- Provision of gender-specific outside recreation areas has the potential to enhance amenity of inpatient environments for women patients.
- Policies and education re usage of such facilities are needed to support staff to enable women patients to fully utilise such provisions.

### Models of Good Practice – Women's Outside Recreation Areas

- Alexander Bayne Centre – Bendigo Health
- P Block - Monash Medical Centre

## **Family Visiting Areas**

Lack of appropriate family visiting areas within wards was an issue commonly raised by nurse unit managers and consumer consultants

*'In our ward there is a small quiet room / family room but it is inadequate ...patients have observed that the ward is not a satisfactory environment for children.'* (CC)

In one rural area, the theme which emerged during consumer consultations was the need for a relaxed area within the ward where children could safely run around, and where women, including those requiring high dependency care, could engage in family therapeutic interactions.

A working party comprising management, nursing staff, consumer and carer consultants, occupational therapy, Occupational Health and Safety and Engineering was formed. Drawing on local contacts, the Horticultural Department of the local TAFE college became involved and a brief for a Sensory Garden which would provide some privacy for families and women with children was developed.

At this point the project really began to gather momentum evolving into something more akin to community development. TAFE incorporated the project into their curriculum with students being asked to develop risk free garden designs for families. Five of these students had been male clients of the ward who were encouraged to enrol in this horticultural course by the ward occupational therapist who also works part-time in the community. The students presented their designs to the Working Party who chose the final design for the Sensory Garden which incorporates a rotunda to provide shelter, attractive paths, a water feature and a play area for children. A number of the students who had been former patients have also been involved in the construction of the garden which is expected to be completed by the end of 2008. Ideally, former female patients could also play a part in the design and construction of future projects of this kind.

Primarily established to provide safe space for families, the garden also provides a separate space for the women's group to meet in, as well as a day time alternative for women in HDU.

### **Key Learnings**

- The establishment of a specific area where women with children and families can visit greatly enhances the safety and amenity of inpatient environments for these groups.
- Family visiting areas need to be located near the entrance to the ward as it is not desirable for children to go through the main part of the psychiatric unit to visit their parent.

- There is potential for former patients and external organisations to contribute to improving inpatient environments. This potential is also demonstrated in the way women from a local service organisation have sought to assist women inpatients. *'Rotary women have taken on the task of supplying women's packs containing soap / toothbrush / sanitary items which can be supplied on admission to women who may have come into the ward with nothing.'* (NUM)

#### **Models of Good Practice**

- Sunburst Garden – Kerford Unit, Northeast Health Wangaratta
- Family Visiting Room – IPU 1, Maroondah Hospital

## **Gender Sensitive Practices in High Dependency Units (HDU)**

The Nowhere To be Safe report (VWMHN, 2008) notes that women consumers commonly report feeling unsafe in High Dependency Units because of the higher proportion of males, being located next to male patients in rooms that do not lock, increased vulnerability associated with heavy sedation and the lack of a continuous staff presence at night.

Contact with mental health staff highlighted evidence of opposing views and practices in relation to the use of HDUs. In some units, women are placed in HDU when they report feeling unsafe.

*'If women are feeling sexually vulnerable, they are generally placed in HD where they feel protected.'* (NUM)

At the same time, HDUs were frequently identified as the most volatile part of ward with the most unwell patients.

*'Staff are aware that women may be particularly vulnerable in this environment with very unwell men engaging in very disinhibited behaviour such as publically masturbating.'* (NUM)

Acknowledgement of this kind of behaviour raises concerns for patients in general but particularly highlights the very real risks for re-triggering women with past experience of trauma, part of whose sexual abuse may have entailed being forced to witness such acts.

One unit manager described a recent incident in HDU when a female patient was hit and pushed against a wall by a male patient. In response to this assault the woman was transferred to another ward. This example highlights the safety risks for women in mixed wards as well as the potential for more gender-sensitive responses to women inpatients in the event that staff are unable to protect them from assault. In these highly regrettable situations, it is suggested that women be given the choice of remaining in the ward or being accommodated in another unit. The practice of automatically transferring women patients in such situations may perpetuate the view that it is they, rather than the male patient involved, who is responsible for the violent behaviour which has occurred.

As an option to exposing women to volatile HDU environments, one unit has a practice of keeping women who need extra attention in the open area of the ward in the care of a special nurse.

Many nurse unit managers expressed the view that HDUs should be separated into male and female areas. The need for a constant staff presence in HDUs was also highlighted.

*'There are extended periods when our HDU is not in use...when it is, there is a constant staff presence even overnight.'* (NUM)

Thirteen units (50%) which had more than one bathroom in their HDU have been able to designate separate male and female facilities.

*'We've introduced gender specific bathroom facilities in our acute medical area...the patients really appreciate this.'* (NUM)

One unit, which has three bathrooms in its HDU, has a practice of only doing this if there are at least three females in this section.

### **Key Learnings**

- Staff experience indicates that women face increased risks in mixed HDUs.
- To ensure patient safety, a constant staff presence is required in HDU's including overnight.
- Provision of separate bathroom facilities improves safety and amenity safety for women patients being cared for in HDUs.
- To further increase safety and gender sensitivity, services should explore the potential to provide gender specific HDUs in new ward designs and in redevelopments of existing wards.

### **Models of Good Practice**

- Provision of separate bathroom facilities in HDU – P Block, Monash Medical Centre
- Policy to ensure constant staff presence in HDU including overnight – Ward 9, South West Healthcare Psychiatric Services Division

## Gender Sensitive Seclusion Practices

As part of the Office of the Chief Psychiatrist's Creating Safety : Addressing Seclusion and Restraint Practices project undertaken during 2007-08, a number of area mental health services were funded to pilot approaches to reduce the use of seclusion and to improve seclusion environments for consumers.

The VWMHN is also aware that a number of areas who were not chosen as pilots as part of this project have continued to work on identifying and implementing local strategies to improved seclusion practices, many of which include more gender sensitive treatment in seclusion. As the significant positive work that is being undertaken via these pilot projects will be documented elsewhere, it is not the intention to address the issue of seclusion practices in detail in this report.

The VWMHN commends area mental health services for the significant positive work that is being undertaken and notes the following comment by a nurse unit manager as evidence of the increased awareness of the potentially traumatising impact on women of being admitted to seclusion.

*'As result of feedback from a female consumer that 'being secluded was like being raped' we now seclude patients in their own clothes...we don't strip patients or put them in pyjamas.'*

## Key Learnings

- Potential for traumatisation and re-triggering of those patients with past histories of abuse can be reduced by allowing patients to be secluded in their own clothes.

## Resources

- DHS Website – [www.health.vic.gov.au/creatingsafety](http://www.health.vic.gov.au/creatingsafety)
- Seclusion Policy – Werribee Mercy Mental Health Program

### **Access to Female Contact Nurse**

Women's desire to be treated by female staff where possible, particularly at night, was repeatedly highlighted during VWMHN consultations with women consumers during the Listening Events project in 2007.

A commitment to responding to women's expressed preference for a female contact nurse when possible was mentioned frequently by staff as well as some consumer consultants, indicating their awareness of the potential for this practice to impact on women's sense of safety.

### **Key Learnings**

- Allocation of contact nurse needs to take into account gender of patients and the expressed preference of many women consumers to be treated by female staff.
- Services need to ensure an adequate gender mix of staff across all shifts.

## **Gender specific group programs : Women's groups**

Women specific programs have been established in a number of wards and are being planned in several other areas. Nurse unit managers spoke positively about establishing women's groups as part of ward programs not only in terms of benefits for women consumers but also as a valuable source of information for staff.

One nurse unit manager highlighted that the establishment of the women's group had made staff aware that prior to the group women consumers had tended to keep things to themselves.

*'The general discussion group format provides space for women to raise issues that are important to them, including if they're not feeling safe...there can then be discussion of strategies that women can use to feel safer. As well staff are alerted to women's feelings of lack of safety in particular situations. For example, when one woman disclosed that she was fearful of aggressive young men while lining up for meals, other women were able to also reveal similar fears. Women's group meetings are anonymously minuted and issues raised can be discussed at team meetings. This has had effect of lifting the profile of these issues and the needs of vulnerable women.'* (NUM)

The female Consumer Consultant who is also involved in the women's group reinforced the potential for such programs to provide staff with important information about how women are experiencing the ward environment.

*'Some staff can become blasé... regular feedback from our women's group helps to heighten their staff awareness that there are gender issues that they need to be sensitive to... women will talk differently when men aren't around...in a group they will open up if they are frightened of another patient...staff are surprised by some of the issues women raise...this process gives women some sense of power and a chance to have their say.'* (CC)

## **Men's Groups**

The potential for men's groups to be established as part of ward programs was also raised by both staff and consumer consultants. In some areas, such groups are being explored in collaboration with staff from the local PDRS service who have experience in facilitating men's programs. Support for this approach was also expressed by consumer consultants.

*'A lot of male patients need information and coaching about how to conduct relationships in non power-using ways. You wouldn't want to admit the same men and have them behaving inappropriately in these kind of ways time after time. Services should help men to get better at relating...this could be done in groups perhaps facilitated by occupational therapy or social work staff at a fairly low cost.'* (CC)

*'Certain staff hold beliefs that gender sensitive practice is too difficult and that we have to expect and accept that incidents will happen on inpatient units. The same patients are often readmitted...nursing staff get to know their triggers...part of the role is working with them to prevent unacceptable / violent behaviour. (CC)*

Another consumer consultant noted that group therapy may not be appropriate for everyone as some people respond better to the opportunity to be heard individually.

### **Key Learnings**

- Group programs can play a positive role in patients' treatment and recovery. In particular, the provision of gender specific groups can greatly enhance the level of safety and well-being experienced by women consumers during an inpatient stay.
- Gender specific groups can provide an additional source of information about patients which can assist staff to provide more responsive inpatient care.
- There is potential to expand the range of ward based group activities through collaboration with local PDRS services.

### **Models of Good Practice**

Women's group – Kerford Unit, Northeast Health Wangaratta

Gender specific group programs - Ballarat Psychiatric Services :

- Anxiety management groups for women
- Aggression management for men

### **Patient Orientation Information**

The potential for patient orientation to be used as an opportunity to increase safety on wards through the provision of clear information about expected standards of behaviour was identified by both staff and consumer consultants.

*'Consumers need to be educated that harassment is not ok. Patient orientation needs to include information about clients' rights but also about expectations of appropriate behaviour and clarification of what is inappropriate behaviour... there needs to be consumer input into this.'* (CC)

A number of services have developed pamphlets which detail client rights and responsibilities which are distributed as part of patient orientation. A further service has plans to develop an 'Admission DVD' as an education tool which will include sections on care and treatment within the unit as well as highlighting gender specific facilities.

In addition to written material, some wards have identified the potential for information which promotes gender sensitivity to be communicated verbally to patients. *'Staff need to communicate more with women consumers...make sure they know who their contact nurse is and who they can talk to if they have concerns, let them know they we can provide 15 minute observations.'* (NUM)

The need to communicate with male patients about how some of their behaviour can impact on women patients who may have experienced past trauma was also raised. In one unit, two female staff, one of whom is the nurse unit manager, spoke with male patients as a group about this. *'The men appeared to understand and indicated they would remain on their side of the ward.'* (NUM)

*'Some men are sensitive too and get embarrassed when other male patients are hitting on women patients. We need education sessions about responsible behaviour on the ward for staff and patients.'* (CC)

*'We talk to people about not forming intimate relationships when they're on the ward and in a vulnerable state.'* (NUM)

### **Questionnaires**

Questionnaires seeking information about the specific needs and experiences of consumers were raised by two services. One survey focussing on women's experience, that was undertaken by the consumer consultant, revealed that while 50% of women were 'happy with their inpatient experience', the remaining 50% had identified 'some level of uncomfortableness', for example in having to use shared recreational spaces.

Another service utilises a 'Ward Feedback Card' (a consumer developed exit survey tool) that has been utilised for six years. Reports are produced after each 50 cards are collected and these reports are disseminated to all ward staff, nurse unit managers, the quality officer, quality committee, acute program managers and the acute program committee. The Ward Feedback Card includes questions regarding ward safety and gives an opportunity for people to say 'What is the first, most important thing to improve about the ward' and 'What is the best thing about the ward you don't want to lose'. The Ward Feedback Card does not record any demographic details such as gender.

#### **Resources**

- Questionnaire for women consumers – Ward 5, Mildura Base Hospital
- Ward Feedback Card – Consumer Participation Program, Alfred Psychiatry
- Admissions DVD (planned) – Alexander Bayne Centre, Bendigo Health

#### **Gender Sensitive Audits**

Two services had undertaken environmental audits to assess the level of gender sensitive service provision within their organisations.

Drawing on suggestions contained with the 'Nowhere To be Safe' report, one nurse unit manager proposed a gender sensitive audit of her organisation's residential services encompassing inpatient units, community care units, secure extended care units and the adolescent inpatient unit.

A tool for undertaking this audit was developed by the Quality Manager and following the audit a report was prepared identifying changes that are needed to increase the level of gender sensitive service provision within the organisation.

#### **Key Learnings**

- An audit to assess current level of gender sensitive provisions can assist inpatient units and other services that provide bed-based care to determine priorities for action to increase safety and gender sensitivity.
- A gender sensitivity and safety audit needs to be conducted periodically, for example, every two years.

#### **Resources**

- Women's Safety Inpatient Survey - Southern Health Mental Health Program
- Gender Audit Tool - Alfred Psychiatry

## Policies to promote gender sensitive practice

The development of policies that promote gender sensitive practice represents a key strategy to ensuring that recent gender sensitive initiatives become enshrined in practice. Contact with staff revealed that a number of areas are engaging in policy development which highlights core elements of promoting sexual safety such as :

- Assessment of potential to harm others
- Assessment of risk of harm from others
- Identifying past experience of sexual assault
- Managing sexually disinhibited behaviour and preventing sexual activity
- Responding to sexual assault

Some policies emphasise an 'individual' understanding of sexual safety highlighting staff responsibility to assess and manage patients who because of various factors, for example, sexual disinhibition, 'lack' sexual safety. This individual emphasis is also reflected in the observation 'mental illness and medications may impair women's judgements and make it difficult for them to protect themselves against assault and coercive sex.' (DHS, 2008b, p3).

It is important to note that sexual safety can also be understood as having an 'environmental' dimension. Within this meaning, service responsibility extends to ensuring a sexually safe environment for all patients rather than focussing on the individual behaviour of those patients assessed as being vulnerable. Service guidelines which clearly state that sexual activity in inpatient units is unacceptable are essential to promoting sexual safety and it is positive to note that a number of services have developed policies which address this. Despite there being widespread acknowledgment that women patients are more at risk within IPUs from male patients, some policies lack appropriate reference to gender differences which impact on sexual safety within wards.

The need for policies to guide staff in responding to physical assault was also identified but as one consumer consultant noted '*such policies need to be upheld...we have a sign on our ward stating there is 'Zero tolerance to Violence' but patients are not held accountable to this.*' (CC)

One area has begun to address this issue through the development and promotion of a Patient Code of Conduct which clarifies expectations regarding acceptable and unacceptable behaviour within the ward environment. A copy of this code is clearly displayed in poster form in a prominent position on the ward as well as being given to each patient as part of their orientation to the ward.

This strategy was endorsed by consumer consultants, one of whom identified the potential for such a code to be '*developed collaboratively by staff and consumers.*'

## **Key Learnings**

- Services need to support staff to consistently implement gender sensitive practice through the development of clear and practically implementable policies.
- Policy documentation needs to identify when and how the policy will be applied, by whom, as well as the staff member/s who hold responsibility for ensuring the policies are adhered to.

## **Good Practice Models**

- Sexual Safety Guidelines – Ward 9, South West Healthcare Psychiatric Services Division
- Safety in Mixed Inpatient Settings – Peninsula Mental Health Services (adult acute unit)
- Gender-Sensitive admissions guidelines – Peninsula Mental Health Services (adult acute unit)
- Patient Code of Conduct – Alfred Psychiatry
- Sexual Assault and Trauma Guidelines – North West Mental Health Service

## **Incorporation of gender-sensitive practice principles in core training for mental health staff**

At the time of its release, the Gender Sensitivity and Safety report (DHS, 2008b) identified that no services included gender issues in their training program and that limited information about gender issues was available to staff.

Information gathered through this project found that two services now routinely include the issue of gender sensitive practice as a topic in mandatory core skills staff training. In one service, the gender sensitive practice module is provided by the women's portfolio holder and includes the presentation of some statistical information about women's vulnerability, discussion about what constitutes gender sensitive practice as well as opportunities for staff to explore their responses to the ideas that have been raised. The issue of gender sensitive practice is also now included in this service's aggression management training module.

### **Key Learning**

Core staff training sessions provide a useful opportunity for the principles of gender sensitive practice to be raised with new staff members.

#### **Good Practice Models**

- Staff training in gender sensitivity – Alfred Psychiatry
- Gender sensitive training package – Peninsula Mental Health Services (adult acute unit)

## Women's portfolio staff positions

The Gender Sensitivity and Safety report (DHS, 2008b, p14) highlighted that inpatient units that had a strong emphasis on providing gender sensitive and safe patient care 'typically had clinicians responsible for and providing leadership in this area.' Information gathered through this project identified two services that have established women's portfolio staff positions with a dedicated allowance of hours which has made possible a range of gender-sensitive practice initiatives including service audits of gender sensitive provisions, the establishment of women's mental health interest groups and the development of policies to promote gender sensitive practice. Within one service the position has also enabled the introduction of gender sensitive practice as a topic within various components of the service's core skills training program, for example, aggression management training. In this service the Women's Portfolio position is held jointly by two nurses who identify that their shared responsibility and opportunity to collaborate has been instrumental in the success of this initiative.

Another two services have nominated women's portfolio staff positions with no dedicated hours or resources which significantly limits their potential effectiveness. Within the remaining services, responsibility for promoting gender sensitivity rests either with nurse unit managers or is not specifically allocated.

The establishment of designated women's portfolio positions within services is an initiative which is endorsed by consumer consultants. *'There is a lack of time to follow up action regarding these kind of issues...it would help to have designated staff member with women's / gender portfolio.'* (CC)

*'If staff are aware of the need to be sensitive to women's privacy and safety concerns they can model appropriate behaviour for patients. A staff member with a gender portfolio could help promote this practice. Nurse educators could be well placed to take on this role.'* (CC)

## Key Learnings

- The establishment of a Women's Portfolio position with dedicated staff hours enhances the promotion and sustainability of gender-sensitive practice within inpatient units. The allocation of two staff to share this responsibility increases capacity to respond to these issues in an ongoing and sustainable way.
- Nurses, in particular, nurse educators, are well placed to promote this role, however there is also potential for other staff to be active in this area, for example within another unit, the women's portfolio is held by the ward social worker.

### Models of Good Practice :

Women's portfolio / nurse educators - Alfred Psychiatry

## **Formation of Women's Mental Health Interest Groups**

A number of services have established ongoing groups focussing on women's mental health and safety issues. In one service the Women's Mental Health Interest Group is multidisciplinary and mixed gender with membership drawn from nursing and nurse educator staff, social work, psychology, psychiatry and consumer and carer consultants. This group has indentified priority actions for increasing gender sensitivity and has overseen the development of related policy and client information. Research contrasting the experience of women patients accommodated in women's corridors with those who treated in mixed wards is also being considered.

Another service has formed an ongoing multidisciplinary staff working group to develop, deliver and evaluate a gender sensitive staff education package to enhance the provision of women sensitive practices. The working group meets monthly and comprises staff from nursing / medical / allied health and the consumer consultant. The group has developed practice guidelines for staff relating to mixed sex environment within inpatient units, for example, admissions procedures specifying room allocation in separate areas. The group has also conducted an environmental audit regarding the current level of gender sensitive practice and on the basis of this has identified priority areas and formulated an Action Plan. Surveys for consumers have been conducted and have identified that women feel more unsafe than males in inpatient settings and would prefer to be treated in separate units

In another area a Women's Safety Consultation Group has been formed comprising the women's mental health portfolio holder and staff from the inpatient unit, community rehabilitation service and prevention and recovery centre as well as women consumers from the local psychiatric disability rehabilitation support service. The group also liaises with the carer consultant as well as senior management. The group meets bimonthly with the aim of increasing women's experience of safety within services through the development of trusting relationships with women consumers and the promotion of dialogue about staff / consumer perceptions of treatment. The group has reviewed consumer pamphlets and identified the need for women's packs to be made available to women on admission.

Lastly, another service has established an 'Inpatient Group' to identify actions needed to improve the ward environment, particularly in relation to responding to the needs of women consumers. This group meets monthly and is comprised of the area manager, clinical director, nurse unit manager, consumer consultant and another female consumer representative.

## **Key Learning**

The establishment of ongoing multidisciplinary women's mental health interest groups has the potential to promote gender-sensitive awareness more broadly throughout area services, to implement more initiatives and to embed gender-sensitive practice within the culture of mental health organisations.

### **Models of Good Practice**

Women's mental health interest groups :

- Patient Safety and Privacy Group - Alfred Psychiatry
- Women's Safety Staff/Consumer Collaboration Group - Swanston Centre, Barwon Health
- Kya Weave Working Party - Peninsula Mental Health Services (adult acute unit)
- Broadmeadows Inpatient Group - North West Mental Health

## **Preventing and promoting gender sensitive practice**

As part of the Gathering Information Project, nurse unit manager and consumer consultant participants were asked to identify factors that prevent and promote the development of gender-sensitive practice.

### **Factors most frequently identified as preventing gender-sensitive practice :**

- Lack of staff time because of paperwork / other tasks
- Patient acuity / changing client population with varied needs resulting in a chaotic ward environment
- Lack of staff awareness of gender-sensitivity
- Lack of consideration of consumers' experience

### **Other organisational and staff related factors noted by participants included :**

- Existing poor treatment environments
- Mismatch between organisational expectations and available resources
- Targets / pressure for throughput
- Costly quotes that restrict implementation of initiatives
- Lack of organisational structures to support gender sensitivity
- Lack of clear policy direction from DHS
- The predominance of male staff in senior positions.
- Unwillingness to recognise women's specific needs
- Belief that gender sensitive practice is too difficult / incidents are inevitable
- Frequently changing staff requiring ongoing education
- Lack of agreement about how to proceed
- Inadequate staff levels
- Exclusive focus on patient safety in terms of clinical risk (of self harm / suicide) and lack of attention to other aspects of physical and psychological safety
- Minimisation of males' violent behaviour

**Factors most frequently identified as promoting gender sensitive practice :**

- Team approach / forming a group to work on gender sensitive issues
- Education / opportunities for staff to talk about gender sensitive issues
- Senior management awareness / support / leadership
- Staff presence on the ward / communication / positive relationships with clients

**Other organisation and staff related issues noted by participants included :**

- Leadership from DHS Mental Health and Drugs Division
- Adequate funding / resources / grant initiatives
- Organisational / staff leadership
- Clear staff accountability structures / procedures / policies
- Comprehensive admissions procedure (assessment of past trauma)
- Time for patient orientation that identifies inappropriate behaviours
- Incorporation of gender sensitivity in core staff training
- Having women's portfolio with at least two staff to keep things moving
- Multidisciplinary involvement
- Gender balance in ward staff including female consumer consultant
- Recognition of staff responsibility to protect sexually disinhibited women
- Consultation with women consumers
- Staff attitude of belief / empathy for experience of women consumers
- Belief that action to improve ward environment is possible
- Persevering with incremental actions although change feels daunting

## **Discussion of issues**

### **Design of new wards / Redevelopment of existing wards**

Contact with staff from the Mental Health and Drugs Division as well as staff from some areas where new wards are being appears to indicate a trend in designs away from corridors and towards wards which feature courtyards. These designs provide for individual rooms arranged around a courtyard. Based on provisions observed in psychiatric wards in the United Kingdom, it is proposed that it is possible to install doors at regular intervals which can be closed to create gender-specific sections. This type of design is also seen as providing flexibility to respond to varying demand for male and female beds.

In seeking to identify designs which ensure safety and gender sensitivity, the VWMHN feels that more information is needed about courtyard options. Key questions include :

- How separate are the spaces that can be created by the multiple sets of doors?
- In day-to-day practice, are the doors to create gender separation routinely closed? Are these doors able to be locked?
- What has been the experience of women consumers in UK wards where they have been installed?
- How safe are these designs for women?

### **Separate youth wards – Implications for women consumers**

Discussions are also occurring within some area services about the possibility of establishing wards for younger patients. While acknowledging the needs of young people, especially those experiencing first episode psychosis, the VWMHN is concerned that young women would potentially be just as at risk of harassment / abuse from males within such mixed youth wards.

### **Gender specific psychiatric wards**

In some area services consideration is also being given to the potential for establishing completely separate wards for women and men.

As previously indicated, a majority of both nurse unit managers and consumer consultants support the provision of gender specific corridors within inpatient units. Approximately one third of both groups also indicated support for the provision of separate wards for women and men.

*'My ideal model of care is separate wings based on gender – in mixed wards both men and women are caught...neither feel safe...men are also concerned they will be accused of something.'* (NUM)

*'Separate female and male areas are a given – separate wards would be my policy of choice.'* (CC)

*'Men and women respond to different approaches...in the outside world, women have the choice not to interact with men – separate wards would be better for women who have experienced past abuse.'* (CC)

In addition, all the key informants consulted as part of the DHS Gender Sensitivity and Safety project were of the opinion that women should have the choice of gender-separate areas (DHS, 2008b, p 13). This level of support from a variety of informed sources indicates that further exploration of the option of separate wards for women and men is warranted. A detailed study is required which could more thoroughly evaluate the range of gender specific and gender sensitive designs which have been implemented in the UK as well as assess the local need for more responsive treatment environments for specific groups of women, for example, pregnant women requiring inpatient care, women with physical / sensory disabilities and women with a history of severe sexual abuse trauma.

### **Maintaining separation to ensure gender sensitivity**

As previously identified, a number of nurse unit managers expressed concerns about the practice of needing to place males in women's corridors when no beds are available in the men's area. The VWMHN is particularly concerned about the potential re-triggering effects of this practice on women who have a history of trauma, who have felt safely accommodated in a women's corridor and are then required to deal with the placement of a male patient in a nearby room.

The VWMHN suggests that, within metropolitan areas at least, there is potential to make separation of females and males more consistent through a combination of use of existing space and admission policies.

Using this approach wards could have women's corridors with designated beds. If the demand for male beds exceeded availability, the male patient could be admitted to another ward within the service or to a ward in neighbouring area then brought back to his own area when a bed in the male area became available.

This strategy expands on the current 'outlier' practice whereby patients are temporarily admitted to other hospitals when there are no vacancies in their local inpatient units. Importantly, the proposed option also takes account of gender - vacancies are utilised and safety and gender sensitive practice is maintained.

## **Potential loss of gender sensitive provisions in new designs**

Consultation with staff in areas where future redevelopment of wards is being planned highlighted the potential loss of gender-sensitive provisions made possible by the environmental upgrade grant. For example, a courtyard design which does not include separate designated female and male corridors or recreation areas is being considered as part of the redevelopment of the two inpatient units at Dandenong. Adoption of this design could mean a loss of the gender specific corridors currently provided by the two wards as well as of the women's outdoor space planned for one of these wards.

## **Impact of Design on Safety**

A number of nurse unit managers identified the impact of limited communal space on the atmosphere and potential level of aggression within wards. While individual rooms with private ensuites were seen as enhancing safety, some nurse unit managers identified that this development had resulted in an overall reduction of space available for common areas arising from the limitations of space provisions allowed by the generic design footprint. This issue has potential implications for overall ward safety and is acknowledged by the Mental Health and Drugs Division. Provision for adequate communal space is an issue which needs to be taken account of in any future review of design guidelines.

## **Gender Upgrade Grants**

While many positive initiatives have been implemented as a result of the environmental upgrade grants, the project identified that a number of improvements were yet to be completed almost twelve months after the specified date for expenditure of funds. This appears to have occurred as a result of lengthy delays in commencement of works requested (for example, installation of locks, fencing to secure a women's courtyard) and in receiving items ordered, for example, furniture to refurbish rooms as women's lounge areas. Nurse unit managers and consumer consultants expressed significant frustration at these delays. Lack of information about the grant also appeared to be an issue – one nurse unit manager was not notified of the grant until 2008 and others were unclear about how the process for gaining access to these funds in order to proceed with implementation of the planned gender-sensitive initiatives.

## **Wider Applicability within mental health for Gender Sensitivity**

Contact with nurse unit managers identified that recent action to increase gender-sensitivity in acute inpatient units has also raised awareness of implications for other parts of mental health services as well as for drug and alcohol services.

*'Things are changing but the change needs to occur not just in inpatient units but also in the other residential services that come under mental health.'* (NUM)

Examples include :

- A gender sensitivity and safety audit of all bed based services including inpatient units, secure extended care unit, adolescent unit and community care unit.
- Involvement of community care unit (CCU) staff in an ongoing women's mental health interest group and adaption of a ward's patient Code of Conduct to make it relevant to the CCU.

## Staff Responsiveness

Maintaining responsiveness to women's experience was identified as a challenge for staff by both nurse unit managers and consumer consultants.

*'After a while, staff don't see these things or you minimize them...staff can underestimate how fearful or stressed someone can be because you've become so accustomed to the ward environment...there's many times that patients won't speak up.'* (NUM)

Communication and responsiveness to patient needs were emphasised by a consumer consultant who noted *'the patient / nurse relationship transcends any particular model of care.'* (CC)

Echoing this sentiment, another consumer consultant highlighted that inpatient treatment should not be about *'just providing custodial care and reliance on medication and support...there needs to be recognition that 70-80% of people can recover – not thinking of people as 'cases' can promote a different kind of relationship between staff and consumers.'* (CC)

*'Dignity is central...all consumers – both women and men – should be treated respectfully and given some say about the manner in which they are kept safe during their inpatient stay.'* (WMHN Consultant)

Another consumer consultant highlighted that – *'Recruitment practices need to ensure that all staff are sensitive to consumer / carer needs and have an awareness of gender sensitive issues.'* (CC)

Another consumer consultant suggested that gender sensitivity needs to include an awareness of issues related to staff conduct associated with organisational procedures, for example searches conducted on admission, night staff doing bed/sleeping checks, waking patients for medication or to get up in the mornings, the use of physical restraint, the implications of primary nurses not being available due to working shifts in HDU and the safety and gender implications of the use of primarily male security staff during admissions to seclusion.

This consumer consultant cautioned against focussing only on design issues to the neglect of staff practice issues -

*'There seems to be a view that making changes to the physical environment of the wards will magically 'fix every-thing'. It doesn't address differences by gender of medication prescribing patterns, or differences by gender in medication dosage prescribing, or differences by gender in the use of seclusion, or differences by gender in the use of HDU, or differences by gender in the use of physical restraint by ward staff, or the differences by gender in physical restraint by security staff. Not looking at these sorts of things is the biggest barrier.'* (CC)

The need to include male staff in strategies to increase gender sensitive practice was highlighted by one consumer consultant –

*'We can't increase gender-sensitive practice and ignore male staff. For example, recently a male staff member walked in on female patient while she was naked...the consumer had discussed (this incident) with the staff member who maintained he hadn't acted unprofessionally however her experience was of feeling intruded on. She hadn't felt able to raise this further with staff but spoke with me and in my role as consumer consultant I supported her to complete a complaint. Staff responsibility should be to knock and if there is no answer to cautiously check if it is appropriate to enter the consumers' room, for example to pop their head around the door rather than fully entering the room.'* (CC)

One consumer consultant identified a tendency in some staff to minimise violent behaviour by male patients, for example, a male patient with a previous history of having being charged and found guilty of rape was described as having engaged in 'sexual conduct without consent.' (CC) This consumer consultant also identified a much stronger focus by mental health services on risk related physical safety within wards, for example the elimination of hanging points while other dimensions of physical safety and also consideration of psychological safety tended to be overlooked.

### **Staff Presence**

Many nurse unit managers and consumer consultants expressed the view that safety on wards was greatly expanded when there was a constant staff presence.

*'Nurses being out on the floor talking to patients...patients feel safe...they don't feel alone...it makes a big difference.'* (NUM)

*'A priority is nursing staff working out in the ward on the floor. This has really reduced over the last fourteen years because of demands of paperwork. DHS needs to simplify this – Nursing not Notes!'* (CC)

*'What is needed is a policy of having a nursing presence on the ward at all times.'* (NUM)

The view that the lack of continuous staff presence in common areas is a major problem underlying lack of safety for both female and male patients in inpatient units was reinforced by consumer consultants.

*'There should be two staff on the floor in public areas at all times so that patients have someone they can speak to and report feelings of lack of safety....often patients who report feeling unsafe are not listened to or taken seriously but instead are offered more medication.'* (CC)

*'Guys feel unsafe too... women get harassed by other women .... young people also feel unsafe...there is insufficient monitoring of external areas...incidents which could be managed or prevented often escalate out of control... this impacts on consumers and family members.'* (CC)

*'There need to be more opportunities for communication with staff. This could diffuse situations between patients before they develop into sexual harassment incidents. If there was a greater staff presence out in the ward there would be interactions between patients that staff could notice and respond to.'*(CC)

*'There need to be written policies which ensure adequate staff presence in public areas 24/7. Also written information on display in wards which provides information about safety and identifies the processes patients can follow if they're not feeling safe. Organisational charts identifying the nurse unit manager, shift leaders and other staff would also be useful. Patients may not know who is staff and who is a visitor...in one of our wards we have implemented a visitors sign- in book.'* (CC)

The need for visitors to be clearly identified was also raised by a woman's mental health consultant – *'wards need to have a clear policy about who is able to let visitors on to the ward...there also needs to be adequate communication with potential visitors so that staff are aware what their relationship to the patient is and that the consumer will be safe in receiving this visitor. For example, staff need to be aware of the possibility that some women consumers may have experienced family violence in their past or current relationship'*. As previously stated, it is not acceptable for psychiatric inpatients who are acutely unwell to be involved in sexual activity, either with other inpatients or current partners who may be visiting them.

At least one area has responded to this issue of the need for a more constant staff presence through a policy initiative -

*'We now a policy of having a physical presence in LDU all the time – this has had a significant calming effect on ward atmosphere.....There are extended periods when our HDU is not in use...when it is, there is a constant staff presence even overnight.'* (NUM)

## **Consumer Consultant Issues**

Only a handful of areas were found to employ both female and male consumer consultants although this was a practice consumer consultants identified as desirable.

One consumer consultant identified a role for trained consumers to act as volunteer 'go to' persons with whom patients on the ward can raise issues including lack of safety. It was noted that *'patients are often reluctant to complain because of fear of retribution.'* (CC)

Nurse unit managers from one service identified difficulties with accessing consumer consultants as an issue. The Gender Sensitivity and Safety project report (DHS, 2008b) also noted that although consumer consultant involvement was requested in the site visits conducted as part of this project, this was not achieved in most cases.

A number of consumer consultants and staff identified that the Consumer Advisory Groups in their area had difficulty attracting members and in three areas there was currently no such group at all. These difficulties highlight in different ways, the need for well supported consumer participation structures within area mental health services to ensure meaningful collaboration with consumer consultants and consumers generally.

## **Key Learnings**

- It is desirable that services employ both female and male consumer consultants to ensure that consumers have the choice to access the consumer consultant of the gender with whom they feel most comfortable.
- Nurse unit managers identify consumer consultant presence on the ward as important to both staff and patients.
- Dedicated staff time could support consumer consultants to strengthen community participation structures, for example, consumer advisory groups.

## Relationship between Gender Sensitive and Women Responsive Practice

A small number of staff commented that recent gender sensitive initiatives appear to have focussed on women consumers. However a majority of staff who were consulted appeared to support a need for the focus on women because of the multiple issues which they recognise female consumers are dealing with. These include that :

- Women are generally in the minority in inpatient units often comprising approximately 40% of patients
- Women are more at risk of harassment / assault in inpatient units
- More women (68%) who have a serious mental illness have experienced past sexual trauma (compared with 40% of male patients) (Goodman et al, 2001)
- Women are more likely to be dealing with issues relating to care of children

As one nurse unit manager noted - *'A lot of women consumers are victims of past trauma and many are mothers who are involved with child protection – these are complex issues which males are less likely to be dealing with'. (NUM)*

Gender sensitive practice recognises that different approaches are called for when working with women and men. Women responsive practice acknowledges the different factors which advantage or disadvantage women and develops services that are based on understanding women's needs and preferences. (WHAV, 2001). To achieve women responsive practice, workers need to be informed about the specific mental health needs of women and trained in practice that enables them to respond to the emotional and social needs that impact on their mental health.

As a women's mental health organisation, the VWMHN supports the need for women responsive practice and also seeks to promote the idea that gender sensitive service provision need not be an either / or competition between the sexes. Becoming more aware of gender sensitivity in the way that services are delivered need not mean focussing on women and ignoring men's needs.

The view supported by the VWMHN is that women's and men's experience of mental illness is different and that for services to be responsive and equitable, these differences need to be acknowledged. By becoming more responsive to women's experiences, services can also create the space and hopefully the energy for increased awareness of men's needs. For example, after initiating a women's group as part of their ward program, staff from one service were prompted to explore the possibility of collaborating with local PDRSS staff to develop a men's program. The following comments by a consumer consultant and nurse unit manager highlight this approach.

*'The attitude of some staff is that acknowledging women's needs means men's needs are being ignored. This is exemplified in the response 'we need to look after*

*men not just women'. No one should be assaulted on an inpatient unit but we need to start by addressing the needs of the population that is most vulnerable – getting this right will also help to clarify the processes that are needed for responding to men.'* (CC)

*'Men have also benefitted from the recent focus on gender sensitivity. After our women's program was established, our social worker and occupational therapist became motivated to start a men's group...overall it's led to a softening of the environment with the aim of making it less traumatic for everyone'* (NUM)

### **Responding to allegations of sexual assault**

Each of the Listening Events conducted by the VWMHN during 2007 (Eastern, Southern, Northern, Barwon) were attended by women consumers who disclosed that they had been exposed to sexual assaults during their admissions to mixed inpatient units. Women also often reported that their disclosures had not been believed or adequately responded to by staff. Nurse unit managers and consumer consultants contacted as part of this project also acknowledged the occurrence of sexual assault on wards.

The importance of demonstrating belief for women who disclose sexual assault during an inpatient admission, coupled with a recognition that this response is not always available to women, was particularly highlighted by consumer consultants.

*'Staff sometimes raise questions – are women saying something has happened because they are unwell? Women need to be responded to with belief and awareness that the inpatient environment may have triggered past trauma.'* (CC)

*'Women should never have reports of abuse or difficulty discounted, on the basis that they have an illness and so their testimony is unreliable. If all consumer reports – women and men – are taken seriously, this seems to me the basic foundation of a respectful service.'* (CC)

*'Women used not to be believed but practice is changing...previously if a woman alleged sexual assault the response would be - she's unwell or she provoked it or he's unwell too - but being unwell doesn't outweigh the safety needs of other patients...one day we will be rightly and successfully sued by the family of a female patient who has been assaulted.'* (CC)

Consumer consultants also identified the need for clear organisational protocols to guide staff responses in these situations. *'Management has a role in the introduction of tighter structures so that staff are more accountable and expectations regarding standards of staff behaviour are clearer, for example, if a consumer makes an allegation, police are notified.'* (CC)

## **Trauma Informed Care**

Consumer consultants also made suggestions to increase responsiveness to consumers with previous experience of abuse.

*'It would be good if there was more infrastructure to support women who have been through trauma, for example, women only wings and lockable doors. The current mixed sex wards risk making things more difficult for women who have experienced trauma – for these women it would be better if they were able to speak with a female consumer consultant.'* (CC)

*'Patients should be given the option of talking about past abuse with staff who feel confident with this kind of work....some staff have concerns about opening up these issues but unless someone is floridly psychotic, it is possible to support them to make a start...mental health services need better links with centres against sexual assault.. there could be potential for sexual assault counsellors to visit people on the ward.'* (CC)

As previously noted, the majority of female patients who experience serious mental illness, as well as a significant minority of males, are likely to have experienced sexual abuse in the past. When people's abuse history is acknowledged, symptoms which have been previously linked with mental illness may be understood as trauma symptoms.

Such responses include fearfulness / lack of trust, suspiciousness, paranoia, confusion about relationship boundaries, hypervigilance, inability to sleep, avoidant and obsessive behaviours, easily triggered defensiveness and anger, dissociation and flashbacks including visual, auditory and sensory or tactile.

Trauma informed care recognises that trauma related symptoms develop as attempts to cope with intolerable circumstances and that such symptoms develop in the context of abuse.

Knowing the history of past and current abuse in the lives of mental health service clients promotes greater potential for more responsive treatment. Awareness and avoidance of potentially re-traumatising practices is central to this approach. (Harris and Fallot, 2001).

For example :

- Being stripped of clothing in front of male attendants and forcibly injected with medication
- Being restrained and secluded in a locked room
- Having responses to situations minimised, discredited or ignored
- Having intense feelings, for example anger or rage, suppressed and labelled pathological
- Having reports of abuse disbelieved by staff

The Gender Sensitivity and Safety report (DHS, 2008b, p16) suggests that 'changing clinical practice to minimise the re-traumatisation of patients with histories of trauma when they are admitted to psychiatric units appears to be an emerging issue.' While inpatient units may not be considered appropriate environments to undertake trauma therapy, admissions can provide opportunities for some initial work.

Providing information which helps consumers to understand the links between their current symptoms and traumatic events helps them to understand their behaviour and to believe that it is capable of being brought under control. For example, one area service has collaborated with the local centre against sexual assault in the development of a pamphlet for patients which provides information about common effects of sexual abuse, how these may be related to mental health symptoms and how counselling and support can help to address these. Allied health staff from this unit also have regular liaison meetings with local CASA staff to facilitate referrals, secondary consultations and increased communication and collaboration.

**Resource**

Information pamphlet for patients 'Help for people dealing with mental health and sexual abuse issues' – Northern Area Mental Health Service, Northern Hospital

## **Responding to women with specific needs**

Part of gender sensitivity involves recognition of the particular treatment needs of women with specific issues, for example, young women, women with physical disabilities or cognitive impairments, women who are mothers, same sex attracted consumers, women residents of secure extended care units and women at risk of self harm / suicide. While it is beyond the scope of this project to fully explore specific responses to all of these groups of women, some key issues and practice suggestions are identified for a number of these groups.

### **Women who are mothers**

Women with children who are admitted to inpatient units require a range of gender sensitive responses. Women who are admitted post-natally need to be supported to have as much safe contact as possible with their baby, as well as being offered opportunities to make contact with the person who is caring for their child. Wards also need to be able to make available a private and comfortable space if a mother is continuing to breast feed her baby.

Where a woman's children are older, staff need to have contact with her family so they are aware of who is looking after her children, can facilitate support / counselling for them if required and ensure appropriate liaison with family members regarding discharge.

### **Women consumers at risk of self harm / suicide**

One service identified the need for a package of treatment responses that would better meet the needs of women at risk of self harm and suicide. The nurse unit manager who raised this issue noted that such women were often younger, had past experience of sexual trauma and were frequently labelled as having borderline personality disorder. They were often briefly admitted to inpatient units but were also presenting in increasing numbers within case management caseloads. This group of women were described as not requiring significant acute psychiatric care but as having high social support needs.

A need for a more targeted treatment response was identified that would identify a clinical pathway for these clients linking them to other appropriate services, for example centres against sexual assault / psychiatric disability rehabilitation support services and family and community support agencies. Such a package would be consistent with the need for treatment responses identified in the Because Mental Health Matters Green Paper (DHS, 2008a) which focus more on early intervention and prevention especially for young people and which promote alternatives to inpatient treatment as well as targeting consumers with 'complex needs' who are dealing with multiple issues.

## Women residents of secure extended care units

Although secure extended care units were not a primary focus of this project, it was suggested that contact with a nurse unit manager from at least one SECU could provide an indication of potential gender sensitive implications for these treatment environments. Victoria currently has three secure extended care units located in the West, Northern Eastern and Southern regions. Female residents are in an extreme minority with less than ten women currently estimated to be accommodated in SECU's across the state.

A nurse unit manager was consulted from one of these facilities which currently accommodates two female and twenty four male patients. This NUM identified that there are major gender issues and implications for secure extended care units particularly associated with the reality that currently a handful of women must share a ward with approximately 25 males. She suggested that the principle of needing to be aware of gender sensitivity should apply to all residential services and therefore that secure extended care units should be included in any broader mental health sector discussions with this focus. She also identified a lack of safety for women residents -

*'Secure extended care units are for people with treatment resistant psychosis...we accommodate some dangerous males...there have been a couple of incidents involving males being sexually inappropriate to a female resident...we currently don't provide anything extra to make the women feel safe, for example, no designated separate area.'* (SECU NUM)

A number of issues and suggestions for improving gender sensitivity in secure extended care units were identified via this consultation including the need for :

- Support and direction from MHDD around how to tackle gender issues in secure extended care units.
- Area service based focus groups for mental health residential services to discuss potential gender-sensitive issues / initiatives / improvements.
- Funding, as occurred with the environmental upgrade grants to acute adult inpatient units, to enable secure extended care units to make environmentally based gender sensitive improvements.

## Alternatives to Admission

The issue of providing alternatives to inpatient admissions was also raised by one consumer consultant who identified this as particularly important for women with children.

*'If women could be admitted to a facility more able to provide consistency and more conducive to children visiting... What is the impact of the inpatient environment on women who are depressed? Being located with hostile men in a noisy environment where they perceive there is not enough staff and people are acting crazy...no way should they be there.'* (CC)

One such alternative is the women's crisis house model developed in the UK in response to the Department of Health directive in 2002 that all areas needed to provide women specific mental health treatment facilities. While some areas have developed self contained women only inpatient units, others have established smaller community based facilities which are located in ordinary residential streets.

Croyden Women's Crisis House in London provides 24 hour crisis care for women with enduring mental health problems and offers an alternative to local acute wards which are all mixed. The unit is nurse led but has access to a female consultant psychiatrist who reviews clients weekly and liaises with their local psychiatrists. Patients meet with their primary nurse three times per week and attend daily therapeutic groups.

A three year study (Meiser-Stedman et al, 2006) found that 78% of admissions to this unit were completed within the thirty day target admission period and that women patients experiencing improved functioning on discharge. A further study (Howard, 2008) of four London based units of this type found that women's crisis houses are providing a real alternative to traditional mixed psychiatric wards for women with severe mental illnesses who do not require intensive observation.

In its recent submission to the Because Mental Health Matters consultation, the VWMHN advocated for the establishment of a women specific community based treatment facility and would be keen to work with the MHDD and area services in further developing a pilot project of this kind. It is also important to note that the establishment of a women's only Prevention and Recovery Centre (PARC) has also been identified as a future mental health service initiative.

## **Sustainability of gender sensitive initiatives**

Very few of the mental health staff contacted as part of this project were aware of the DHS women's mental health policy 'Tailoring Services to meet the needs of Women' (DHS, 1997) or the state wide initiative in 1988 which enabled the employment of women's mental health consultants in each region for a period of one year.

With one exception, staff were unable to identify any practice or policy initiatives that have been sustained from this time suggesting that there has been a significant loss of gender-sensitive knowledge and work undertaken during this earlier period. One service had located past reports which also identified a lack of safety for women and recommended the provision of gender specific wards.

Only three areas – Eastern, Northern and Bendigo have continued to employ women's mental health consultants in a part-time capacity. A further six services identified designated women's portfolio staff positions although only two of these positions were allocated any dedicated hours to undertake and progress gender related initiatives.

Eleven of the area mental health services contacted had no designated women or gender focussed position.

The general lack of awareness about the women's mental health policy, the attrition of women's mental health consultants and the variability in establishment of women's portfolio positions are all causes for concern about the potential for the current positive gender-sensitive initiatives documented in this report to be sustained and extended. The implications for the Mental Health and Drugs Division and area services seem clear if the progress that mental health services have made in increasing gender-sensitivity is once again not to be gradually eroded.

*As one consumer consultant identified 'Practice within mental health services has been cruising since 1997 when the Tailoring Services to meet the needs of women policy came out...women's safety and gender sensitive practice has been deemed to be not important enough... services need to be directed to provide safe inpatient environments for women.'* (CC)

This issue will begin to be addressed in 2009 as DHS commences a three stage implementation of the recommendations of its recent Gender Sensitivity and Safety project (DHS, 2008b) encompassing the development of Chief Psychiatrist Guidelines to promote sexual safety and manage allegations of sexual assault in acute inpatient units (Stage 1), development of service guidelines (Stage 2) and facilitation of gender sensitive design in acute inpatient units (Stage 3).

**Need for Women's Mental Health Consultants**

In addition, it is suggested, DHS should make funding available for women's mental health consultant positions to guide and support area mental health services in initiating gender-sensitive policy and practices. Such a provision would be consistent with processes adopted in the United Kingdom since 2002 where a 'women's lead' position is employed in each service to promote the effective implementation of gender-sensitive service responses. (Department of Health, 2002). As has occurred in the three regions where women's mental health consultants continue to be employed, there would be considerable potential for such positions to be linked with or collaborate with the Families with Parents with a Mental Illness (FAPMI) coordinators.

**Establishment of Women's Portfolio Positions**

At a minimum, a women's portfolio position needs to be identified within each area service with a designated allocation of hours. Experience from the field identified through this project would suggest that this portfolio is most productively shared by at least two staff who are able to support each other in this work. The effectiveness of such portfolio positions would be further strengthened by access to a centrally funded state wide Women's Mental Health Coordinator.

### **Last words from mental health staff....**

The Gathering Information Project has provided the opportunity to hear from staff working in Victorian area mental health services about how they are responding to recent challenges to increase gender sensitivity and safety in acute adult inpatient units. The process has enabled the documentation of the diverse initiatives that are being developed and the instructive experiences of staff involved in their implementation. The learnings that have resulted are rich indeed.

Some final words of wisdom from mental health staff...

*'When I'm visiting the ward and I witness an awful and dramatic incident, I am reminded that nurses are keeping the lid on so many things – I understand that gender sensitivity can feel like just one more thing but we need to find a way for it to be recognised... I feel like we've only just begun...the gender upgrade grant began things but it's a work in progress.'* (Women's MH Consultant)

*'It needs to be recognised how important the issue of gender sensitivity is and how undervalued it's been...in the last six months there's been phenomenal change on our ward with increased vigilance and reporting of the female experience...DHS needs to prioritise this issue and provide firm directions.'* (NUM)

*'Gender sensitive practice needs to be incorporated in nurse training...the medical model has high jacked mental health and taken away much of traditional psychiatric nurse activity including the act of being kind to people.'* (NUM)

*'We need to be aiming to provide a standard of service that we would want for our mothers, sisters and daughters.'* (CC)

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## **Appendix**

### **Gathering Information Project : Questions for Nurse Unit Managers**

1. Are you aware of the 2007 Mental Health Branch Project 'Increasing Gender Sensitivity and Safety in adult acute inpatient units'?
2. In mid 2007 as part of this project, each service was allocated an environmental upgrade grant to improve the ward environment for women. Can you tell me about the process adopted within your ward, for utilising this grant?
3. Can you describe the gender-sensitive improvements that have resulted / are planned in your ward from this grant? If planned, what is the anticipated completion date?
4. What has been the impact of these improvements on women consumers admitted to the ward? How have you been able to assess these impacts?
5. Are you aware of any safety and privacy concerns that some of the women consumers who are admitted to your ward may have?
6. What do you see as the three priority actions for improving the delivery of gender sensitive and safe treatment and care in inpatient units?
7. Are there plans to undertake further action to increase gender-sensitivity on your ward in future? Please elaborate.
8. Is there a staff member who holds the women's / gender portfolio on the ward / in your service?
9. Are you aware of any processes still in place as a result of work undertaken by past regional women's mental health consultants employed during 1998?
10. What in your experience promotes / prevents gender-sensitive responsiveness on a day-to-day basis in an inpatient unit environment?

## **Gathering Information Project : Questions for Consumer Consultants**

1. Are you aware of the Mental Health Branch Project 'Increasing Gender Sensitivity and Safety in adult acute inpatient units'?
2. In mid 2007, as part of this project, each service was allocated an environmental upgrade grant to improve the ward environment for women. Within your ward, what process was adopted in utilising the environmental upgrade grant?
3. As a Consumer Consultant, were you involved in this process?
4. Were other consumers, for example, Community Advisory Group members involved in this process?
5. What gender-sensitive improvements have resulted in your ward from this grant?
6. What has been the impact of these improvements on women consumers admitted to the ward? How are these being monitored?
7. Are you aware of any safety and privacy concerns that some of the women consumers who are admitted to your ward may have?
8. Are there plans to undertake further action to increase gender-sensitivity in your ward in future?
9. What do you see as the three priority actions that could improve the delivery of gender sensitive and safe treatment and care in inpatient units?
10. Is there a staff member who holds the women's / gender portfolio on the ward / in your service?
11. Are you aware of any processes still in place as a result of work undertaken by past women's mental health consultants employed during 1998?
12. What in your experience promotes / prevents gender-sensitive responsiveness on a day-to-day basis in an inpatient unit environment?