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*Women and Secure Psychiatric Services:
A Literature Review*

CRD REPORT 14

**WOMEN AND SECURE PSYCHIATRIC SERVICES:
A LITERATURE REVIEW**

RACHEL LART

SARAH PAYNE

BILL BEAUMONT

GERALDINE MACDONALD

TARA MISTRY

**SCHOOL FOR POLICY STUDIES
BRISTOL UNIVERSITY**

April 1999

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ISBN 1 900640 12 0

This report can be ordered from: Publications Office, NHS Centre for Reviews and Dissemination, University of York, York YO10 5DD. Telephone 01904 433648; Facsimile: 01904 433661; email: crdpub@york.ac.uk

Price £12.50

The NHS Centre for Reviews and Dissemination is funded by the NHS Executive and the Health Departments of Scotland, Wales and Northern Ireland; a contribution to the Centre is also made by the University of York. The views expressed in this publication are those of the authors and not necessarily those of the NHS Executive or the Health Departments of Scotland, Wales or Northern Ireland.

Typesetting and printing by York Publishing Services Ltd.

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AUTHORS AND ACKNOWLEDGEMENTS

Rachel Lart was previously a Research Fellow and is currently a Lecturer in the School for Policy Studies, University of Bristol. She has researched and published in the fields of drug misuse policy and services and the mental health of offenders.

Sarah Payne is a Lecturer in Social Policy in the School for Policy Studies, University of Bristol. Her research interests are health and poverty, and she has published on gender issues in the use of psychiatric services and on the links between poverty and mental health.

Bill Beaumont is currently a Lecturer in Social Work in the School for Policy Studies, University of Bristol. He previously worked as a probation officer and as General Secretary of the National Association of Probation Officers. He has written extensively on probation work and recent research includes work on managerialism in the probation service, risk in work with offenders, clients' views of probation supervision and young black people in a local criminal justice system.

Geraldine MacDonald is Professor of Social Work in the School for Policy Studies, University of Bristol. She is particularly interested in questions of effectiveness and evidence-based practice in social work interventions, and has published on these areas. She is Archie Cochrane Research Fellow at Green College, Oxford.

Tara Mistry was a Lecturer in Social Work in the School for Policy Studies, University of Bristol. Her publications include work on group work with black women offenders, and on feminist models of group work. She is currently a Non Executive Director at Avon Health Authority as well as a freelance trainer and group work consultant.

The research team would like to thank the following for their help and support in the preparation of this report:

Commissioning body: NHS Executive High Security Psychiatric Services Commissioning Board
Professor Pat Carlen, University of Bath
Adrian Grounds, Lecturer in Forensic Psychiatry, University of Cambridge
Professor John Gunn, Maudsley Institute of Psychiatry
Professor Barbara Hudson, University of Oxford
Dr. Dilys Jones, HSPSCB
Liz Mayne, WISH
Professor Hershel Prins
Professor Trevor Sheldon, University of York

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EXECUTIVE SUMMARY

This review was commissioned by the NHS Executive High Security Psychiatric Services Commissioning Board through the NHS Centre for Reviews and Dissemination, York University. Both the HSPSCB and the CRD offered valuable support to this project, and in addition the research team would like to thank the panel of referees who provided useful comments at various stages of the project.

The objectives of the review are:

- to describe systematically models for the delivery of secure psychiatric services to women, in the UK and abroad
- to identify problems associated with existing models
- to identify alternative service models proposed
- to examine the evidence for effectiveness and efficiency of different service delivery models
- to identify gaps in existing knowledge about the effects of different service models
- to recommend key areas for future research

Methods

This report is based on the findings from a systematic review of literature relating to women in secure psychiatric services. The method adopted involved devising and agreeing a protocol which identified the criteria by which the literature which was found would be included in the final report. Having agreed these criteria, a search was conducted using electronic databases and key words and also key informants. Literature identified by this search was then tested against the agreed criteria, and material which met the criteria was read by two reviewers, each of whom completed a data extraction form. These forms constitute the research findings and the basis of this report.

Key Findings

Context:

- although female patients make up less than one fifth of the population in secure settings in Britain they are a heterogenous group with a wide range of ages, personal, psychiatric and forensic histories
- as a group, women patients are different from male patients in significant ways: women patients are less likely to have committed serious criminal offences in comparison with men, but are more likely to have experienced previous psychiatric admission
- women in secure psychiatric services have a different pattern of diagnosis to men; in particular they are more likely to be diagnosed as having a personality disorder, and diagnosed as having a borderline personality disorder, than are their male counterparts. This is especially true in the medium secure services

Review of descriptive studies

- Most papers on services describe services where women are in a minority and follow the same treatment programmes as men. We have divided these into two types: Type A, in which women appear to be an afterthought, and Type B, which appear to be gender blind
 - Type A: women as afterthought:* wards are segregated, there are several male wards, differentiated by legal category of patient, diagnosis of patient, or by function, but only one ward for women
 - Type B: gender blind provision:* In other services, wards are mixed and most papers contain no particular discussion of this
- What is striking about the papers describing service models is that none of the models have been evaluated in terms of the impact they have on women. Very few papers even discussed the implications of the service model for women or suggest that there may be a need to make specific provision. Routes into and out of forms of secure care for women: at every stage of the process, women are more likely to receive a psychiatric disposal than men, although total numbers for both are a small proportion of all offenders, and women are always outnumbered by men
- The criminal justice system is not the only route into secure care. A higher proportion of women than men in high security care in England and Wales have arrived there from within the NHS psychiatric services as a result of being regarded as difficult to manage within lower levels of security
- The papers found are largely uncritically supportive of mixed therapy groups and therapeutic regimes, although some writers argue that mixed treatment presents problems for women who have experience of abuse
- Staffing: there is a need for high ratio of female: male staff to provide appropriate care for female patients
- Few papers address the question of treatment regimes specific to women. Those that do highlight women's history of physical and sexual abuse and the implications of this for therapeutic regimes, and also issues relating to women as parents
- No papers discuss discrimination and oppression

Review of population studies

Many papers did not give data separately for women

Demographic data shows a disproportionate number of women from minority ethnic groups, but less than the female prison population and less than male population of secure psychiatric services

Psychiatric disorders:

- Substance abuse/dependence is the largest category of disorder, often co-existing with other disorders
- High proportion of women in conditions of security with personality disorder, in particular borderline personality disorder
- High proportion of women have history of self-harm
- Amongst women transferred to prison health care facilities due to concern over their mental health, similarly high proportions of women with substance abuse/dependence, personality disorder

- High proportion of female population had history of sexual and physical abuse
- Major implications for service delivery include unmet need for responses to personality disorder, substance dependence and trauma therapy relating to history of abuse

Review of studies on effectiveness of psychiatric care

Only one study was identified. This study found a poorer outcome amongst women admitted from psychiatric hospital compared with women admitted from courts.

Conclusions

Issues for policymakers

- need to consider appropriate size of unit vs. geographical distance from home community, and segregation vs. integration of sexes
- the development of a focus on needs as well as on diagnoses/MHA categories, and reconsider conceptualisation of 'security'; a shift towards relational security would enable more individualised levels of security to develop in response to women's needs
- the need to ensure that NHS purchasing structures do not create perverse incentives toward particular forms of care or prevent resettlement in a woman's area of choice, if this is not her home community
- how to ensure community based provision to prevent readmission
- the response to the recommendation from the national surveys of prisoners that a therapeutic community facility for women be developed within the prison system (Gunn et al 1991; Maden et al 1995)
- the need to facilitate the involvement of women patients as stakeholders in the planning of their care and treatment. This is important not only in relation to empowerment, but also for therapeutic reasons

Research issues

The key gaps appear to be:

- any knowledge about the effects of different service models
- wider aspects of women's lives and the impact of gender and social inequalities: their experience of discrimination, sexual and physical abuse, poverty, social isolation, families, children, sexuality. In particular how they see themselves and their actions and needs
- ways of measuring need, to complement use of diagnostic groups as a way of describing women and planning service responses
- research into the experiences and needs of women diagnosed as having personality disorders
- research into the experience of the very small number of women from minority ethnic groups within the secure services
- In-depth and comparative research into offending/social profiles of female/male patients and response to female/male patients by the criminal justice and psychiatric systems
- need for a wider range of methodologies, and in particular more qualitative work, alongside the more traditional kinds of psychiatric research
- all studies of mixed populations should give figures broken down by sex

Practice issues

The issues for practitioners follow from the policy and research issues raised above:

- multi disciplinary training needs to include training in gender awareness, which would highlight issues relating to power. This would include training in the practice and value of a range of research methodologies
- the development of concepts of security based on staff as well as physical features, which links in with training issues, as above
- the development of individualised needs assessment
- the need for good links into community services and smooth discharge planning, using the Care Programme Approach
- the need to recognise the very high proportion of women patients who have suffered childhood sexual abuse and abuse in adult relationships and to develop treatment strategies in which this is recognised and addressed

INTRODUCTION

This review was commissioned by the NHS Executive High Security Psychiatric Services Commissioning Board through the NHS Centre for Reviews and Dissemination, York University. Both the HSPSCB and the CRD offered valuable support to this project, and in addition the research team would like to thank the panel of referees who provided useful comments at various stages of the project.

The objectives of this literature review are to identify and describe models for the delivery of secure psychiatric services to women, in the UK and abroad, to identify problems associated with existing models and alternative models, and to identify gaps in knowledge in order to recommend key areas for future research.

We have addressed issues in the provision of secure care which are either specific to women, or else have a particular significance for women. In general we have avoided issues which are of general relevance, assuming that these will be dealt with in the other reviews commissioned by the HSPSCB.

Context

Services to provide psychiatric intervention within conditions of security exist in most developed countries. The need for such services arises out of the perceived link between mental illness or mental disorder and behaviour which is harmful or dangerous to others or self to the extent that an individual must have their liberty restricted. Such services may be closely linked to the criminal justice system of a given society, and will have a basis in statute defining the powers of society's representatives to limit freedom, and the individual's rights against those powers. In England and Wales that statutory basis is the Mental Health Act (MHA) 1983.

Secure psychiatric services in England and Wales are arranged in broadly three tiers; the three 'special' or high security hospitals, the medium or regional secure units, and low secure units which may be wards within general hospitals with higher levels of security than the open wards. Medium secure provision has been expanded rapidly over the last few years, from 600 places in 1991 to 1029 by the end of 1996, with a target of 1250 purpose-built places by the end of 1998. Such developments are a priority for the NHS, and the overall target is for 2400 secure psychiatric places by the end of 1998, including places purchased from the independent sector.

The term 'mentally disordered offenders' has become common in the UK to describe people with mental illness or disorder who become involved in the criminal justice system, many of whom will spend some time in secure psychiatric conditions. However, not all patients in secure psychiatric services are 'offenders' who have arrived there from the criminal justice system. Civil patients may also be moved into the secure services if assessed as dangerous or as needing to be contained for their own safety.

Similarly many offenders with mental health problems will not be diverted or transferred from the criminal justice system into the psychiatric system, either because they are not ill enough to warrant such diversion under the Mental Health Act or because there is no place for them. Psychiatric care is, therefore, provided within the prison system, by both the Prison Healthcare Service and by NHS providers on an outpatient basis.

For these reasons, and because other models of provision may make a distinction between people who have been convicted of offences and those who have not, this review will encompass the provision of psychiatric services in conditions of security, whether to 'offender-patients' or civil patients.

Women in secure settings

An issue of major concern in the planning and provision of secure psychiatric services is that of how to meet the specific needs of women effectively. Women form a minority among those receiving psychiatric care in medium and high security settings, and there is concern that they are being cared for inappropriately in services designed primarily to meet the needs of men. In the special hospitals, provision is segregated, but in the medium secure sector, provision is currently generally mixed.

Thus although female patients make up less than one fifth of the population in secure settings in Britain (Hemingway, 1996), as a group they are a 'heterogenous collection of women with a wide range of ages, personal, psychiatric and forensic histories, who nevertheless share some characteristics and experiences' (Dolan & Bland, 1996, p26). However, women patients are also different from male patients in significant ways: women patients are less likely to have committed serious criminal offences in comparison with men, but are more likely to have experienced previous psychiatric admission (Bartlett, 1993).

Women in secure psychiatric services have a different pattern of diagnosis to men; in particular they are more likely to be diagnosed as having a personality disorder, and diagnosed as having a borderline personality disorder, than are their male counterparts. This is especially true in the medium secure services, where 29% of women and only 9% of men were diagnosed as having a personality disorder in 1994 (SHSA, 1995), and patients are predominantly male and diagnosed with a psychotic disorder. They are also much less likely to have entered the secure psychiatric system from the criminal justice system: 44% of women and 16% of men in the special hospitals are under civil sections of the Mental Health Act, rather than those sections which relate to criminal justice (Maden et al, 1993).

Movement within the secure psychiatric system is difficult generally because of the level of demand placed on the existing resources of the medium secure services by remand prisons (Murray, 1996). Since the Reed Report in 1992 (DH/HO 1992), much effort has gone into identifying people with mental health needs within the criminal justice system and diverting or transferring them into the hospital system. However, even with the expansion of medium secure

provision described above, this has resulted in difficulties for the movement of people down the levels of security. Even when people have been assessed as suitable for lower level of security they may wait for long periods, even years, before a place becomes available to them.

Two changes in the broader context of mental health care are of relevance to a discussion of secure services. The first of these is the general shift away from large scale provision of long-term inpatient care towards the maintenance of people with mental illness in the community, with inpatient care focused on assessment and treatment of particular episodes of ill health. This increases the importance of effective integration between the secure system and mainstream mental health services, including community based provision. It also raises the question of whether and how the philosophy of community care could be applied to secure services.

The second is the development of the mental health users' movement, and the significance now given in policy to issues of advocacy and empowerment. While services must be evaluated in clinical terms, there is also a framework of civil and human rights which can be drawn on. For women this is particularly important — women patients' human rights are violated in a number of ways: the level of security at which women are held, inappropriate treatment, delays in transfers and discharge, as well as issues relating to privacy, dignity, security and protection from harassment and sexual or physical assault.

The Special Hospitals Services Authority Strategy for women requiring secure psychiatric services proposes a specialist service for women, and outlines key principles and service requirements of such a service (SHSA,1995). There is a need to bring together from across a range of disciplines the literature which can inform planning and implementation of such a strategy, and this review aims to do this.

There are two broad approaches or perspectives on issues regarding women and secure psychiatric services. The first is a primarily medical (forensic psychiatric) approach, focusing on individual pathology and diagnosis. This approach acknowledges that there are specific issues relating to providing services to women, but tends, in practice, to describe apparent gender differences in diagnosis without being able to account for them or suggest changes in service delivery. The other approach is a much wider one, locating the issue in the broader context of gender relations in society and specifically in women's relationship to psychiatry. This approach is taken by academic sociologists (Carlen, 1985;Sim, 1990), some forensic psychiatrists (Mezey and Bartlett, 1996) and by campaigning groups in the field (WISH, MIND). Mezey and Bartlett (1996) provide a review of current literature from this perspective.

This review can perhaps be criticised for exploring more thoroughly the first of the two perspectives described above. The review was commissioned within the York CRD model of systematic review to search the literature to provide a clear basis for moving forward. In practice in the time available for the review, its focus has been on the published literature, which is dominated by the medical model. Some papers identified through calls for information, rather than through

the electronic bibliographic databases, have not been obtained in time for inclusion in this paper, and are listed separately in the references section.

Objectives

The objectives of the review are

- to describe systematically models for the delivery of secure psychiatric services to women, in the UK and abroad
- to identify problems associated with existing models
- to identify alternative service models proposed
- to examine the evidence for effectiveness and efficiency of different service delivery models
- to identify gaps in existing knowledge about the effects of different service models
- to recommend key areas for future research

METHOD

Research Protocol

The first stage of the research was the agreement of a research protocol. The protocol (see Appendix C) identified the objectives of the literature review, the questions to be examined, the criteria by which the literature found in the search would be included, an outline of the forms which would be used to enter findings from the research and also details of the search strategies which would be used. Identification of the inclusion criteria was based on an assessment of relevant time scales where electronic data bases were used, and also by reference to the central objectives of the research itself. Papers based on studies of mixed sex samples but where no data broken down by sex were given were not included. Similarly, papers which were commentaries rather than evidence based were excluded (see below for summary of criteria).

This protocol was peer reviewed and revised after comments from the reviewers. This agreed protocol formed the basis of subsequent action.

Organisation of research material

The review itself was organised into two parts. The objectives of the first part were:

- the systematic description of service models in the UK and abroad, and of the populations deemed to require secure care
- the identification of problems associated with existing models
- the identification of alternative service models

The objectives of the second part were:

- the examination of the evidence for effectiveness and efficiency of different service models
- the identification of gaps in existing knowledge on the effects of different service models
- the recommendation of key areas for future research

The literature was searched for accounts of how secure psychiatric services for women are provided or proposed to be provided in the UK and abroad.

Descriptive studies of service models were looked for which provided a range of information about the ways such provision can differ, what problems are associated with different models, and how these are addressed in different ways. As well as aspects of the internal organisation of services, information was sought on the routes into secure care, the links services maintain with other agencies, and the way they enable (or not) women to maintain links with family, friends and community.

Descriptive studies of populations of women deemed to require secure psychiatric care were searched for. Of interest is how women are defined as needing secure care and what patterns of mental ill health and other difficulties they experience. Information on ethnic background and sexuality were also looked for.

Studies of the effects of services were searched for. It was anticipated that there would be few randomised controlled trials, and that the majority of outcome studies would be observational studies.

Research Questions

We defined three sets of research questions addressing:

- a. different service models for providing psychiatric care in conditions of security
- b. information about populations of women deemed to need psychiatric care in conditions of security
- c. evidence for effectiveness of different service models.

Service models

a. What are the routes into and out of forms of secure care for women?
b. How are women allocated to different levels of security, and to what extent, if any, are services tailored to individual need?
c. What are the dimensions along which service models can differ? e.g.: What information is there about institutional versus domestic settings? What information is there about single gender versus integrated services? What diagnostic groups are managed in what settings?
d. What information is there about staff to patient ratios and different treatment regimes?
e. How, if at all, do services maintain links with the criminal justice system and with other health and social services?
f. How are women's relationships with their children and families facilitated?
g. Are there specific issues of discrimination and oppression, in terms of ethnicity and sexuality for example, and if so, how are these addressed?
h. Describe the training, education and support of staff in services.
i. What problems or advantages are attributed to different service models?

Populations

a. How are women defined into populations requiring secure care, i.e. how assessed?
b. What do we know about the patterns of mental disorder and mental ill health among women needing secure psychiatric services? Are these patterns the same in the UK as elsewhere? What other difficulties do women with mental disorders that warrant treatment in a secure setting experience in their lives (abuse, drug misuse, deprivation etc.)?
c. What are the critical characteristics of groups of women, relevant to service delivery? e.g. What do we know about the ethnic background of women in secure psychiatric settings, or their sexuality?
d. Are there women who have been assessed as not needing the level of security they are currently experiencing? How are they so assessed?

Effects

a. What evidence is there about the relative effects of different interventions/regimes on a variety of aspects of life for this group of women?
b. What evidence is there about the relative effects of different types of staff?
c. Where are the gaps in our knowledge about effects? Aspects of life of interest would relate to: self harm harm to others mental health social functioning offending behaviour

The following databases were searched (for search strategies see Appendix D):

Medline
Embase
Psychlit
Sociofile
Cochrane Library
SIGLE
Mental Health Abstracts

Calls for information were sent to government departments, professional organisations, relevant agencies and key researchers and authors.

Inclusion criteria

Papers meeting the following criteria were included in the review:

Descriptive studies, service models

Studies of services for people who have been assessed as needing psychiatric care in conditions of security. Services may be whole systems or specific parts of a system, but must provide for women.

Descriptive studies, populations

Studies of populations held in conditions of security. The studies examine mental health and a range of other characteristics. The populations studied must be either women only or include women. Where the population is mixed, a useful amount of data must be given about women separately.

Effects studies

We anticipated that there would be few outcome studies in this area. An initial mapping exercise would include all studies which provide information on short, medium or long-term outcomes of interventions/regimes in services for women assessed as needing psychiatric care in conditions of

security. A further set of stricter criteria would then be applied to identify papers which provided data on effectiveness. However, no papers met this second set of criteria.

Judgements about inclusion were made by two independent reviewers. Disagreements were to be resolved by discussion between assessors, and reference where necessary to a third member of the team - however, this did not prove necessary. Issues regarding the quality of research design were dealt with at the level of data extraction and analysis.

Summary tables of inclusion/exclusion criteria

Papers meeting all of the criteria below for their study type were included:

Descriptive studies, population

Criteria	Include	Exclude
1. Study published during or after 1972	yes	no
2. Study of people in conditions of security	yes	no
3. Study includes data on mental health	yes	no
4. Study includes useful data specific to women (i.e. more than simply proportion of sample who are women)	yes	no

Descriptive studies, service models

Criteria	Include	Exclude
1. Study published during or after 1972	yes	no
2. Study describes service involving conditions of security	yes	no
3. Study describes psychiatric service	yes	no
4. Study describes service which includes women (may be women only)	yes	no
5. Study discusses either a system or part of a system	yes	no

Effectiveness studies - mapping of all studies

Criteria	Include	Exclude
1. Study published during or after 1972	yes	no
2. Study is of services for women assessed as needing psychiatric services in conditions of security	yes	no
3. Outcomes study	yes	no

Effectiveness studies - stricter criteria

Criteria	Include	Exclude
1. Study published during or after 1972	yes	no
2. Study is of service or part of service for women assessed as needing psychiatric services in conditions of security	yes	no
3. Study design is one of the following: well-designed randomised controlled trials well-designed controlled trials with pseudo-randomisation well-designed controlled trials with no randomisation well-designed cohort studies (prospective) with concurrent controls well-designed cohort studies (prospective) with historical controls well-designed cohort studies (retrospective) with concurrent controls well-designed case-control (retrospective) studies	yes	no

RESULTS

Identification of papers

Each of the electronic databases searched revealed in the region of 150 to 200 papers of potential interest. Obviously, a number of these were duplicates of each other, where databases overlap. Other papers were identified as clearly not relevant after a review of the title and abstract and were not followed up. After this first stage 202 papers were seen as potentially appropriate for the literature review, and were read in full. These papers were then subjected to the inclusion criteria, listed above, and after such assessment a total of 140 papers were excluded from the next stage, leaving 62 papers which were included. The great majority of those which were excluded were papers in which the material relating to women in secure settings was limited to summary data only and detailed data was not broken down by sex.

Most of these papers were describing populations or services in England, Australia or the United States, although a small number were from Scandinavian countries. Most were in English language, and very few papers were identified in other languages.

Descriptive studies

The aim of this section was systematically to describe existing and proposed service models (Tables 1-2) for the delivery of care to women. Bartlett (1993) reviews literature on English special hospitals, Eastman (1993) reviews the whole system of forensic psychiatric services in Britain. Together these cover the non-gendered literature. Here we focus on papers that describe where women fit into a model of service delivery or which discuss issues relating to women. Papers which made no specific mention of women were excluded. In fact the literature contains very little on models of service delivery, either descriptive or evaluative, and what there is seldom explicitly discusses women. The majority of papers identified in the searches were studies of populations of women in secure conditions. Some of these papers provide insights into service delivery issues (Tables 3-7). In this section we provide an overview of the papers in each of these two categories. We then address, as far as is possible from the literature, the specific questions the descriptive part of the review was intended to address.

Existing service models

Most included papers describe services where women are in a minority and follow the same treatment programmes as men. We have divided these into two types: Type A, in which women appear to be an afterthought, and Type B, which appear to be gender blind.

Type A: women as afterthought:

In many services described, wards are segregated and there are several male wards, differentiated by legal category of patient, diagnosis of patient, or by function, but only one ward for women (Sieg et al, 1995; Dixon & Rivenbark, 1993; Wack, 1993; Clark et al 1993; Hodgins, 1993; Brooks & Mitchell, 1975). There is no discussion in all but two of these papers as to what, if it is deemed

necessary to differentiate provision for men, are the implications of not doing so for women. The exceptions are Sieg et al (1995) and Brooks & Mitchell (1975). Sieg et al (1995) comment that women in different diagnostic groups, i.e. those with axis I and those with axis II disorders, need different treatment regimes. Brooks & Mitchell identify two broad groups of women patients; those transferred from other hospitals and those sent by the courts, who have very different patterns of diagnosis and treatment needs, and comment that it may be inappropriate to treat them together.

Type B: gender blind provision:

In other services, wards are mixed (Higgins, 1981: Gudjonsson & Mackeith, 1983: Gordon, Kirchhoff et al, 1996: Kleve, 1996: Feldbrugge & Haverkamp, 1993). Responses to calls for information confirmed that this was the pattern in Norway and Finland. Again, most papers contain no particular discussion of this. An exception is Feldbrugge & Haverkamp (1993) who refer to the development of programmes specifically for women. Further details of these have been requested from the authors, but no response at time of writing. Gordon, Kirchhoff et al (1996) comment that mixed sex wards are the norm in all Israeli psychiatric services even though this causes problems for both Muslim and Jewish patients, but do not discuss this further.

In some models women receive a different service to men because there is no specialist service for them. For example in New South Wales, there is inpatient psychiatric provision within the prison system for men but not for women, who receive outpatient care within the prison and are transferred to local psychiatric hospitals when in need of inpatient care (Finlay-Jones & Nielssen, 1993). The authors of this article argue the need for a forensic psychiatric service separate to the prison medical service for both sexes, but see the existing position for women as preferable to that for men.

What is striking about the papers describing service models is that none of the models have been evaluated, certainly not in terms of the impact they have on women. Very few papers even discussed the implications of the service model for women or suggest that there may be a need to make specific provision. No purpose designed models in other countries emerged from either the searches or calls for information. The only description of an existing women only service identified was the operational policy document of an independent sector medium secure unit (Pastoral Homes Ltd nd). We are aware, however, that some NHS and independent providers are planning women only developments (Mayne, personal communication). These would provide an opportunity for evaluation, and it seems important that they be researched and their experience fed into the policy making process.

Proposed service models

Three other papers provided descriptions of proposed models. Following a similar categorisation as above, it is possible to describe two of these as 'limited integration', and the third as 'gender blind' as in type B above.

Limited integration:

In a paper discussing the need for long term medium secure care, Taylor et al (1996) address the issue of services for women. They argue for the need for units to serve a large enough catchment area that the numbers of women in any one unit would be substantial and form a 'real peer group'. They also argue that they need to be integrated with other services and suggest 'one or two centres of excellence in larger hospitals' rather than small local services which could become isolated. In terms of our typology, their model is one of separate wards or units for living accommodation, but shared treatment programmes, what they describe as 'judicious sex mixing for therapeutic, work or social activities'. Wholly segregated services, they argue, would be counter-therapeutic. While fewer larger units might mean greater geographical distance from women's communities of origin, this may actually be an advantage for many women whose experience of their families and communities of origin has been abusive and damaging. In practice, they recommend that the high security hospitals be funded to provide purpose designed long term medium secure care to, among other particular groups of people, women.

The second paper which fits this categorisation of limited integration is the most detailed description of proposed model, contained in the Special Hospitals Services Authority's strategy for women requiring secure psychiatric services (SHSA 1995). This describes a separately managed and distinct framework of services for women, with two assessment centres aligned with high security care provision and linked to a number of local treatment units providing secure care. While these might be on the same site as services provided to men, integration should only be at the choice of the individual patient and her care team. The development of a distinct women's service would enable the concentration and development of appropriate expertise.

Gender blind:

The third paper fits more within the 'gender blind' categorisation. Milne et al (1995), in a paper examining the different routes into and out of a medium secure unit for men and women, comment on the fact that the unit seems to be less therapeutic for women, and that this is likely to be because of their extreme minority position. They suggest that a solution to this would be for some medium secure units to specialise in admitting women, so that on these units there would be a more equal gender mix. There is little discussion of the extent to which such an equal mix might still pose problems for women.

Routes into and out of forms of secure care for women

Allen (1987) provides an overview of the gendered picture of the criminal justice route into secure care in England. This shows that at every stage of the process, women are more likely to receive a psychiatric disposal than men, although total numbers for both are a small proportion of all offenders, and women are always outnumbered by men.

However, the criminal justice system is not the only route into secure care. A higher proportion of women than men in high security care in England and Wales have arrived there from within the NHS psychiatric services as a result of being regarded as difficult to manage within lower levels of

security. Analysis of data from the Special Hospitals Case Register provided by Women in Secure Hospitals (WISH 1997) showed the following patterns in the 1996 population of the three high security hospitals:

Detained under:	Women	Men
Court order	51.3%	52.9%
Prison transfer	17.4%	32.9%
Civil order	26.2%	8.9%
Other	4.9%	4.5%

Home Office figures relating to restricted patients (i.e. under ss 41 or 49 of MHA 1983) show that women were 10% of all restricted patients admitted to hospital during 1996; 13% of those admitted to high security and 9.5% of those admitted to other psychiatric hospitals (Kershaw & Renshaw 1997). However, male offenders are more likely than women offenders to be restricted patients; 73% of male offenders and 49% of female offenders admitted to high security hospitals are subject to a restriction order (WISH 1997).

The offences which have led to admission are also very different for men and for women. In 1996, 38% of women in high security hospitals had index offences of violence or sexual offences, compared to 76% of men, whereas 26% of women had an index offence of arson, compared to 7% of men (WISH 1997).

At the medium secure level, a study of admissions to one NHS unit found that women constituted 12% of admissions over a 12 year period. They were 1.9 times as likely as men to be admitted from the NHS and 2.7 times as likely to be transferred on to high security provision (Milne et al 1995). Moss et al (1996), looking at admissions to an independent sector medium secure unit found that 20% of admissions in the first three years were women, and comment that this is a higher proportion than is usually found in NHS units. Murray et al (1996) show that 17% of patients in NHS medium secure care at any one time are women, but this does not describe routes into these units. The recent survey by Coid of admissions to medium secure care should provide a national picture and more detail about this, but was not available in time for the review. If women form a larger proportion of admissions to independent sector units than to NHS units, this may reflect the fact that fewer are admitted from the criminal justice system, and of those that are, fewer are subject to a restriction order. Several papers comment that the women civil patients are likely to have been admitted to secure care as a result of assaultive behaviour in other hospitals, but this is not quantified (Mezey and Bartlett, 1996; Higgins 1981; Brooks and Mitchell 1975). Milne et al (1995) hypothesize that the patterns they found could be due to an admission policy which resulted in a relatively high threshold for bringing women into secure psychiatric setting, which meant that only the most disturbed women were admitted. Milne et al (1995) also considered the part played by different staff reactions to women's violence as inpatients; and that the unit may be less therapeutic for women than for men.

Dell et al (1993a;1993b) looked at routes into services for remanded women in Holloway identified by psychiatrists working within the prison as needing some form of psychiatric intervention. Remand had been used by the courts as a way to try to ensure psychiatric help, for both psychotic and non-psychotic women. While most of the women diagnosed as psychotic were eventually admitted to hospital, delays in admission for those who were admitted bore heavy costs for the women, and for all agencies involved. The authors suggest that more use could be made of s48 of MHA 1983, to transfer remanded prisoners. Most of the women diagnosed as non-psychotic were not admitted to hospital. For those not admitted, the courts were unable to make arrangements for community based services.

The 45 women patients discharged from the high security hospitals in 1993 went to the following destinations (Howlett, 1994);

Court or prison	5
NHS Regional secure unit	10
Other NHS	15
Private sector	4
Community	11

There is some evidence that because of pressure on the medium secure sector from the remand prisons the needs of special hospital patients for transfer, or for civil patients requiring higher levels of security are not being met. In a census of all medium secure patients only 11% of first admissions and 12.5% of all patients were NHS transfers, the majority were from remand prisons (Murray et al 1996). Because women are more likely to be civil patients, this pressure may disproportionately affect their opportunities to move between levels of secure care. There is currently a debate about the need to expand the size of the medium secure sector, and in particular to develop longer stay medium secure provision; existing medium secure provision is intended to offer stays of up to 18-24 months only. Taylor et al (1996) estimate the need for around 1000 longer term medium secure beds in England and Wales, while Reed (1997) estimates that 740 long term medium security and 620 long term low security beds are needed by people currently in the medium and high security hospitals and in prison.

A further issue in terms of routes out of secure care for women is the proportion who are civil patients, and so have no index offence. This is important in terms of risk assessment; instead of an offence, the circumstances of which have been examined in court, women may have descriptions of their behaviour in their notes which are less open to scrutiny or discussion (Mezey and Bartlett,1996).

Non UK studies do not particularly add to our knowledge about routes into and out of secure care, largely because of differences between countries in the statutory and policy frameworks for dealing with people deemed to need secure care. However, the problem of difficulties in moving

people out of high security care because of a shortage of accommodation at lower levels of security is commented on in relation to the Norwegian system (Kleve,1996).

Assessment for secure care

Not all papers were clear about the process for assessment, but where information was given, assessment for admission to hospital outside the criminal justice system is carried out by psychiatrists from the health rather than the prison services (Gordon et al, 1996). Such assessment may also include other disciplines from within the health service, such as nursing or psychology (Finlay-Jones and Nielssen, 1993; Hodgins, 1993). However, such assessments must then be accepted by a court before an order for hospital admission is made. Different countries' mental health laws allow diversion from the criminal justice system into the psychiatric system under different circumstances. The main point of difference of relevance to women seems to be whether the law allows for diversion in the case of people diagnosed as having a personality disorder or not; for example the Norwegian system does (Kleve, 1996), while the Israeli one does not (Gordon et al, 1996).

Assessment may be carried out within prison, (Kleve, 1996), or people may be transferred to secure psychiatric services for assessment. As described above, most service models do not have separate facilities for women admitted for assessment and women admitted for treatment.

Allocation to different levels of security

There was no information on the actual process of assessment for levels of security - most papers simply named the level of security the service model was said to provide. In most cases, this depended on physical features such as perimeter walls and fences, camera systems and alarms. In some cases, such physical security was provided by a separate uniformed staff, while ward level security was said to be provided by adequate staff:patient ratios, training, clear policies and procedures and the philosophy of the service (Wack, 1993). Issues relating to levels of security are discussed in more detail later in the review.

Individualisation of services

Where descriptions of services included this, they stated that they worked with individualised care plans (Hodgins,1993; Dixon & Rivenbark,1993; Higgins, 1981), and some form of key worker system (Kleve, 1996). However, it is difficult to assess from the papers how real this individualisation was.

Single gender versus integrated services

The debate on segregated services is largely based on opinion. The only comment made in the papers describing existing service models are about the benefits of mixed therapy groups 'in making women's patterns of relating to men more visible and therefore amenable to treatment' (Seig et al, 1995) and about the need for men and women to participate in the same programmes, with the intention of avoiding the problems to which 'restriction of social intercourse' may lead (Feldbrugge & Haverkamp, 1993), although the latter authors qualify this by saying that women's

minority position is a problem. In the proposed models, Taylor et al (1996) express similar views to Seig et al (1995), while Milne et al (1995) comment that men in single sex services would be at a disadvantage.

However, as in mainstream mental health services, the dangers posed for women in mixed-sex wards have been highlighted by some writers — particularly in the context of the history of sexual abuse amongst women in secure settings. The mixed ward at Ashworth Hospital (now closed) was severely criticised by some writers such as Liebling et al (1997). The particular criticism made is that it is especially inappropriate to expect women who have experienced extreme levels of abuse from men in their lives to mix with men who often have a history as abusers; 'lack of recognition of the effects of mixing this group of women with male patients, often sex offenders is appalling' (Liebling et al 1997, p435)

Staff to patient ratios

Information on staff to patient ratios is patchy, and not easily comparable as different authors refer to different staff groups. The highest staff to patient ratios described were in the Norwegian system, where maximum security units have nurse to patient ratios of between 4.7:1 and 5.7:1, and minimum security units of between 2.3:1 and 5.5:1 (Kleve 1996). Other ratios described were: a 1:1 ratio of 'Forensic Security Aides' (FSAs), who carry out most of the day to day care, to patients (Clarke et al 1993), 1.5:1 staff to patients (Higgins,1981) and an 8 person multi-disciplinary team per 25 bed ward (Wack, 1993).

The SHSA paper comments on the need for a high female:male staff ratio to ensure appropriate care.

Treatment regimes

Some of the papers describing services say that a range of treatment regimes are available including psychotherapy, milieu therapy, education, life and social skills training (Hodgins, 1993; Feldbrugge & Haverkamp, 1993; Wack, 1993) also individual behaviour modification and occupational therapy (Gudjonsson & Mackeith, 1983). Others describe the regime specifically as a therapeutic community (Higgins, 1981), or as milieu therapy (Clarke et al 1993). Dixon and Rivenbark (1993) state that while there is no single treatment regime, a cognitive-behavioural approach pre-dominates in the service they describe. All descriptions of service models comment that psychotropic medication is central to treatment.

Only one paper (Wack,1993) discusses issues particular to women in relation to treatment regimes. This paper comments that women are very preoccupied with their role as parents and issues around this and seem to prefer individual work to groups to discuss these issues.

Wack (1993) also comments that 'vast majority' of women have experiences of physical and sexual abuse, but has no discussion of how this is addressed. This abuse tends to be severe and prolonged at childhood stage and is often replicated in adult relationships, with severe consequences for

mental health in adulthood. The literature shows that these issues are largely not addressed in treatment programmes, which reduces women's ability to move forward towards discharge into the community.

Links with the criminal justice system and with other health and social services

Although some papers mention that social workers were included in staff teams (Dixon & Rivenbark, 1993; Wack, 1993; Higgins, 1981), and Higgins states that the unit had a probation liaison officer, there is very little discussion of how links to other services were maintained, if at all. In some services, most patients came from and returned to other psychiatric hospitals, and so links with these were the most important. The service described by Hodgins (1993) included a specialised aftercare team. In the UK, the Care Programme Approach should provide the framework for multi agency work in mental health, and Taylor et al (1996) and the SHSA paper refer to this as the link between different parts of the secure services and between the secure services and other services.

Women's relationships with their children and families

The only discussion of provision is in Wack (1993). Within 48 hours of any admission, the unit social workers contact family to invite them to meet the team and participate in the treatment plan. Families are sent extensive literature about the hospital, and asked to return a questionnaire about the patient's history. The visiting room has a nursery area and provision for families to bring in food so that they and the patient can eat together. The SHSA paper stresses the need for specialised support to maintain family links, where appropriate, especially 'consistent and meaningful contact with children'.

Issues of discrimination and oppression

None of the papers discusses these sorts of issues in existing services.

Training, education and support of staff in services

There is very little detailed information on these issues. Staff come from a range of disciplines. In some services day to day care is provided by nursing staff, with security staff separate, in others ward staff combine these functions.

What problems or advantages are attributed to different service models?

Because most of the papers do not discuss specific issues relating to women, there is very little in the descriptions of existing models to identify particular problems or advantages for women in the models. The only comments are reported above, and relate to the issue of mixed sex treatment programmes.

In the proposed models, geographical distance from home is seen as potentially both a problem and an advantage of fewer larger units. Distance may be appropriate for some women. However, there may be administrative problems in resettlement caused by the purchasing structure of the NHS which currently requires a notion of home community. Problems associated with smaller single sex units are isolation from academic and service links and the absence of the perceived

benefits of mixed groups in treatment. Advantages of larger units are the ability to sustain effective links with other services, not least through the development of the Care Programme Approach. (Taylor et al, 1996). In the SHSA proposed model, the separate and distinct management of a women's service would enable effective links between stages of the system, and the development of a national resource of expertise. The development of a specialist assessment service is seen as a key advantage of the SHSA model (SHSA 1995).

Population studies

Many papers did not give data on women separately, except as a proportion of total sample/population, and these were excluded from the review. The figures for women are usually too small for statistical purposes, but not to give them separately hides any clue to gender differences.

Papers included on the mental health of populations variously describe:

- prison populations (Table 3)
- women offenders admitted to prison hospitals for mental health reasons (Table 4) or referred for psychiatric evaluations (Table 5)
- secure hospital populations (Table 6)
- women who have received a mental health related adjudication such as not guilty by reason of insanity, or guilty but mentally ill (Table 7)

Comparison groups include: women in the general population; men in the same circumstances; non-offending women with the same diagnosis. Measures of mental health used vary between studies.

The patterns of mental disorder among women in conditions of security

The mental health of all women prisoners:

In England and Wales, the two surveys carried out by the Institute of Psychiatry provide baseline information about the mental health of women sentenced prisoners (Maden et al, 1994a) and women remand prisoners (Maden et al, 1995). Here we describe findings for psychoses, personality disorders, major depression and learning disabilities among women prisoners. We then go on to look at rates of substance use and self harm among women prisoners.

For psychoses, Maden et al (1994a, 1995) report prevalences of 1.6% among sentenced women and 4.1% among remanded women. Elsewhere, studies have found higher rates: 10% among sentenced women in Melbourne (Hermann et al 1991) for example. However, the largest study of remand prisoners in the USA (Teplin et al 1996) reports very similar rates to those of Maden et al: 4% for schizophrenia and manic episode combined.

Maden et al (1994a;1995) report 18% of sentenced women and 15.5% of remanded women diagnosed as having a personality disorder, though they caution that these are likely, given the methodology of the surveys, to be underestimates. Elsewhere, rates given are similar or higher,

especially for sentenced women; Jordan et al (1996) report 28% prevalence of borderline personality disorder among sentenced prisoners in North Carolina, while Daniel et al (1988) report 29% prevalence of antisocial personality disorder among sentenced women in Missouri.

Major (non-psychotic) depression is harder to compare between studies. Maden et al group depressive disorders with all neuroses, and give figures of 16% for sentenced women and 43.7% for remanded women. Teplin et al (1996) give a rate 13.7% for major depressive episode in remands and Jordan et al (1996) report 10.8% among sentenced women. Both these studies suggest high rates of post-traumatic stress disorder; Teplin et al (1996) assessed for PTSD formally and found a rate of 22.3%, while Jordan et al (1996) say that 30% reported 6 or more PTSD symptoms in the previous six months.

Only Maden et al (1994a; 1995) report figures for women with learning disabilities. They assessed 2.4% of remanded women as having 'mild mental retardation' and 2.3% of sentenced women as having 'mental handicap', but suggest that these may be underestimates.

Using a fairly strict definition, and excluding the use of cannabis, Maden et al (1994a, 1995) report rates of alcohol and drug dependence among both remand and sentenced populations; 9% of sentenced and 8.2% of remanded women for alcohol, and 26% of sentenced and 33.5% of remanded women for drugs. Teplin et al (1996) report rates of 23.9% for alcohol abuse/dependence and 52.3% for drug abuse/dependence, and Jordan et al (1996) who report 17.1% for alcohol abuse/dependence and 30.3% for drug abuse/dependence. Where reported, substance abuse/dependence is consistently the largest category of disorder, often coexisting with other disorders.

Maden et al (1994a, 1995) report that 32% of sentenced and 39% of remanded women have a history of self harm, the majority of episodes occurring outside custody. Rates of self harm reported elsewhere range between 22% of sentenced and remanded women in Brisbane (Hurley & Dunne 1991) and 50% of remanded women in Scotland (Davidson et al 1995). Two studies give more detail about specific acts: Turner & Tofler (1986) report 6% of remanded women had self mutilated, while Wilkins & Coid (1991) found 7.6% of remanded women had self mutilated.

Women admitted to prison healthcare centres for mental health reasons:

In this section we discuss studies which looked at women prisoners who had been admitted to prison health care facilities because of concern about their mental health. Dell et al (1993a, 1993b) looked at 196 remanded admissions to the medical unit of Holloway. Of the 196, 95 (48%) were diagnosed as psychotic, and 101 as non-psychotic. Of the non-psychotic group, 29% had been given a diagnosis of personality disorder, 3% of depression and 19% of mental handicap; 30% were drug dependent. Of the 196, 19% had been referred to the medical unit for reasons that included being considered a suicide risk. Birecree et al (1994) looked at women referred after a screening process on admission to prison; approximately half of all women screened were referred for further evaluation. This study found very low levels of psychotic disorders; no women with

schizophrenia and a 1% lifetime history of bipolar disorder. They suggest that this was due to earlier diversion under insanity defence legislation of women with psychotic illnesses. Figures given in this study are of lifetime prevalence, and so tell us less about the women's mental health while in prison, however, 23% were diagnosed with antisocial personality disorder and 91% had any substance abuse or dependence. Previous suicide attempts were reported by 31%, a history of sexual abuse by 45% and of physical abuse by 47%. Lamb & Grant (1983) found a rate for schizophrenia of 59%, major affective disorder of 35% and personality disorder of 2% among women referred by jail staff for evaluation. However, those with a primary problem of drug or alcohol abuse, or developmental disability had been excluded from the sample. Dolan & Mitchell (1994), looking specifically at personality disorder, found that 76% of a sample of women admitted to the medical wing of Holloway met the criteria for at least one category, and 64% met the criteria for more than one category of personality disorder.

Implications for service delivery of the prison studies:

Several of the American studies comment on the need to develop comprehensive psychiatric facilities within the prison system. In the UK, following the basic principle of the Reed report that people requiring services should have them provided by health and social services rather than the criminal justice system, the main issue is the ability of prison healthcare services to recognise need and liaise effectively with other agencies. Dell et al (1993a) comment that the quality of service provided by what were effectively 'contracted in' NHS psychiatrists was good, and they endorse such a model, but stress the need for experienced experts with a long term commitment to working with offenders. However, they also point to the needs of the women who were not eventually admitted to hospital and did not receive custodial sentences, and the need for liaison between a much wider range of agencies to provide community based care, 'based on appropriate financial structures'.

The numbers of women prisoners with psychotic illnesses is fairly low in the UK - the main issues for this group are the process of liaison between prisons and the NHS, and the environment of the secure services. The extent of a history of self harm among women prisoners is an added dimension to the need for quick and effective liaison with the NHS, as women with a psychotic illness are at increased risk of suicide.

The main implications for service delivery drawn from the UK studies of prison populations are the extent of unmet need for responses to personality disorder and drug dependence. Maden et al (1995) recommend the development of a range of residential facilities for women with severe personality disorder, both within the prison system (along the lines of HMP Grendon) and in the NHS. They also recommend the development of drug treatment services within prisons, and access to services outside prison.

Women in secure psychiatric settings

The studies discussed in this section include those that are specifically of women referred for assessment or pre-trial evaluation (Table 5), those that are of all women in secure settings (Table 6),

who may have been admitted for assessment and/or treatment and those that are of women admitted following a mental health related adjudication (Table 7). As we saw in the discussion of service models, with the exception of Norway, in most secure psychiatric services women are admitted to the same wards for assessment and treatment. In Norway assessment is carried out in detention centres which are part of the prison system (Kleve 1996); this affects the study by Rasmussen and Levander discussed in this section. Because of the very small number of women admitted to secure psychiatric services, several of the studies are either of very few women (e.g. Rasmussen & Levander, 1996; Morgan et al, 1988; Gudjonsson & MacKeith, 1983, Higgins, 1981) or else cover fairly long time spans, with consequent changes in legislation or diagnostic practices (e.g. Milne et al, 1995; Brooks & Mitchell, 1975; Offen, 1986). The studies also vary in whether they report more than one diagnosis per individual; Rasmussen & Levander, 1996; Strick, 1989; Gudjonsson & MacKeith, 1983 and Seig et al, 1995 all do so, and consequently have some of the highest rates for particular diagnoses.

All of this makes detailed comparisons difficult, but two broad patterns emerge: the highest rates of personality disorder are generally to be found in the settings of higher security, and the highest rates of mental illness are found in medium secure settings and locked wards in general psychiatric hospitals. This is likely to reflect the fact that thresholds for admission for personality disorder are comparatively high, and so women who are admitted with this diagnosis are more likely to be defined as needing high levels of security.

Where reported, rates of self harm were high. Liebling et al (1997), reporting a study of 75% of women patients in Ashworth Hospital, two thirds of whom were defined as having a personality disorder, states that all the women interviewed had self harmed at some time, most starting before their early teens. Rasmussen & Levander (1996) report 57% of their sample as having self harmed, while Brooks & Mitchell (1975) report 67.7% as having a history of self harm. Seig et al (1995) report 49% of their sample had a history of suicide attempts. Liebling et al's (1997) interviewees directly linked starting to self harm with experiencing sexual, physical and psychological abuse. Aderbigbe et al (1996) report that 16% of their sample had been physically abused, and 18% reported sexual abuse.

Coid (1992, 1993) looks in depth at the women detained in English high security hospitals under the MHA 1983 category of 'psychopathic disorder'. While 97% met the criteria for one or more category of DSM-III axis II disorder, the same proportion also met the criteria for one or more lifetime axis I disorder, in two thirds of women this was depression. Nearly all, 91%, reported a history of self mutilation, and 80% had overdosed at some time. Sexual abuse by a family member was reported by 28%. These papers and two others, which examine a group of remand prisoners who had self mutilated (Wilkins & Coid, 1991; Coid et al, 1992) are discussed further below in a section on personality disorder.

Some of the studies comment that there appear to be two broad groups of women among those in secure care. Brooks & Mitchell (1975) describe one group as those coming from other hospitals

because of violent behaviour in those hospitals; this group was younger and predominantly diagnosed as having mental subnormality or personality disorder. The other group was those admitted from the criminal justice system following conviction for a single act of violence. This group was predominantly diagnosed as having schizophrenia or a personality disorder. The authors question whether these groups should be treated together as they have different needs. They suggest that the second of these groups did not need maximum security, and could have been adequately treated in local secure units, which were just being developed at the time. For the first group, they argue that the hospital provided a source of 'asylum and respite' in crises. A similar pattern is observed by O'Connor & O'Neill (1991), although all the women they describe had been transferred from prison. They argue that most did not need high security care and could have been effectively treated in local psychiatric hospitals but that this was not possible under Irish mental health law. The remainder tended to be those with personality disorders, who were transferred to the hospital at times of crisis such as depressive or suicidal episodes and returned to prison when these crises passed.

Wong et al (1995), in a study of high security hospital patients over the age of 60 identified a small group of women who resemble Brooks & Mitchell's second group, still detained in maximum security into their old age; predominantly diagnosed with a mental illness they had been admitted following a single act of serious violence (homicide in eight of the nine cases), mostly committed in their 20s or 30s.

Daniel & Harris (1981) found differences between women aged above and below 40, who had been referred for pre-trial evaluation. Those under 40 had longer criminal histories and were more likely to be diagnosed as having a personality disorder, while those over 40 were more likely to be first time offenders and to be diagnosed with depression or alcoholism.

Personality disorder

One of the key issues in studies of women requiring secure psychiatric care is that of severe personality disorder or psychopathic disorder. As noted earlier, the majority of women patients in this category are diagnosed as having borderline personality disorders. For many, this is related to severe post-traumatic stress syndrome and there are possibilities for treatment focusing on this link, particularly with trauma therapy (Mayne, written communication). However, Dolan and Coid's (1993) review of treatment and outcome in psychopathic and antisocial personality disorder demonstrated the paucity of studies in the published literature which include women.

A critique of use of the term 'personality disorder' is central to much of the sociological work on women's experiences of forensic psychiatry (Carlen, 1985). Psychiatry itself acknowledges the difficulties of definition and the paradox of using behaviour as both a criterion and an outcome of a diagnostic category. A complementary direction would be to look at the needs of women being defined as having a personality disorder. Coid and colleagues have published a series of papers looking at women in prison who self mutilate (Wilkins & Coid 1991; Coid et al 1992) and at women who are detained in high security hospitals under the MHA 1983 category of psychopathic

disorder, who also have very high rates of self mutilation (Coid 1992;1993). From these studies, Coid (1993) builds up a picture of a group of women who have experienced very damaging and damaged childhoods, and turbulent adolescence. Among the women in the high security hospitals, those who displayed mood instability were selected (Coid 1993). These women describe a repetitive pattern of severe and debilitating symptoms of anxiety, anger depression and tension. These symptoms built up and led to a compulsive urge to act out, in the form of self-mutilation, assaultiveness, appetite disturbance or firesetting. Acting out brought relief of symptoms. For most of them these mood disturbances had started in late childhood or early adolescence, and reached a peak in their mid 20s, leading to psychiatric admissions, involvement with the criminal justice system and poor social relationships. They were labelled as having borderline personality disorders and the majority had been admitted to special hospitals in their mid 20s. For many, an improvement began in their mid 30s. Coid (1993) suggests that the mood disorder the women described 'amounts to an affective disorder in its own right' (p647), and that 'a radical shift in emphasis from attempting to change core personality features to the treatment of affective symptoms could lead to future developments in this area' (p649).

Although starting from a somewhat different perspective, Liebling et al (1997), interviewing women in a high security hospital, two thirds of whom had been diagnosed as having a personality disorder, find a very similar pattern of early experiences, and of a cycle of emotional build up and relief through self harm; 'before self harming women felt depressed, angry, upset, anxious or suicidal. Afterwards they were relieved, felt better, more in control and less tense'. (p431). Most saw self harming as secondary to other problems such as fear of reoffending and of having to cope in the community, and they had insight into their own behaviour and needs. They experienced most staff responses to self harm as unhelpful and punitive. To some extent current self harm was a response to the immediate situation of being in the hospital, but the authors comment 'Self harm has many positive functions. It has evolved as a means of coping with severe distress due to women's very painful life experiences...it has enabled women to cope with abusive situations and to cope with the extreme pressures of being in a special hospital.' (P434). Both these studies point to ways forward in work with women who have been defined as having personality disorders; moving away from the focus on behaviour and responding to needs which relate to underlying distress.

Ethnic background

The women in the secure psychiatric services of England and Wales are predominantly white: in the high security hospitals, 88.5% of women are white, 9.6% are African/Caribbean and 1.9% are from other ethnic groups (Howlett, 1994). In the NHS medium secure sector, 86% of women are white, 12.9% are African/Caribbean and 1.1% are Asian (Murray 1996). While the proportion from ethnic minorities is still disproportionate to the general population, it is less so than either the female prison population at 24% (Home Office RSD, 1997) or the male population of secure psychiatric services. Ethnic minority women therefore represent a minority within a minority in the secure services.

Sexuality

Very little is known about the sexuality of women in secure services. Eaton & Humphries (1996), in their interviews with women in Ashworth Hospital found that the women did not easily fit labels or customary categories, and of the fifteen women interviewed, four discussed having sexual relationships with other women, nine referred to sexual relationships with men.

Levels of security

A report by the Special Hospitals Services Authority (Howlett, 1994) estimated that only 22% of women in the high security hospitals needed maximum security provision, 31% needed medium security and 42% low or no security. This estimate is based in part on a study of treatment and security needs of patients in special hospitals which gives estimates for the whole high security hospital population of 37% requiring maximum security, 46% requiring medium security and 18% requiring low or no security (Maden et al 1993). It would appear from these estimates that women in the high security hospitals are much more likely than men to be being held in excessive conditions of security.

The most recent survey of security needs is that reported in Reed (1997), which was carried out to assess the extent of need for longer term medium and low security care. The NHS current medium secure services are intended to provide for stays of up to 18-24 months only. Concern has grown that the lack of longer term care at this level of security, together with the lack of beds in wards of low security, has contributed to the length of stay in high security care, difficulties in admitting people from prisons and detention of people in inappropriate levels of security (Taylor et al, 1996; Reed 1997).

Need for longer term care was assessed by a survey of all patients in high or medium secure units, NHS and independent sector, in England and Wales in December 1994, by questionnaire to their consultants (Reed,1997). This found that there were 227 women within the secure services who were deemed by their consultants to need long term low or medium secure care. Of these 227, 138 were currently in high security care, 51 were in NHS medium secure units and 38 were in independent sector units. These figures represent approximately half the women in high security and NHS medium security care at the time (Howlett, 1994; Murray 1996). Long term low secure care was deemed to be needed by 41%, and long term medium secure care, by 59%.

Within the literature, security is referred to as being either 'relational'/'internal' or 'perimeter'/'physical'. Kinsley (cited in Howlett, 1994) defines relational security as being dependent on detailed, multidisciplinary knowledge of the patient and good inter professional relationships. Perimeter or physical security depends on physical barriers; perimeter walls and locks. Taylor et al (1996) describe 'perimeter' security and 'internal' security, suggesting that those who need the former are likely to be 'those with persistent delusional disorders and some disorders of sexual preference'. On a daily basis this group present little threat to themselves, immediate others or staff, but need a perimeter wall. Those needing internal security are described as 'those who are repetitively destructive to self, property and other people'. This group need high levels of

internal security. In reality, at present, levels of security are defined in terms of the buildings; the three maximum security hospitals and the medium secure units. The numbers of people, but particularly women, who are in levels of security they are seen as not needing raises questions about how relevant these levels are when they refer to separate buildings. A move towards relational security would enable levels of security to be individualised.

Effects studies

Only one study was found which provided any assessment of outcome for women who had been in secure psychiatric care. This was Brooks & Mitchell's (1975) study of women admitted to a Scottish special hospital. The study attempted only what the authors call a 'subjective rating' of progress, based on subsequent psychiatric condition, behaviour in and out of hospital or prison, work record, further court appearances and hospital re-admissions. Of the 32 women followed up, 18 were given a rating of 'poor' outcome, and 14 one of 'good' outcome. The group of women admitted from other psychiatric hospitals, particularly those admitted following violence in hospital, tended to have poorer outcomes than those admitted from the courts. Outcome was not related to length of stay.

The lack of outcome studies was not particularly surprising; Dolan & Coid (1993) found no outcomes studies of treatment regimes provided in secure conditions which provided separate data on women. Although their review focused on psychopathic disorder and antisocial personality disorder, many of the special hospital studies they looked at involved people with a range of diagnoses. The lack of detailed descriptions of treatment regimes and processes within service models would anyway make it hard to attribute effects. Dolan & Coid (1993) suggest 'there is a need for new research strategies which take a naturalistic approach by following large cohorts of patients through a number of statutory and voluntary treatment, with differing levels of security, within health, social and penal services',(p272). Although they are referring to specific diagnostic groups, this suggestion is a reasonable one to apply more generally to women who experience the secure psychiatric services.

SUMMARY AND DISCUSSION

Taken as a whole, the papers identified in this literature review offered some valuable information regarding the subject area. In particular, papers show that there is a need to consider the female population of secure systems separately from the male population. Women differ from men in a number of ways, and in particular their routes into the system and out of the system, and the diagnostic groups identified - most notably borderline personality disorder. The relevance of these women's history of abuse in childhood and the implications of this for treatment approaches also cannot be overstated.

However, the research found also suffered from major weaknesses, and this is significant in terms of how far conclusions may be drawn from this literature.

The vast majority of papers that were identified in the initial search stages but were then excluded from the next stage of the research were limited in their presentation of data relating to women. A large part of the literature fails to identify women separately and thus can offer nothing in terms of insight into the particular issues which are relevant for this population. Very little has been written specifically about this population, in comparison with research which either focuses on men alone or which is gender blind and reports for a population as a whole, and many of the most important questions relating to women's experiences of the secure system are relatively unexplored.

Many of the papers which did deal with women consisted of a catalogue of the female population within secure settings of different kinds. With these, a number of areas remained largely unexplored (for example, relating to parenting, sexuality, ethnicity and early history). A number of papers gave proportions of women at different levels of security with different diagnoses and this does offer more information about the population, but needs to be added to with other data about the women's social and personal circumstances.

The literature also suffers from other weaknesses. One major difficulty is that researchers often use different diagnostic criteria in their discussions of women's mental health's status and comparisons across different papers are particularly difficult. This is exacerbated by differences between countries and across time, but is also found in comparisons of papers within the same country.

An additional weakness lies in the base population used in many of the descriptive studies. A number of the papers described populations who had been referred for psychiatric evaluation and this also prevented comparison with other papers which had a different base population.

In terms of methods used, two major approaches were identified: quantitative research with large numbers which described populations and which were often based on assessment of medical notes, court records and clinical observations, and more qualitative approaches based on observation and unstructured or semi-structured interviews with the population. There is an important difference

between quantitative research which often focuses on and objectifies the individual, identifying pathology and abnormality in terms of difference from accepted norms, and other models of research, often within a feminist or sociological paradigm, which locate the individual in wider social practices and which seek, to varying extents, to make the individual an active subject.

One of the weaknesses of research based on individual pathology is that the material found cannot be contextualised with information about the women's social lives. However, it has also been argued that such research adds to the disempowerment of women in the secure system. Writers such as Carlen (1985), Liebling et al (1997) and Eaton & Humphries (1996) have all argued that traditional models of research are not just inadequate to address the needs of women, but are in practice part of the exercise of power over women's lives.

Liebling et al (1997) describe their dilemma as researchers 'in attempting to enable a Special Hospital system to recognise and address the reality of women's experiences. Thus they discuss their use of psychometric assessment tools in their study of a group therapy approach for women who self-harm, commenting that whilst such data appeared to be the only aspect of the research the 'system would respond to' (Liebling et al, 1997, p431), the women themselves were unhappy about the scales, made negative statements about them and appeared to feel that the scale increased the facilitators control over the group (Liebling & Chipchase, 1996).

Criticism of the limitations of existing methodologies has also come from within the field of forensic psychiatry. Dolan & Coid (1993), in their review of the literature on psychopathic and antisocial personality disorders, comment on the particular inappropriateness of 'methodological approaches derived from the medical model of treatment evaluation...when applied to a construct that is partially socially defined' (p270). In defining outcomes for evaluation, research models have to allow for the fact that treatment for severe personality disorder 'is usually a multi-agency reshaping procedure extending over a long period of time' (p271). Similarly, Eastman (1993) argues the need for research on social processes within institutions; 'process in psychiatric services cannot be viewed as the equivalent to the "black box" of the "double blinded trial" for drugs but, rather, as a complex medico-social activity which is as dependent on the latter as on the former'(p21). Thus research needs to take more account of the social factors involved in the delivery and outcome of psychiatric services in secure settings.

This does not mean that there is no place for quantitative research, but rather that, given the small numbers of women involved, and the kinds of issues that need exploring, there is a need for a wider range of methodologies, and in particular more qualitative work. This is also a practice and training issue; interdisciplinary work requires knowledge of and respect for the different research methodologies that underpin each discipline. One way in which this might be achieved is through commissioning research which includes, as part of the research team, a wider range of people from different perspectives — both within the system and outside it.

There were fewer papers describing services and as seen above, very little which offered an evaluation of a service model. This is a major deficiency in this part of the literature. Many of those papers describing services also lacked independence, in that the author was often working within the system being described and whilst this may enable a clear and detailed account to be given, there must also be some concern that this will affect the paper's content.

Thus the conclusions to be drawn from the review are limited by these weaknesses and whilst to some extent the literature does offer a valuable insight into particular needs which should be addressed by those planning services, there is also an urgent need for further research into this specific population.

CONCLUSIONS

We have organised the conclusions to address four constituencies; policymakers, researchers, practitioners and the public, though the same themes run through each section.

Issues for policymakers

The current policy context for women's secure services is one of change and opportunity. There seems to be general agreement that the current model of services in England and Wales is inappropriate for the particular needs of women as a minority group. The development of the purchasing/commissioning structure of the NHS has opened up possibilities for innovation, though in the case of a low volume/high cost area such as the secure psychiatric services this may need to be managed carefully.

In developing new models of service, there appear to be two initial choices:

- appropriate size of unit vs. geographical distance from home community
- segregation vs. integration of sexes

The literature is not particularly helpful here, because of the lack of evaluated models. Both these issues must at present be argued from first principles rather than empirical research. However, there is a general literature on women's prisons, exploring issues relating to geographical distribution of facilities versus centralisation, and this should be consulted.

Taylor et al (1996) stress the benefits of size: large enough catchment areas to ensure reasonable numbers of women, and location: integration with other services and the prevention of isolation and the development of a different form of institutionalisation. Against this must be put the argument that larger units would mean fewer units, with more women at longer distances from their home communities. However, it is not clear how real an issue this would be; do the women in secure services have concerns about connections with a particular community, given how many of them have been abused and damaged by their families and previous relationships? For those that do, the policy response may more appropriately be to explore ways to maintain those links. The SHSA paper (SHSA 1995) also argues that the balance is in favour of fewer, but specialised units. Reed (1997) cites a statement from the patient's council at Broadmoor Hospital stating that 'Given the choice between a larger, more remote establishment and a smaller, local one with drastically reduced opportunities for occupational, sporting and social activities, many currently at Broadmoor would unhesitatingly opt for the former' (p210). This cannot be taken as a statement of the views of women in the range of secure accommodation, but suggests that this is an issue which could be explored with them.

In terms of segregation, there are again theoretical arguments on each side but very little empirical evidence. Much of the argument against segregation seems to rest on a notion of the role men and

women play for each other in therapeutic settings; that of a resource through which to address issues relating to gender roles. It may be that there are other ways to provide this resource than to use other patients. Advocates of segregation stress that what they are arguing for is a real choice for women about whether they are treated in mixed settings or not. This is in line with the Patient's Charter and NHS Executive guidance (EL(97)3), which specifically discusses issues of safety, privacy and dignity within mental health services.

In the absence of research evidence on the issue of segregation, the way forward may be to allow the development and evaluation of such services. As discussed earlier, this is already happening to some extent. One important point to note is that any such evaluation must take account of the fact that segregated services within a system for a minority group usually cost more and are less fully used than the existing system. Evaluation of new services in these circumstances needs therefore to avoid criteria based on cost and utilisation.

Other policy issues are:

- the development of a focus on needs as well as on diagnoses/MHA categories. This is in line with general changes in the provision of health and social care. Alongside this is the way 'security' is conceptualised; a shift towards relational security would enable more individualised levels of security to develop in response to women's needs.
- the need to ensure that NHS purchasing structures do not create perverse incentives toward particular forms of care or prevent resettlement in a woman's area of choice, if this is not her home community. This is linked to the prior question of the size and location of units; if a model built on fewer specialised units is developed to replace the current system of regional secure units for women.
- how to ensure community based provision to prevent readmission. There was very little discussion of the Care Programme Approach in the UK literature. Again, this issue is linked to that of the national structure of services. There may be a need to provide expert advice and back up to professionals at local level.
- the response to the recommendation from the national surveys of prisoners that a therapeutic community facility for women be developed within the prison system (Gunn et al 1991; Maden et al 1995). Ultimately this is an issue for the Prison Service, and views on it may be influenced by the outcome of the review of therapeutic community provision commissioned by the HSPSCB. A policy issue for the NHS would be to ensure that any such development did not create incentives towards not admitting women to hospital where this was the more appropriate form of care. However, the literature suggests that there are women in the prison system for whom admission to hospital under the MHA 1983 would be inappropriate and for whom such provision would be a widening of choice.
- the need to facilitate the involvement of women patients as stakeholders in the planning of their care and treatment. This is important not only in relation to empowerment as discussed earlier, but also for therapeutic reasons — where women have been used to having no sense of control, and their thoughts and views are not valued and validated, the genuine involvement of women patients offers an important opportunity to counter this experience.

Research issues

In relation to research there are two broad themes. One is the substantive gap in knowledge, the other is of appropriate methodologies, as discussed above.

Gaps in knowledge

The key gaps in knowledge appear to be:

- any knowledge about the effects of different service models. As discussed in the section on policy implications, the opportunity for developing and monitoring different service models should be taken and comparative evaluation studies carried out. This should involve good descriptive accounts of the services.
- wider aspects of women's lives and the impact of gender and social inequalities: their experience of discrimination, sexual and physical abuse, poverty, social isolation, families, children, sexuality. In particular how they see themselves and their actions and needs.
- ways of measuring need, to complement use of diagnostic groups as a way of describing women and planning service responses
- research into the experiences and needs of women diagnosed as having personality disorders
- research into the experience of the very small number of women from minority ethnic groups within the secure services
- in-depth and comparative research into offending/social profiles of female/male patients and response to female/male patients by the criminal justice and psychiatric systems.

Methodological issues

- where statistics are reported, all studies of mixed populations should give figures broken down by sex, if only to make trends across studies visible.
- there is a need to consider a full range of methods, including both quantitative research which continues to add to knowledge about this population, and also methods which involve women in secure settings in the research process and see women as active participants rather than research objects

Practice issues

The issues for practitioners follow from the policy and research issues raised above:

- multi disciplinary training needs to include training in gender awareness, which would highlight issues relating to power. This would include training in the practice and value of a range of research methodologies
- the development of concepts of security based on staff as well as physical features, which links in with training issues, as above
- the development of individualised needs assessment
- the need for good links into community services and smooth discharge planning, using the Care Programme Approach.
- the need to recognise the very high proportion of women patients who have suffered childhood sexual abuse and abuse in adult relationships and to develop treatment strategies in which this is recognised and addressed.

The Public

There is no doubt that the high security hospitals cast a long shadow in the public mind, and neither the publicity around recent incidents on the male personality disorders ward at Ashworth nor the media presentation of homicides by people with serious mental illness have helped this. While there are reasons to be concerned about the construction of the image of the male 'mentally ill killer', particularly the racial dimensions of such a construction (Payne, 1998), public fear is particularly misplaced in relation to women who have experienced the secure psychiatric services. There is a need for better public understanding of the particular nature of the needs and lives of women in secure hospitals - particularly the very different patterns of violence women manifest. However, much of the public concern with mental health services is not peculiar to the secure services but is part of a wider perception of the 'failure' of community care. The risk is that this perception may create a climate in which it is difficult to develop new models of care, particularly ones which rely less on the symbols of security such as walls and locks.

APPENDIX A: TABLES

Table 1: Descriptive Studies, Service Models

Table 2: Proposed Service Models

Table 3: Prison populations

Table 4: Women offenders admitted to prison hospitals for mental health reasons

Table 5: Women offenders referred for psychiatric evaluations

Table 6: Secure hospital populations

Table 7: Women who have received a mental health related adjudication such as not guilty by reason of insanity, or guilty but mentally ill

Table 8: Effects studies

Descriptive studies, Service Models

Table 1: Existing service models

Reference	Location	Service delivery model	Advantages attributed to model	Disadvantages attributed to model	Comments or discussion relevant to women
Moss et al (1996)	Describes Stockton Hall Hospital, private medium secure unit	Type B 20% of admissions in first three years were female	None specific to women	None specific to women	Comments that women form a higher proportion of admissions than in average NHS secure unit, but no further discussion
Gordon, Kirchoff et al (1996)	Describes national system of secure care in Israel, in comparison to England & Wales	Type B locked wards in general psychiatric hospitals are mixed sex Only maximum security unit for offenders is within prison system, in this 5 of 50 beds are for women, but on integrated ward	None specific to women	None specific to women	Comments that mixed sex wards cause problems for both Jews and Muslims. However, discussion of women and secure care is mainly about England & Wales - implies the same issues exist, but does not actually discuss in the context of Israel
Kleve (1996)	Describes system of forensic psychiatric services in Norway	Type B Less than 10% of patients in secure units are women	None specific to women	None specific to women	No discussion of women
Sieg et al (1995)	Describes Colorado Mental Health Institute, Colorado	Type A One women's forensic ward	Trend towards mixed sex groups for treatment, which authors say is beneficial in making women's patterns of relating to men more visible and therefore amenable to treatment	None specific to women	Suggests women with different diagnoses (Axis I and Axis II disorders) need different treatment regimes
Dixon & Rivenbark (1993)	Describes Taylor Hardin Secure Medical Facility, Alabama	Type A Only 5 out of 137 beds are for women, in one multi-function ward	None specific to women	None specific to women	No discussion of women, except to comment that are very much in the minority among both assessment and treatment patients

Table 1: continued

Reference	Location	Service delivery model	Advantages attributed to model	Disadvantages attributed to model	Comments or discussion relevant to women
Feldbrugge & Haverkamp (1993)	Describes Dr Henri van Hoeven Kliniek, Utrecht	Type B Around 10% of patients are women (service has 75 beds)	Men and women participate in the same programmes, with the intention of avoiding the problems to which 'restriction of social intercourse' may lead	Women's minority position within the service means assumption about benefits of integration being reviewed	Separate programmes for women being developed, but no details
Hodgins (1993)	Describes mental health treatment services in Quebec for people accused or convicted of criminal offences. System includes general and psychiatric hospital wards, one forensic outpatient clinic and one secure hospital. Most of paper is description of the secure hospital	Type A At the secure hospital, one 21 bed ward out of 15 is for all women, and less than 4% of patients are women. In the general and psychiatric hospitals, 15- 25 % of accused or convicted patients are women	None specific to women	None specific to women	Paper gives very detailed descriptions of the different regimes on the men's wards, but only comments that for women 'treatments are as described above for male patients'. Not clear whether men and women treated together. No discussion of issues specific to women
Finlay-Jones & Nielssen (1993)	Describes system of psychiatric care for prisoners in New South Wales	Women receive outpatient care within prison, but can be transferred to local psychiatric hospital for inpatient care. Male offenders in need of psychiatric care are held in hospital within prison	None specific to women	None specific to women	Most of paper is about prison based facility for men. Ideal model is described, but no comment on specific needs of women

Table 1: continued

Reference	Location	Service delivery model	Advantages attributed to model	Disadvantages attributed to model	Comments or discussion relevant to women
Clark, Holden et al (1993)	Describes Center for Forensic Psychiatry, Michigan	Type A One unit out of seven is for women held on all types of orders	None specific to women	None specific to women	No discussion of women
Waack (1993)	Describes Kirby Forensic Psychiatric Centre, New York State	Type A One 25 bedded unit out of six is for all women patients	None specific to women	None specific to women	Discusses women's role as parents and issues around this, have found that women prefer individual work to groups to discuss these issues. Also comments that 'vast majority' of women have experiences of physical and sexual abuse, but no discussion of how this is addressed. Provide 'exercise and beautification groups' to address issue of self-image and appearance
Gudjonsson & Mackeith (1983)	Describes English interim secure unit - one ward in general psychiatric hospital	Type B 7 out of first 23 patients were women	None specific to women	None specific to women	No discussion of issue of mixing male and female patients. Had target of 2:1 male to female nursing staff, but difficulties in recruiting women nurses.
Higgins (1981)	Describes English interim secure unit - one ward in general psychiatric hospital	Type B 14 out of first 35 admissions were women	None specific to women	None specific to women	Comments on relatively high proportion of women (40%), but no discussion of specific needs. Easier to recruit and retain female nurses
Brooks & Mitchell (1975)	Describes only special hospital in Scotland	Type A One female ward Ratio of patients at any one time is 11:1 male to female	None specific to women	Comment that it may be inappropriate to deal with all women in one ward, given different patterns of diagnosis and treatment needs	See previous box

Table 2: Proposed service models

Reference	Advantages attributed to the model	Disadvantage attributed to the model
Taylor et al 1996	<p>Type A: Creation of 'one or two centres of excellence' for women, within existing system. Separate living accommodation but mixed groups for therapeutic, work or social activities</p>	<p>Larger numbers of women would create 'real peer group'. Mixed facility enables treatment of and support with problems of distorted relationships with men. Dislocation from home community may be an advantage for some</p>
Milne et al 1995	<p>Type B: Concentration of women in medium secure sector in a few existing units to create equal mix of men and women.</p>	<p>Prevents extreme isolation of women in current situation</p> <p>Other units would become men only environments, which might increase difficulties in developing appropriate rehabilitation and social skills programmes for the men in those units</p>
SHSA 1995	<p>Distinct framework of women's services, separately managed. Comprising two specialist assessment centres, alongside high security provision, and dedicated medium secure services at more local levels. Outreach to women in prison</p>	<p>Specialist assessment service would provide a concentration of expertise, the centre of a coordinated service, a focal point for all referrals and would ensure common and consistent standards of assessment. Dedicated services at local level would ensure women received appropriate levels of care and could move through levels of security</p>

Descriptive Studies, Populations

Table 3: Prison populations

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
A) Teplin et al 1996	A) Stratified random sample female arrestees awaiting trial (n=1272)	DSM-III-R	A) Six month prevalence: Schizophrenia/schizophreniform 1.8% Manic episode 2.2% Major depressive episode 13.7% Dysthymia 6.5% Alcohol abuse/dependence 23.9% Drug abuse dependence 52.3% Panic disorder 1.4% Generalised anxiety disorder 2.2% Post-traumatic stress disorder 22.3% Antisocial personality disorder 13.7% Any of the above disorders 70.3%	Rates for most disorders higher for non-Hispanic White women than for either Hispanic women or African-American women, significantly (p<.05) so for: major depressive episode (non-hispanic white = 20.4%), alcohol abuse/dependence (35.5%), drug abuse/dependence (56.5%) and antisocial personality disorder (20.5%) comment on 'striking percentage' with PTSD: 'many...were victims of rape or other violent assault	A) 'jails need treatment programmes for persons with co-morbidity', in particular co existing mental disorders and substance use • extent of and treatment needs of PTSD 'relatively unexplored, but important' • 'community based programmes rarely available for released jail detainees, who often have complicated diagnostic profiles and special treatment needs' • 'Ironically, the relatively small number of women in jail makes the per capita cost too high to provide them with needed services' (p511) B) low number of those identified as needing services who received them
B) Teplin et al 1997	B) Subgroup followed up for receipt of services while in jail (n=955) 1991-1993 Chicago		B) 10.7% defined as 'needing services', of these, 24% received them		

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Jordan et al 1996	Census of all women sentenced to prison for felony offences (n=805) 1991-1992 North Carolina	DSM-III-R, but did not assess for schizophrenia or manic episode	Six month prevalence: Major depressive episode 10.8% Generalised anxiety disorder 1.4% Panic disorder 4.7% Alcohol abuse/dependence 17.1% Drug abuse/dependence 30.3% Antisocial personality disorder 11.9% Borderline personality disorder* 28% Any current disorder 46.3% *prevalence for borderline personality disorder is 2 years not 6 months	'Sexual abuse at or before age 10 years [was] a significant predictor of borderline personality disorder in this sample' (p518) '30% of our sample reported having experienced a traumatic event and having experienced 6 or more post traumatic stress disorder symptoms in the past 6 months' (p518) Trend for rates for white women to be higher for all disorders than for African-American women	<ul style="list-style-type: none"> Programmes to address exposure to trauma and its sequelae, and treatment for substance abuse problems should be high priorities for women's prisons
Maden et al 1995	82% sample of all women remanded to custody in England and Wales, (n=245) 1993-1994	ICD-10 individuals could have up to three classifications	Psychoses 4.1% Neuroses 43.7% Personality disorders 15.5% Substance dependency/harmful use: alcohol alone 8.2% other combinations 33.5%	History of self harm 39%, in 26% this was multiple. Majority had self harmed outside custody	<ul style="list-style-type: none"> Unmet need for specialised units for women with personality disorder within both the prison system and the NHS
Denton 1995	All women prisoners (sentenced and unsentenced) in medium security prison on census date (n=56) Melbourne 1991	DSM-III-R classification, but only Axis I disorders reported	Current prevalence (one month) Mood disorders 13% Psychotic disorders 7% Substance dependence 61% Mood or psychotic and substance 9%	'Women with a disorder were young, white Australian born, unemployed, sole parents, with low levels of education' (p175), though except on age and unemployment similar to those without a disorder	<p>Need for comprehensive psychiatric services and drug intervention in prison. In particular: Prevalence of mood disorders suggests risk of self harm</p> <ul style="list-style-type: none"> Lack of services for 9% with coexisting substance dependence and mental illness

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Jones et al 1995	All women sentenced to custody 1981-1990 (n=210) Tasmania	Data collated from prison records and Mental Health Services Database	Schizophrenia 1.4% Affective disorders 0.5% Neurotic disorders (principally depressive) 5.2% Personality disorders 9.5% Acute reaction to stress 2.9% Disturbance of conduct 1%		
Davidson et al 1995	50% random sample of all remand prisoners in Scotland on census date. n= 18 women 1993	ICD-10 No measure of personality	Diagnostic groups not given by sex Previous psychiatric inpatient 17% Previous psychiatric outpatient 50%	50% of women had a history of self-harm	
Holley et al 1995	Random sample of remand prisoners n= 106 women Calgary	DSM-III-R Hare Psychopathic Checklist Standardised questions on suicide history	Diagnostic groups not given by sex	34% of women had a history of one or more suicide attempts	<ul style="list-style-type: none"> Study demonstrates that 'knowledge of past suicide attempts was found to be of considerable diagnostic utility as this item correctly predicted the presence of mental illness 71% of the time and the absence of mental illness 56% of the time' (p205). Asking relatively simple questions about suicide can be practical tool for identifying individuals who need more detailed assessment

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Gunn et al 1991 Maden et al 1994a Maden et al 1994b Maden et al 1994c Maden 1996	Cross-sectional sample comprising 25% of all women serving a prison sentence in England & Wales (n=258) 1988-1989	ICD-9 individuals could have up to three classifications	Psychosis 1.6% Neurotic disorder 16% Personality disorder 18% Drug abuse/dependence 26% Alcohol abuse/dependence 9% Mental handicap 2.3%	History of self harm 32% (30% had self harmed outside custody)	<ul style="list-style-type: none"> • Unmet need for drug treatment services • Unmet need for therapeutic community type service
Herrman et al 1991 Herrman et al 1994	Stratified random sample of sentenced prisoners, excluding those receiving prison psychiatric care, in three prisons n= 31 women 1987 Melbourne	DSM-II-R Previous use of psychiatric services, data from interview with prisoners and Victorian Psychiatric Case Register Did not assess for personality disorder	Current prevalence one category Mood disorders 13% Psychotic disorders 10% Lifetime prevalence* Substance use disorders 36 two categories Mood and substance 26% Psychotic and substance 7% *information on current substance use disorders was not collected systematically, 'for ethical reasons'		
			Previous inpatient psychiatric contact in Victoria 48% Previous outpatient psychiatric contact in Victoria 13% majority of all these contacts was for substance abuse disorders		

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Hurley & Dunne 1991	98% of women prisoners (sentenced and remand) in women's prison in one week n= 92 1989 Brisbane	DSM-III-R General Health Questionnaire (GHQ-12) Hamilton Depression Rating Scale (HAM-D) Follow up at four months with all women still in prison (n=49)	Current (one month) prevalence at first interview: Adjustment disorder - with depressed mood 18.5% - with anxious mood 1.1% Major depressive episode 1.1% Panic disorder 1.1% Opioid withdrawal symptom 3.3% Schizophrenia, chronic paranoid type 2.2% Antisocial personality disorder 19.6% Borderline personality disorder 17.4% Schizotypal personality disorder 1.1% Dependent personality disorder 1.1% Any of the above disorders 53.3% Lifetime history of substance use disorder all prisoners 55% Lifetime history of substance use disorder in those diagnosed with current psychiatric disorder 71% GHQ-12 score of 4 + (high to severe disturbance) 43.4%	Twenty women (22%) had a history of at least one event of self harm... 10 had harmed themselves before, 6 during and 4 both before and during the current imprisonment' (p465) 13% (12) of the sample were Australian Aboriginal, no difference in GHQ or HAM-D scores between ethnic groups. At follow up Aboriginal women who had been seen by psychiatrist during imprisonment much less likely than other ethnic groups to have requested this. 36% (33) of the sample had at least one child aged 12 or less	<ul style="list-style-type: none"> Specialised alcohol and drugs services needed, with follow up after release Services acceptable to Aboriginal women needed, integrated with community Aboriginal Health Service Post-release treatment and counselling services needed, with evaluation More research on self harm needed

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
A. Wilkins & Coid 1991	All women remanded to custody over eight week period, who were found by screening at reception to have a history of self-mutilation (n=74, 7.6% of all remands during the period) plus controls selected at random from remaining pool of prisoners (n=62) London	Clinical interview for DSM-III axis I disorders Checklist for DSM-III axis II antisocial, borderline and schizotypal personality disorders Item sheet designed to elicit information on the phenomenology of self-mutilation	<p>A. No significant differences between subjects and controls in the numbers manifesting DSM-III axis I disorders in previous month. However, 84% of subjects and 16% of controls diagnosed as having one or more Axis II personality disorders.</p> <p>Other items where differences reached statistical significance were a history of:</p> <p>S C previous psychiatric admissions 70% 1% absconding or discharging self from psychiatric hospital 50% 3% alcohol abuse 62% 23% anorexic episodes 49% 0% bulimia 30% 0% bulimia nervosa 19% 0% overdose 78% 13% firesetting 34% 11% pyromania 19% 0%</p>	<p>A. 73% of subjects and 19% of controls had experienced one or more of the following in childhood: loss of parent, being in care, cruelty, incest, sexual abuse. In comparison to controls, subjects' adult psychosexual history showed 'poor adjustment in their sexual development, uncertainty in later sexual orientation and identity, failure to develop stable relationships and polymorphous perversity' (p259).</p> <p>Only significant differences in current charges were that subjects were more likely to be charged with property damage, and less likely to be charged with drugs offences. However their mean age at first court appearance was younger (S:18.2 years, C:24.3 years and they were significantly more likely to have previous convictions for</p> <p>S C arson 26% 5% property damage 55% 19% acquisitive offences 74% 58%</p>	<p>A. Hospital admissions policies have increasingly excluded people with personality disorders, and limited admissions to periods of acute illness. This group has therefore been excluded, and 'the containment of such disturbed and damaged women has now shifted from the psychiatric to the penal system' (p265) Although the prison environment may exacerbate self harm, this group within the prison population is already highly prone to self harm.</p>

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
B. Coid et al 1992			<p>B. Divides the women with a history of self mutilation into two subgroups: Cluster I was characterised by a build up of aversive affective symptoms without identifiable cause, and to which self-mutilation provided a relief (n=51). In cluster II self mutilation was provoked by external stressful events, or (in one case) by presence of auditory hallucinations, and did not in most cases provide relief of symptoms (n=23)</p> <p>No significant differences between cluster I and cluster II in the numbers manifesting DSM-III axis I disorders in previous month. However, 96% of cluster I and 57% of cluster II diagnosed as having one or more Axis II personality disorders. Cluster I were significantly younger at first hospital admission, and were significantly more likely to have a history of overdose, alcohol abuse and firesetting. They were also more likely to have an additional impulse disorder.</p>	<p>B.82 % of cluster I and 52% of cluster II had experienced one or more of the following in childhood: loss of parent, being in care, cruelty, incest, sexual abuse. There were trends for cluster I to have 'abnormal psychosexual adjustment in adulthood'; these were non-significant except for the trend towards homosexual experiences.</p> <p>Cluster I were significantly younger at first court appearance; 16.8 years against 21.5 years for cluster II, and had significantly more previous convictions in all classes of offences.</p>	<p>B. Cluster I demonstrate a close association between mood and behavioural disorder, with self injury providing symptom relief.</p> <ul style="list-style-type: none"> • Need for further research into possible affective component of borderline personality disorder. • This may open up new treatment possibilities, which might ultimately reduce the therapeutic nihilism that is currently associated with a diagnosis of personality disorder...[and] might also shift responsibility for the care of these women from the penal to the health care services'(p12).

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Robertson 1990 (using data gathered by Gibbens)	Women admitted to Holloway Prison n=210 1967	Qualitative interviews by psychiatrist (part of larger project) Home Office data at 10 year follow up (1977)	Diagnoses made by interviewer: Psychotic 6% Mood disorder 11% Alcohol abuse 4% previous inpatient treatment 19%	Author stresses heterogeneity of the women, but 'one is struck by the recurrence of certain themes, the most notable being the ill-treatment which many of these women received throughout their lives - usually at the hands of men'. (p173)	<ul style="list-style-type: none"> Apart from three first time offenders who received hospital disposals, the women diagnosed as psychotic made many court appearances before receiving hospital disposal if any. Original researcher commented that hospital treatment not always appropriate, and that 'social assistance at home to go on living as she does now' might be more useful in at least one case. (p172)

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Daniel et al 1988	100 consecutive women sentenced to prison, Classification Centre Missouri	DSM-III	<p>Six month prevalence:</p> <p>Schizophrenia 7%</p> <p>Major depression 17%</p> <p>Mania 2%</p> <p>Alcohol abuse/dependence 10%</p> <p>Drug abuse dependence* 26%</p> <p>Phobia 20%</p> <p>Panic disorder 2%</p> <p>Obsessive compulsive disorder 5%</p> <p>Antisocial personality disorder 29%</p> <p>* lifetime prevalence, figure for 6 month prevalence missing</p> <p>90% of sample received at least one lifetime diagnosis, 67% received more than one diagnosis</p> <p>Of the 29 women with antisocial personality disorder, 27 also had an Axis I disorder, mostly substance abuse/dependence or major depression</p>	<p>Race not associated with six months prevalence of depression</p>	<ul style="list-style-type: none"> • Need for comprehensive diagnostic and therapeutic services to be made available to all prisoners • Offender classification system on reception to prison should include screening and diagnosis of mental disorders

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Turner & Tofler 1986	Random sample of all women admitted to Holloway Prison over 8 month period n=708 1984-1985	Self reported history	Psychiatric history* 18% Neurological illness 3% Current drug usage 29% *Inpatient or outpatient treatment, excluding treatment for drug dependence or attendance for court reports Overlap between groups: 4 out of 5 women with a psychiatric history either selfharmmed, or used drugs or both	Previous self harm: Overdose and cutting 28% Previously cut themselves 6%	<ul style="list-style-type: none"> Need for psychiatric services in women's prison: 'given the random process of admission, the often urgent need for skilled assessment and nursing, this unit must be on-site, have a high staff to patient ratio as psychiatric acute units or medium secure units and have expertise in detoxification and withdrawal from drugs with links to outside services.' Women often admitted to Holloway because nowhere else to go; thus initiatives to alter policies of admission to psychiatric hospitals should be 'vigorously pursued' (p653)

Table 3: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Washington & Diamond 1985	Random sample of all prisoners currently in five county jails on one day, with sample of admissions during following month n = 115 women California 1975	DSM-II	<p>Prevalence across all five jails*</p> <p>Schizophrenia 7%</p> <p>Manic-Depression 0.9%</p> <p>Personality Disorders 22.6%</p> <p>Adjustment reaction 1.7%</p> <p>Depression 6.1%</p> <p>Other neurosis 4.3%</p> <p>68.8% of women given a DSM-II diagnosis and 38.8% of others reported being drug or alcohol dependent.</p> <p>*Rates varied considerable between jails. In the two most rural jails, 75% of women were given a diagnosis, but only 24.4% of women in the two most urban jails.</p>	<p>Only significant demographic differences between women with or without diagnosis was that those with a diagnosis were more likely to be under 30 and less likely to be from an ethnic minority.</p>	<ul style="list-style-type: none"> Differences between jails implies 'different communities respond to these women differently, some by use of jail and others in some other manner' (p41)

Table 4: Women offenders admitted to prison hospitals for mental health reasons

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Dolan & Mitchell 1994	Women admitted to medical wing of women's prison on three days of the week over five month study period, who were not deemed too distressed to be approached, and who agreed to take part n=50 London	Self report Personality Disorder Questionnaire	76% scored above the cutoff point on the impairment distress scale. Five most frequent categories were: Borderline 60% Paranoid 52% Antisocial 44% Histrionic 40% Schizotypal 38% 64% met criteria for more than one category		<ul style="list-style-type: none"> Our study suggests that a larger proportion of the women in Holloway C1 than currently recognised may have a personality disorder. Any treatment for women identified as suffering with PD is likely to be a long term multiagency reshaping procedure involving more than one treatment modality or service. The role of the prison service for these women should not therefore be of a treatment provider but of increased liaison with appropriate outside agencies.' (p140)

Table 4: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Birecree et al 1994	All newly admitted women offenders referred over 8 month period for clinical interview following mental health screening tests ('approximately half of all newly incarcerated women') n=86 Oregon 1990-1991	DSM-III-R	<p>Lifetime history:</p> <p>Major depression 29%</p> <p>Post-traumatic stress disorder 10%</p> <p>Adjustment disorder 22%</p> <p>Dysthymia 6%</p> <p>Bipolar disorder 1%</p> <p>Substance abuse/dependence with no other Axis I disorder 22%</p> <p>Other Axis I disorders 8%</p> <p>Anti social personality disorder 23%</p> <p>Borderline or dependent personality disorder 3%</p> <p>Any substance abuse or dependence 91%</p>	<p>81% were parents, with 42% having their children in care, at least temporarily</p> <p>31% previous suicide attempts</p> <p>47% history of physical abuse</p> <p>45% history of sexual abuse</p>	<ul style="list-style-type: none"> • suggest low level of psychotic disorders due to earlier diversion under insanity defense • need for structured substance use programmes • while screening needs refinement, 'we support the use of standardized testing to objectively screen categories of concern and diagnoses', augmented by clinical interview (p228-9) • 'need for the development of an array of psychiatric services in prison' (p229)

Table 4: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Dell et al 1993a Dell et al 1993b	Newly remanded women prisoners admitted to the prison medical unit 'whose condition caused, or showed need to cause, some psychiatric intervention in the remand process' (1993a, p634) n=196 receptions (176 individuals) Holloway prison 1989	ICD-9	<p>Whole sample is split into those diagnosed 'psychotic' (n=95), and 'not psychotic' (n=101) by psychiatrists working in the prison.</p> <p>Psychotic population: schizophrenia 42% affective psychosis 12% paranoid state 6% other 10%</p> <p>no specific diagnosis ('likely that most were schizophrenia') 31%</p> <p>Non-psychotic population: drug dependence 30% personality disorder 29% mental handicap 19% organic conditions 4% depression 3% alcoholism 3% no disorder 3% other 10%</p>	<p>26% of psychotic group and 10% of non-psychotic group were 'West Indian'.</p> <p>19% of whole sample were referred to the medical unit because considered a suicide risk</p> <p>43% had been living in squats, bed and breakfast accommodation, hostels etc</p>	<ul style="list-style-type: none"> • Authors felt that quality of psychiatric service provided by what were effectively 'contracted in' NHS psychiatrists was good and endorse this model, but stress need for experienced experts who have long term commitment • Remand had been used by the courts as a way to try to ensure psychiatric help, for both psychotic and non-psychotic women. • Delays in admission for those who were eventually admitted to hospitals bore heavy costs for the women, and for all agencies involved. More use could be made of s48 of MHA 1983. For those not admitted, courts were unable to make arrangements for community based services • Demonstrates need for diversion at early stage, for which need 'development of effective liaison, based on appropriate financial structures' between agencies.

Table 4: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Lamb & Grant 1983	Random sample from those inmates of a county jail for women who had been referred by jail staff for psychiatric evaluation. n=101 Los Angeles	DSM-III Excluded those whose primary problem was alcoholism, drug addiction or developmental disability	schizophrenia 59% major affective disorder 35% adjustment disorder 3% dysthymic disorder 2% antisocial personality disorder 2% previous psychiatric hospitalisation 86% Evaluation resulted in recommendation for involuntary hospitalisation for 54% of sample	65% were from ethnic minorities, including 56% who were black 68% had children, the majority of whom were in care	<ul style="list-style-type: none"> Need for more provision within legislation for compulsion to use mental health services

Table 5: Women offenders referred for psychiatric evaluations

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Aderbigbe et al 1996	All female defendants referred for psychiatric evaluation to forensic psychiatry unit of General Hospital over 10 year period n=222 1982-1991 Calgary	Case notes Data from Department of the Attorney General DSM-III, one category from each of Axis I and Axis II allowed	Diagnoses: Axis I Schizophrenia 22.5% Major affective disorder 23.9% Substance misuse disorder 17.1% Mental retardation...5.0% Others...15.8% No I/Axis I diagnosis 15.8% Axis II Borderline personality disorder 7.2% Antisocial personality disorder 8.6% other personality disorder 10.8% Abnormal personality traits 5.9% No Axis II diagnosis 67.6%	16% reported physical abuse 18% reported sexual abuse 18% had spent time in group homes or foster homes and reformatory institutions before the age of 18 Offences with which charged: Against persons 21% Against property 44% Others 35%	
Offen 1986	All white females referred to forensic unit of psychiatric hospital for pre-trial psychiatric evaluation over 42 year period, plus matched controls of 'coloured'* women admitted over same period n=164 1942-1984 Cape Town *women of mixed heritage as defined under South African law at the time	case notes	Psychiatric diagnoses Schizophrenia 22% Affective psychosis 6% Alcoholic 7% Organic brain syndrome 1% mental retardation 12% Significant psychiatric symptoms, but not enough to warrant label of mental illness 34% No psychiatric abnormality 18% 'Abuse alcohol' 35% 'Abuse dagga' (cannabis) 19% In spite of construction of sample, limited data given by ethnic group. 'Coloured' women more likely to be diagnosed as suffering from recognised psychiatric illness and to have previous psychiatric history. More white women diagnosed as alcoholics	17.3% have been 'maltreated' - no further definition Offences with which charged: Against persons 20.8% Against property 77.6% (inc arson...1.9%) Drugs offences 7.4% Prostitution 2.7% Others 11.7% Following evaluation, 65.4% were sent for trial. White women more likely to be sent for trial	Authors comment that the large number of women who were returned for trial may suggest referral was being used inappropriately; many of the women came from 'disturbed family backgrounds' suggest referral used as possible solution to social problems.

Table 5: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
<p>A. Daniel et al 1981 B. Daniel & Harris 1981 (data also reported in Daniel & Harris 1982)</p>	<p>All women admitted to a large state hospital for pre-trial psychiatric evaluation over five year period n=66 1974-1979 Missouri</p>	<p>Clinical interview Case notes from court DSM-II</p>	<p>A. Main diagnosis for all women B. Data broken down by age: women under 40 (n=48), and women 40 or over (18) A. B. women <40 women >40 Schizophrenia 22.7% 20.8% 27.7% Affective disorder 9.0% 0.0% 33.3% Antisocial personality disorder 28.8% 39.6% 0.0% Alcoholism 7.6% 0.0% 27.7% Neurosis 3.0% 4.2% 0.0% Mental retardation 12.5% 11.1% 12.1% Organic brain syndrome with psychosis 7.6% 10.4% 0.0% No mental disorder 9.0% 12.5% 0.0%</p>	<p>A. Ethnic group: black 25.8% white 74.2% B. No difference between the two age groups on race A. Index offences Crimes against the person 51.5% (inc homicide 33.3%) Crimes against property 42.4% Other 6.0% B. No difference between the two age groups on index offence categories, but 60% of younger women had offended before, against 22% of older women</p>	<p>• B. Identified two distinct groups. Women under 40 had longer criminal history, and were more likely to be diagnosed with personality disorder. Older women more likely to be first time offenders, and more likely to be diagnosed with depression or alcoholism. Suggest all mid life women offenders should be given a thorough physical and psychiatric evaluation</p>

Table 6: Secure hospital populations

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Liebling et al 1997	75% of all women patients in Ashworth Hospital n=40	semi-structured interview - the focus of the research study was self harm	MHA 1983 classifications* personality disorder 67% mental illness 21% learning disabilities 7% combination of categories 5% *These classifications were the focus, in our opinion, of women's misdirected treatment' (p429)	'All had self harmed at some point in their lives' (p429) 'The majority of women first self harmed prior to their early teens. Sexual, physical and psychological abuse were common and self-harming was cited as a way of coping with these experiences.' (p431) 50% linked current self harm directly to being in Ashworth. 'Self-harm has many positive functions. It has evolved as a means of coping with severe distress due to women's very painful life experiences...it has enabled women to cope with abusive situations and to cope with the extreme pressures of being in a special hospital' (p434) 5% had no index offence 48% had an index offence of arson	<ul style="list-style-type: none"> Women had insight into their own behaviour and needs, most had ways of stopping themselves self harming and views on how staff could help, but found staff responses to self harm unhelpful and punitive. Unrealistic goals in relation to stopping self harm were set with no discussion with the women; such goals need to be negotiated. Staff need training and support but it is difficult to see how training and support would be effective in a patriarchal, medically dominated and oppressive regime...Positive ways forward would be to involve women themselves in training staff and accessing more appropriate empowering services, for example the Bristol Crisis Service' (p434-435) Comment on the mixed ward at Ashworth that 'lack of recognition of the effects of mixing this group of women with male patients, often sex offenders, is appalling' (p435). Need for 'real choice' of segregated services. Therapeutic communities for women needed.

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Huws et al 1997	All patients transferred from prison to special hospital under s47 MHA 1983 n=42 women 1984-1991 England & Wales	Case notes	Not given by sex		<ul style="list-style-type: none"> • Women 12% of s47 transfers • There was no difference between s47 transfers and other admissions in terms of sex, age, legal category or ethnic origin' (p77)
Rasmussen & Levander 1996	All patients admitted to maximum security psychiatric unit over period of 52 months n =7 women Norway 1987-1993	Case records as source of data DSM-III-R PCL-R	Categories assigned: Schizophrenic disorders 28.6% Non specific psychotic disorders 14.3% Non-psychotic disorders 14.3% Borderline personality disorder 57.1%	4 women (57%) had a history of self-harm 3 women (42.9%) considered a suicide risk	
Murray 1996	All patients in NHS medium secure units on census day n=93 women England & Wales	Case notes	Not given by sex	Ethnic group Caucasian: 86% Afro-Caribbean 12.9% Asian...1.1%	<ul style="list-style-type: none"> • Women were 17% of all MSU patients. In one unit the ratio was 2:1 male to female, but in most the ratio was 4:1 or higher. • Only 11% of first admissions and 12.5% of all patients were NHS transfers, majority were from remand prisons. Pressure from prisons means current bed numbers insufficient to meet needs of special hospital patients for transfer, or for civil patients requiring higher levels of security.

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Milne et al 1995	All patients admitted to a regional secure unit over 12 year period n=44 women 1980-1992 England	Case records DSM-III-R	<p>Primary diagnoses:</p> <p>Schizophrenia 29.6%</p> <p>Organic psychosis 6.8%</p> <p>Other psychosis 2.3%</p> <p>Affective disorders 25.0%</p> <p>Personality disorders 25.0%</p> <p>Mental handicap 9.0%</p> <p>No diagnosis 2.3%</p>	<p>'identified as having significant problems with drug or alcohol abuse' 18.2%</p> <p>'had no prosecuted offence associated with admission' 45.5%</p> <p>index offence of arson 25%</p>	<ul style="list-style-type: none"> Patterns of admissions and discharges show that women were 1.9 times as likely as men to be admitted from NHS hospitals, and 2.7 times as likely to be transferred on to maximum security hospitals; 'overall there was a net movement of 19 male patients out of special hospitals and a net movement of three females into special hospitals' (p59) Hypothesize that these patterns could be due to: <ul style="list-style-type: none"> different admissions policies, with a higher threshold for admitting women to secure care; different staff reactions to women's violence as inpatients; or the unit being less therapeutic for women
Wong et al 1995	All patients aged over 60 in a special hospital n=9 women 1992 England	Case notes	<p>Diagnoses:</p> <p>Organic syndrome 11.1%</p> <p>Schizophrenia 44.4%</p> <p>Schizoaffective psychosis 22.2%</p> <p>Affective disorder 11.1%</p> <p>Paranoid disorder 11.1%</p>	<p>8 women were admitted following homicide, 1 following wounding with intent. 7 of the women were under 50 at the time, 5 of these had one single incidence of violence, rather than being repeat offenders</p>	<ul style="list-style-type: none"> Patients over 60 make up 10% of the special hospital population: 'Most of these elderly offenders (75%) were admitted in their 20s or 30s and were detained into old age because of the seriousness of their offence. This is particularly true for the females' (p323)

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
A. Coid 1992	A. All women patients detained in maximum security hospitals under MHA 1983 category 'psychopathic disorder' n=89 1984-1986 England	DIS SCID Hare's 22 item Psychopathy Scale Item sheet for family history etc	97% of the women met the criteria for one or more DSM-III AxisII categories, with a mean of 3.7 categories. The most frequent categories (assigned to at least a third of the women) were: Borderline 91% Antisocial 44% Narcissitic 37% Paranoid 46% Avoidant...36% 97% of the women met the criteria for one or more lifetime DSM-III Axis I disorders, with a mean of 3.7disorders. The most frequent disorders (assigned to at least a third of the women) were: Depression 65% Alcoholism/abuse 39% Dru dependence/abuse 39% Unspecified psychosis 34% Phobia 43% Hare 22-item psychopathy score low (<24) 28% medium(24-32) 41% high(>32) 31%	History of self-mutilation 91% History of overdose 80% 24% of the women had children 5% were 'non-white' 28% had experienced sexual abuse by a family member Index offences: Murder/manslaughter 12% Attempted murder, GBH 17% Assaults, threats, weapons 16% Robbery 1% Firearms 1% Arson 51% Property damage 15% Burglary,theft 5% Blackmail 1% None (s3 patients) 5%	<ul style="list-style-type: none"> • Comparisons with men held under category of psychopathic` disorder in one special hospital, and men held in prison special units for the management of dangerous and disruptive prisoners showed that the women had similar features to both male samples. The men in the prison sample had higher levels of psychopathy than the men in the special hospital sample. 58% of the men in prison units had either been admitted to a special hospital and then returned to prison, or had been assessed and turned down for admission. Women's prisons had no similar units, and so 'any women posing persistent problems had been sent to a special hospital' (p80).

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
B. Coid 1993		<p>B. Those in the above who met at least five of the DSM-III criteria for borderline personality disorder, including criterion of 'affective instability', who also scored at least 6 on the Diagnostic Interview for Borderlines, and who were not suffering from symptoms of schizophrenia, mania or depressive disorder at the time of the interview. n=72</p>	<p>B. Item sheet to elicit form and symptom content of the mood disorder</p>	<p>B. The women were selected for mood instability. They described a repetitive pattern of severe and debilitating symptoms of anxiety, anger depression and tension. These symptoms built up and led to a compulsive urge to act out, in the form of self-mutilation, assaultiveness, appetite disturbance or firesetting. Acting out brought relief of symptoms. For most of them these mood disturbances had started in late childhood or early adolescence, and reached a peak in their mid 20s, leading to psychiatric admissions, involvement with the criminal justice system and poor social relationships. They were labelled as having borderline personality disorders and the majority had been admitted to special hospital in their mid 20s. For many, an improvement began in their mid 30s.</p>	<p>B.</p> <ul style="list-style-type: none"> • The mood disorder the women described 'amounts to an affective disorder in its own right' (p647) • 'The self reports of these women were pessimistic about the effectiveness of current psychiatric treatments for their described affective syndrome' (p649) • 'A radical shift in emphasis from attempting to change core personality features to the treatment of affective symptoms could lead to future developments in this area' (p649)

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
O'Connor & O'Neill 1991	All women transferred from prison to special hospital n=99 1983-1988 Dublin	Hospital registers and casenotes ICD-9	Primary diagnoses: Schizophrenia 11% Mania 8% Depression/stress 22% Personality disorders* 34% Mental handicap 2% Drug abuse** 18% Other 4% 'The vast majority of personality disorders were anti-social personality disorders' ** 'The majority of those with a primary diagnosis of drug abuse also had a diagnosis of personality disorder'	67% of women were sentenced or remanded for a property offence, only 19% for offences against the person, none of which was homicide. Most of those diagnosed with schizophrenia or mania were remand prisoners, compared to less than one in five of those in other categories. 86% were transferred back to prison on discharge. The remainder were discharged to non secure services.	<ul style="list-style-type: none"> Most did not need security of special hospital, and could have been treated effectively in their local catchment area hospitals, but Irish mental health law makes this difficult. Readmissions tended to be those with personality disorders. The Hospital will take these prisoners in times of crisis such as depressive episodes or suicidal feelings. These crises tend to pass quickly and the person requests return to prison'. Comment that these transfers between prison and hospital are easier under Irish law than would be in the UK
Strick 1989	First 100 admissions to new forensic psychiatric facility for women n=81 1984-1987 Pennsylvania	Case notes ICD-9 and DSM-III	Diagnoses as recorded in casenotes: Schizophrenia 39.5% Bipolar-manic 17.3% Other psychoses 13.6 Non-psychotic depression 7.4% Organic disorder 7.4% Personality disorder (majority 'mixed') 70.4% Other... 7.4%	Ethnic group: white 56% black 43% hispanic 1% 56% of offences were against a person, 20% of which were against children. All defendants involved in crimes against children were actively psychotic on admission.	<ul style="list-style-type: none"> Extent of overlap between psychotic illness and personality disorder Only 7% were discharged from the facility to the community. 69% returned to criminal justice system, 24% to other psychiatric hospitals for ongoing treatment. Need for services for women while in jail and after return to community, whether from jail or hospital.

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Brownstone & Swaminath 1989	All women referred to a medium secure facility over 5 year period n=91 1981-1985 Ontario	Case notes ICD-9	Primary psychiatric diagnoses: Psychoses 42.9% Manic depressive psychosis 8.8% Personality disorder 38.5% Substance abuse* 4.4% Mental retardation 3.3% Adjustment disorder 2.2% *47.3% had abused alcohol, drugs or both previous psychiatric admission 72.6%	'Offenders less than 30 were more likely to be personality disordered and those older than 30 were more likely to be psychotic...W found no difference between the younger and older offenders in respect of violent versus non-violent crime' (p192) 16.5% were charged with or convicted of homicide, 37.3% with other violent crimes, and 14.3% with arson	<ul style="list-style-type: none"> Comment on the need for research into experience of physical and sexual abuse as a child, family psychiatric and criminal history and early loss of a parent
Steadman et al 1988	All admissions to inpatient psychiatric services as a mentally disordered offender in one year (estimated 31773 pa) 1980 USA	Surveys of all inpatient facilities	Overall, women constitute 15.1% of admissions as mentally disordered offender		<ul style="list-style-type: none"> Women comprise 4.3% of the state/federal prison population and 7.1% of the county jail population, so are overrepresented in admissions as mentally disordered offenders
Gudjonsson & MacKeith 1983	First 23 patients admitted to a regional secure unit n= 7 women 1980-1981 England		Primary and secondary diagnoses Personality disorder 57.1% Schizophrenia 57.1% Affective disorder 14.3% Mental Handicap 28.5%	2 women had 'self-destructive behaviour' listed as a presenting problem. Both were diagnosed as having a personality disorder and had been transferred from a special hospital	

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Higgins 1981	First 35 admissions (of 67 referrals) to an interim secure unit n=14 women (21 referred) England		Diagnosis of women admitted (referred): Schizophrenia 57.1% (42.4%) Personality disorder 21.4% (38.1%) Personality disorder/schizophrenia 7.1% (4.8%) Affective psychosis 7.1% (9.5%) Epilepsy/personality disorder 7.1% (4.8%)	Behaviour leading to the admission: Homicide 35.7% Other violence 42.9% Arson 21.4%	<ul style="list-style-type: none"> A higher proportion of women referred were accepted, although had been responsible for the most serious acts and were 'the most difficult to manage'
Baridon & Rosner 1981	All women patients in maximum security facility over 15 month period n=72 1977-1978 Washington DC	Hospital records, FBI and police records	Schizophrenia 71% 'mixture of character disorders' 19% 'Most of the women used at least one drug and more than 26% were polydrug users', who 'were more likely to be diagnosed as having character disorders than schizophrenia'.	72% of women were black, 28% white -same distribution as within city as a whole. 63% had at least one child 'early first institutionalisation {[prison or hospital] was a good predictor of violent behavior' (p52)	

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Brooks & Mitchell 1975	All female admissions to maximum security hospital over 15 year period n=66 1959-1973 Scotland	Hospital records	<p>Primary diagnosis:</p> <p>Mental subnormality 29.2%</p> <p>Personality disorder 41.5%</p> <p>Schizophrenia 20.0%</p> <p>Affective psychosis 4.6%</p> <p>Organic psychosis 1.5%</p> <p>Neurotic illness 4.6%</p> <p>Alcohol abuse 24.6%</p> <p>2 or more previous psychiatric admissions 63.1%</p>	History of self injury 67.7%	<p>Study identified two broad groups: those coming from other hospitals because of violence in hospital (some of whom may have convictions). This group were younger, and predominantly diagnosed as having mental subnormality or personality disorder; and those admitted from the criminal justice system following conviction for single acts of violence. This group were predominantly diagnosed as having schizophrenia or a personality disorder</p> <ul style="list-style-type: none"> • Authors question whether these groups should be treated together, as they have different needs • Suggest second group could mainly be treated in local secure units (just being developed at time). • For first group, the hospital provides 'asylum and respite' in crises.

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Dolan & Bland, 1996	87 women in Broadmoor	Case note survey April-June 1994	<p>63.2% had history of psychiatric problems</p> <p>38% alcohol abuse problems 37% drug abuse 17% eating disorder</p> <p>Under MHA 1983 classifications: 28.7% psychopathic disorder 63.2% mental illness 8% both categories</p> <p>Diagnosis: 63.2% have mental illness including 46% with paranoid schizophrenia, 12.6% schizoaffective disorder, 28.7% personality disorder w/o mental illness</p>	<p>Age range 22 -88, mean 39.24</p> <p>Ethnicity 84% white, 14 black, 2% mixed race</p> <p>Early disturbance: 70% problems at school, 57.5% - diagnosed with conduct disorder in childhood</p> <p>55.2% admitted from custody, 42.5% from psychiatric hospital</p> <p>72.4% no educational qualifications</p> <p>26.4% borderline learning disability</p> <p>42.5% clear history of sexual abuse + further 25.3% likely history of abuse</p> <p>84% self-harm</p> <p>Forensic history: 79.3% assault 47.1% arson 37% theft 21% have killed</p>	<p>treatment issues difficult to address due to lack of information and consensus over diagnosis</p> <p>recommend increased funding for psychotherapeutic input, particularly for personality disorder</p>
Chipchase & Liebling 1996	53 women in Ashworth Special Hospital in past 2 years	Case notes, focus of study was self-harm	<p>94% had self-harmed at some point, 62% were self-harming at time of research</p>	<p>19% poor in childhood, 17% from large families (over 6 siblings)</p>	<p>lack of adequate provision for women</p> <p>lack of facilities for progression</p> <p>Mixed sex model created particular difficulties for women</p>

Table 6: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Maden et al, 1995	20% Sample - 55 women in special hospitals	Casenotes, semi-structured interview with patients and consultant + Nursing Observation rating scale	Psychiatric diagnosis: 67% psychosis 35% personality disorder 36% mental handicap 6% organic disorder	64% self-harm 42% admitted from prison 45% from psychiatric hospital	Research team tended to rate women as needing lower level of security both now and in future

Table 7: Women who have received a mental health related adjudication such as not guilty by reason of insanity, or guilty but mentally ill

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Sieg et al 1995	All women admitted to secure psychiatric facility as not guilty by reason of insanity (NGRI) (pre 1983) or not guilty by reason of impaired mental condition (post 1983) over 10 year period n=37 1978-1988 Colorado	DSM-III, up to 3 diagnoses allowed	Psychotic disorder 70% Mood disorder (non psychotic) 27% Borderline personality disorder 19% Antisocial personality disorder 3% Substance abuse/dependence 16% problems with alcohol and/or drugs 49%	History of suicide attempts 49% Ethnic groups: caucasian 51% minority ethnic group 49% Offences for which found NGRI: Murder 43% Attempted murder 11% Assault 19% Arson 11% Robbery 3% Other 14%	<ul style="list-style-type: none"> Comparison with men found NGRI in same period showed women more likely to be diagnosed with mood disorder or borderline personality disorder. Women had on average been acquitted of more serious offences than the men.

Table 7: continued

Study	Size and setting, date(s) of fieldwork	Classification system used and source of data	Information on mental health of women studied	Other data e.g. family, abuse, self harm, ethnicity	Implications for service delivery drawn by authors of study
Zonana et al 1990	All women found NGRI in Connecticut over 16 year period n=31 1970-1986 Connecticut	Case records DSM-III, one diagnosis only	Schizophrenia 55% Affective disorder 16% Organic disorder 3% Personality disorder 13% Substance abuse 3% Retardation 3% Miscellaneous 6% problems with alcohol and/or drugs 32%	Ethnic groups: white 58% minority ethnic group 42% Offences for which found NGRI: Manslaughter* 32% Assault 36% Arson 10% Burglary/larceny 10% Other 13% * all the victims were spouses/partners or other family members.	<ul style="list-style-type: none"> In comparison with 31 male acquittals matched for date of verdict, women were older, more likely to be married, less likely to be substance abusers and had lower prior and subsequent arrest rates Women were more likely to be diagnosed psychotic than men For both men and women, differences between those diagnosed psychotic and those non-psychotic. Those diagnosed non-psychotic accounted for the majority of prior arrests and re arrests
Morgan et al 1988	All of the first 45 prisoners (7 women) found Guilty But Mentally Ill in South Carolina, who were still in custody at time of study (21 months after introduction of law). n=4 women	Interviews and case notes DSM-III	Schizophrenia 75% Post-traumatic stress disorder 25%	Offences for which found GBMI Murder 25% Manslaughter 50% Assault and battery 25%	<ul style="list-style-type: none"> While men found GBMI are held in a maximum security psychiatric centre for evaluation and treatment until deemed fit for transfer, there is no such service or evaluation for women

Table 8: Effects studies

Study	Sample size, setting, date(s)	Source of data	Outcome measure	Results
Brooks & Mitchell 1975	All women discharged from Scottish Special Hospital 1959-1973, followed up end 1973. n=33	Case records of hospitals and prisons	Subjective rating of 'good' or 'poor' progress, based on subsequent psychiatric condition, behaviour in and out of hospital/prison, work record, further court appearances, hospital re-admissions	Good progress 14 Poor progress 18 Not traced (escaped) 1 Outcome not related to length of stay

APPENDIX B: REFERENCES

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APPENDIX C: PROTOCOL

1. Objectives

- 1.1 to describe systematically models for the delivery of secure psychiatric services to women, in the UK and abroad
- 1.2. to identify problems associated with existing models
- 1.3 to identify alternative service models proposed
- 1.4 to examine the evidence for effectiveness and efficiency of different service delivery models
- 1.5 to identify gaps in existing knowledge about the effects of different service models
- 1.6 to recommend key areas for future research

2. Background

- 2.1. Services to provide psychiatric intervention within conditions of security exist in most developed countries. The need for such services arises out of the perceived link between mental illness or mental disorder and behaviour which is harmful or dangerous to others or self to the extent that an individual must have their liberty restricted. Such services may be closely linked to the criminal justice system of a given society, and will have a basis in statute defining the powers of society's representatives to limit freedom, and the individual's rights against those powers. In England and Wales that statutory basis is the Mental Health Act 1983.
- 2.2. Secure psychiatric services in England and Wales are arranged in broadly three tiers; the three 'special' or high security hospitals, the medium or regional secure units, and low secure units which may be wards within general hospitals with higher levels of security than the open wards. Medium secure provision has been expanded rapidly over the last few years, from 600 places in 1991 to 1029 by the end of 1996, with a target of 1250 purpose-built places by the end of 1998. Such developments are a priority for the NHS, and the overall target is for 2400 secure psychiatric places by the end of 1998¹, including places purchased from the independent sector.
- 2.3. The term 'mentally disordered offenders' has become common in the UK to describe people with mental illness or disorder who become involved in the criminal justice system, many of whom will spend some time in secure psychiatric conditions. However, not all patients in secure psychiatric services are 'offenders' who have arrived there from the criminal justice system. Civil patients may also be moved into the secure services if assessed as dangerous or as needing to be contained for their own safety.

¹ NHS Executive (1996) NHS Annual Report 1995/6

- 2.4. Similarly many offenders with mental health problems will not be diverted or transferred from the criminal justice system into the psychiatric system, either because they are not ill enough to warrant such diversion under the Mental Health Act or because there is no place for them. Psychiatric care is, therefore, provided within the prison system, by both the Prison Healthcare Service and by NHS providers on an outpatient basis.
- 2.5. For these reasons, and because other models of provision may make a distinction between people who have been convicted of offences and those who have not, this review will encompass the provision of psychiatric services in conditions of security, whether to 'offender-patients' or civil patients. Conditions of security will refer to a range of settings; high security or maximum security hospitals, medium secure and low secure provision, and prisons, as well as, potentially, community based facilities where security is provided by some means other than physical containment.
- 2.6. An issue of major concern in the planning and provision of secure psychiatric services is that of how to meet the specific needs of women effectively. Women form a minority among those receiving psychiatric care in medium and high security settings, and there is concern that they are being cared for inappropriately in services designed primarily to meet the needs of men². In the special hospitals, provision is segregated (except for one ward in Ashworth Hospital), but in the medium secure sector, provision is mixed (except for one unit about to open in Chesterfield³). A large proportion of women in secure care have histories of abuse by men, and the placing of such vulnerable women in mixed settings may be particularly inappropriate. Women also form a minority of all prisoners and some of the issues of appropriateness apply to the prison system, for example the distance many women in the system are held from their family home and particularly their children.
- 2.7. Women in secure psychiatric services have a different pattern of diagnosis to men; in particular they are more likely to be diagnosed as having a personality disorder than are their male counterparts. This is especially true in the medium secure services, where 29% of women and only 9% of men were so diagnosed in 1994, and patients are predominantly male and diagnosed with a psychotic disorder⁴. They are also much less likely to have entered the secure psychiatric system from the criminal justice system: 44% of women and 16% of men in the special hospitals are under civil sections of the Mental Health Act, rather than those sections which relate to criminal justice.⁵

2 Special Hospital Service Authority, Strategy for women requiring secure psychiatric services

3 Liz Marne, Director, Women in Secure Hospitals, personal communication

4 Murray, K 'The use of beds in medium secure units in England', *Journal of Forensic Psychiatry*, (1996), 7, 3, 504-524

5 Maden, A Curle, C. Meux, C Burrow, S and Gunn, J 'The treatment and security needs of patients in special hospitals' *Criminal Behaviour and Mental Health*, (1993) 3, 290-306

- 2.8. The Special Hospitals Services Authority *Strategy for women requiring secure psychiatric services* reports that in 1994 nearly four fifths of women in the special hospitals had been assessed as not requiring high security settings, and two fifths did had been assessed as not requiring medium security. Nearly half of all women in the special hospitals were non-restricted. Two thirds of women in medium secure settings had been assessed as needing low rather than medium secure care. These figures demonstrate the extent to which women in the secure psychiatric services are being treated in conditions of higher security than is necessary.
- 2.9. Movement within the secure psychiatric system is difficult generally because of the level of demand placed on the existing resources of the medium secure services by remand prisons⁶. Since the Reed Report in 1992⁷, much effort has gone into identifying people with mental health needs within the criminal justice system and diverting or transferring them into the hospital system. However, even with the expansion of medium secure provision described above, this has resulted in difficulties for the movement of people down the levels of security. Even when people have been assessed as suitable for lower level of security they may wait for long periods, even years, before a place becomes available to them.
- 2.10. Two changes in the broader context of mental health care are of relevance to a discussion of secure services. The first of these is the general shift away from large scale provision of longterm inpatient care towards the maintenance of people with mental illness in the community, with inpatient care focused on assessment and treatment of particular episodes of ill health. This increases the importance of effective integration between the secure system and community based provision. It also raises the question of whether and how the philosophy of community care could be applied to secure services.
- 2.11. The second is the development of the mental health users' movement, and the significance now given in policy to issues of advocacy and empowerment. While services must be evaluated in clinical terms, there is also a framework of civil and human rights which can be drawn on.
- 2.12. The Special Hospitals Services Authority *Strategy for women requiring secure psychiatric services* proposes a specialist service for women, and outlines key principles and service requirements of such a service. There is a need to bring together from across a range of disciplines the literature which can inform planning and implementation of such a strategy, and this review aims to do this.

6 Murray,K 'The use of beds in medium secure units in England', *Journal of Forensic Psychiatry*, (1996), 7, 3, 504-524

7 Department of Health/Home Office Review of health and social services for mentally disordered offenders and others requiring similar services, Cm 2088 (1992), London:HMSO

3. Questions to be addressed

- 3.1. The organisation of the review will fall into two parts. The whole review will be conducted in an explicit and structured fashion, but the methodology of the two parts will vary because of the different nature of the objectives.
- 3.2. The objectives of the first part will be:
 - a. the systematic description of service models in the UK and abroad, and of the populations deemed to require secure care
 - b. the identification of problems associated with existing models
 - c. the identification of alternative service modelsThe objectives of the second part will be:
 - d. the examination of the evidence for effectiveness and efficiency of different service models
 - e. the identification of gaps in existing knowledge on the effects of different service models
 - f. the recommendation of key areas for future research
- 3.3. The literature will be searched for accounts of how secure psychiatric services for women are provided or proposed to be provided in the UK and abroad. Initial searches of the literature suggest that there is very little which is specifically about existing services for women, which may indicate the nature of the problems associated with existing provision. Alongside published refereed articles, it will also be useful to obtain 'grey literature' such as policy documents, guidance, consultation papers and important unpublished reports. As well as searching the SIGLE database, we will obtain grey literature by writing to relevant government departments and non-governmental organisations.
- 3.4. Descriptive studies of *service models* will be looked for which provide a range of information about the ways such provision can differ, what problems are associated with different models, and how these are addressed in different ways. Service models will encompass both whole systems, and specific services which form part of a system. As well as aspects of the internal organisation of services, information will be sought on the routes into secure care, the links services maintain with other agencies, and the way they enable (or not) women to maintain links with family, friends and community. Studies written by women who have experienced secure psychiatric care will be sought. Studies of service models will be assessed on factors such as their source, ie who wrote them, where they were published, how recent they are. A strong example would be a refereed article critically analysing a service model or the report of an independent evaluatory body (eg the equivalent of the Audit Commission in the UK), while a weak example would be a purely descriptive or anecdotal paper written from within a given service.
- 3.5. Descriptive studies of *populations* of women deemed to require secure psychiatric care will be searched for. Of interest is how women are defined as needing secure care and what patterns of mental illhealth and other difficulties they experience. Information on ethnic background and sexuality will also be looked for.

3.6. Identified studies of *effects* will be assessed for validity and quality, based on factors such as study design, sample size and attrition, and conduct. It is anticipated that there will be few randomised controlled trials, and that the majority of outcome studies will be observational studies, often retrospective.

3.7 We have defined three sets of research questions addressing:

- a. different service models for providing psychiatric care in conditions of security
- b. information about populations of women deemed to need psychiatric care in conditions of security
- c. evidence for effectiveness of different service models.

3.7.1 Service models

- a. What are the routes into and out of forms of secure care for women?
- b. How are women allocated to different levels of security, and to what extent, if any, are services tailored to individual need?
- c. What are the dimensions along which service models can differ? eg:
What information is there about institutional versus domestic settings?
What information is there about single gender versus integrated services?
What diagnostic groups are managed in what settings?
- d. What information is there about staff to patient ratios and different treatment regimes?
- e. How, if at all, do services maintain links with the criminal justice system and with other health and social services?
- f. How are women's relationships with their children and families facilitated?
- g. Are there specific issues of discrimination and oppression, in terms of ethnicity and sexuality for example, and if so, how are these addressed?
- h. Describe the training, education and support of staff in services.
- i. What problems or advantages are attributed to different service models?

3.7.2 Populations

- a. How have women been defined into populations requiring secure care, ie how assessed?
- b. What do we know about the patterns of mental disorder and mental ill health among women needing secure psychiatric services?

Are these patterns the same in the UK as elsewhere?

What other difficulties do women with mental disorders that warrant treatment in a secure setting experience in their lives (abuse, drug misuse, deprivation etc.)?

- d. What are the critical characteristics of groups of women, relevant to service delivery? eg What do we know about the ethnic background of women in secure psychiatric settings, or their sexuality?
- f. Are there women who have been assessed as not needing the level of security they are currently experiencing?
How are they so assessed?

3.7.3 Effects

- a. What evidence is there about the relative effects of different interventions/regimes on a variety of aspects of life for this group of women?
- b. What evidence is there about the relative effects of different types of staff?
- c. Where are the gaps in our knowledge about effects?
Aspects of life of interest would relate to:
 - self harm
 - harm to others
 - mental health
 - social functioning
 - offending behaviour

4. Principle Sources Of Information

4.1 Database searches

1. The following databases will be searched (for search strategies see Appendix A):

Medline

Embase

Psychlit

Sociofile

Cochrane Library

SIGLE

Mental Health Abstracts

- 4.1.2. A search of the database of Merseyside Probation Service Library and Information Service was carried out on 'mentally disordered offenders', May 1997, courtesy of CRD.

4.2 Other sources

- 4.2.1. Calls for information: Calls for information to be sent to government departments, professional organisations, relevant agencies and key researchers and authors (see details in Appendix B)
- 4.2.2. Published reference lists: References from papers found through searches and bibliographies of key texts (see Appendix C for texts consulted)

5. Study Inclusion Criteria

- 5.1 The review will consider both published and unpublished work and will not be restricted to the English language. Such work will meet the following criteria:

5.2.1 Descriptive studies, service model

Studies of services for people who have been assessed as needing psychiatric care in conditions of security. Services may be whole systems or specific parts of a system, but must provide for women.

5.2.2 Descriptive studies, populations

Studies of populations held in conditions of security. The studies will examine mental health and a range of other characteristics. The populations studied must be either women only or include women. Where the population is mixed, a useful amount of data must be given about women separately. Where data are given about the equivalent male population these will also be extracted, as will data about mixed populations.

5.2.3 Effectiveness studies

We anticipate that there will be few outcome studies in this area. An initial mapping exercise will include all studies which provide information on short, medium or longterm outcomes of interventions/regimes in services for women assessed as needing psychiatric care in conditions of security. A further set of criteria will then be applied to identify studies with stronger research designs.

- 5.3 Judgements about inclusion will be made by two independent reviewers. Disagreements will be resolved by discussion between assessors, and reference where necessary to a third member of the team.
- 5.4 Issues regarding quality of design will be dealt with at the level of data extraction and analysis.
- 5.5 Summary tables of inclusion/exclusion criteria

Papers meeting all of the criteria below for their study type will be included

Descriptive Studies, Service Models

Criteria	Include	Exclude
1. Study published during or after 1972	yes	no
2. Study describes service involving conditions of security	yes	no
3. Study describes psychiatric service	yes	no
4. Study describes service which includes women (may be women only)	yes	no
5. Study discusses either a system or part of a system		

Descriptive Studies, Populations

Criteria	Include	Exclude
Study published during or after 1972	yes	no
Study of people in conditions of security	yes	no
Study includes data on mental health	yes	no
Only data specific to women given is proportion of total population studied	no	yes
Data specific to women given, beyond simply proportion of total population studied	yes	no

Effectiveness Studies - Mapping Of All Studies

Criteria	Include	Exclude
Study published during or after 1972	yes	no
Study is of services for women assessed as needing psychiatric services in conditions of security	yes	no
Outcomes study	yes	no

Effectiveness Studies - Stricter Criteria

Criteria	Include	Exclude
1. Study published during or after 1972	yes	no
2. Study is of service or part of service for women assessed as needing psychiatric services in conditions of security	yes	no
3. Study design is one of the following: randomised controlled trials controlled trials with pseudo randomisation controlled trials with no randomisation cohort studies (prospective) with concurrent controls cohort studies (prospective) with historical controls cohort studies (retrospective) with concurrent controls case-control (retrospective) studies time series	yes	no

5.7 Table headings for reporting findings

Descriptive Studies, Service Models

Study	Descriptions of national/state/local system	Problems attributed to system	Advantages attributed to system	Implications for service delivery
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Descriptive Studies, Population

Study	Population described	Mental health	Other data	Implications for service delivery
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Effectiveness Studies - Mapping Of All Studies

Study	Intervention	Participants	Outcomes measures	Results
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Effectiveness Studies - Those Meeting Stricter Criteria

Study	Intervention	Participants	Outcomes measures	Results
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6. Data Extraction Forms

Descriptive Studies, Service Models

Reference no:

Reviewers:

A. Study details

Title:

Author(s):

Full reference:

Language:

Type of source:(see prompts)

Site(s):

Method:

Investigator:(see prompts)

B. Descriptions of a national/state/local system

geographical location:

statutory basis for system:

outpatient psychiatric care provided within prison

if yes, by prison staff or visiting staff

inpatient psychiatric care provided within prison

if yes who are staff - prison or health facility

how are transfers between prison and hospital made

who assesses women for transfer

what criteria are used in assessment

women's services separate to men's: yes, completely yes but on same sites no

women offenders and non-offenders held together: yes no

levels of security:

assessment separate to treatment facilities: yes no

are services individualised:

how:

providers are: statutory not-for-profit independent for-profit independent

C. Problems identified with system

Describe:

D. Advantages attributed to system

Describe:

E. Descriptions of particular services

setting: (see prompts)

geographical location:

single sex service single sex part of mixed service mixed service

assessment service treatment service both assessment and treatment

catchment area served (population if given):

no of beds:

allocation of beds (eg 3 wards of 30 beds):

different levels of security on one site:

how linked to prison system:

how linked to probation service:

how linked to other health services:

how linked to social services/social work:

any mother and baby facilities:

provision for family links:

treatment regime (egs):

staff to patient ratio:

types, background and training of staff:

providers are: statutory not-for-profit independent for-profit independent

provision for ethnic or cultural diversity:

staff training in anti-discriminatory or anti-oppressive practices

F. Problems identified with model

Describe:

G. Advantages attributed to model

Describe:

H. Comments

does study meet criteria for other types of study (descriptive studies, populations/effectiveness studies):

summary/reflections/ information which seems important but no space for:

Descriptive Studies, Populations

Reference No:

Reviewers:

A. *Study details*

Title:

Author(s):

Full reference:

Language:

Type of source (refereed journal/published book/government or service statistics/government publication/non-government organisation publication/unpublished research report):

Site(s):

Method:

Sample size(if sample):

How sample obtained:

Investigator: (independent researcher or evaluator/internal staff or service provider/ service recipient)

B. *Population described*

setting (prison/prison hospital/maximum security hospital/medium secure hospital/low secure hospital/general psychiatric hospital/community/mixture* -*specify)

Female

Male

Mixed

size:

ethnicity:

age range (years)

mean age (years, decimal)

sexuality:

geographical location:

mean length of time in present setting (months):

range of length of time in present setting (months)

proportion assessed as needing current level of security

proportion assessed as needing higher level of security

proportion assessed as needing lower level of security

proportion with children under 16

C. *Mental health*

Female

Male

Mixed

psychiatric diagnoses:

proportion who have experienced physical abuse:

proportion who have experienced sexual abuse:

proportion with drug misuse problems:

proportion with alcohol problems:

proportion with history of self harm:

pattern of sections (or equivalent)

D. *Offending*

Female

Male

Mixed

proportion convicted offenders:

proportion remanded:

proportion not guilty because of mental health:

proportion not offenders:

offences:

E. *Comments*

women only discussed in study: yes no

does study meet criteria for other types of study (descriptive studies, populations/effectiveness studies):

Effectiveness Studies

Reference No:

Reviewer

A. *Study details*

Title:

Author(s):

Full reference:

Language:

Funders

Study site(s)

Study design

B. *Intervention*

whole regime or specific service

describe

C. *Participants*

intervention group

control group

comparison group

D. *Outcomes measures*

Types of measures (behavioural/analogue/self-report/clinical reports/standardised tests)

Outcomes of interest:

Services utilisation

premature termination of contact with psychiatric services

compulsory psychiatric hospitalisation

Mental health

Suicide or undetermined death

non-fatal self harm

mental state (clinical interview or validated instrument)

self-esteem

Offending

undetected offending revealed by respondent

detected offences post-discharge (categorise).

Penalty (Imprisonment/community penalty/fine)

breaking of license (or equivalent) conditions

Living circumstances

housing tenure

employment status

in receipt of appropriate benefits
others in household

Social functioning

Contacts with families and friends

Community integration

if mother of children under 18, living with children

in contact with children under 18, but they live elsewhere

not in contact with children

E. Results

follow-up post-test release

follow-up 6 months

follow-up 12 months

follow-up two years

follow-up five years

APPENDIX D: SEARCH STRATEGIES

Medline strategy

Ovid Cd-Rom

1972-6/1997

1. offender\$.tw
2. prison\$.tw
3. criminal\$.tw
4. felon\$.tw
5. crime\$.tw.
6. remand\$.tw
7. convicted.tw
8. sentenced.tw
9. jail\$.tw
10. gaol\$.tw.
11. 1 or 2. or 3. or 4. or 5. or 6. or 7. or 8. or 9. or 10.
12. mentally ill.tw
13. mentally abnormal.tw
14. mentally disordered.tw
15. 12. or 13. or 14.
16. depression.tw.
17. psychos?s.tw.
18. psychot\$.tw.
19. schizophreni\$.tw.
20. personality disorder\$.
21. neuros?s.tw.
22. neurot\$.tw
23. 15. or 16. or 17. or 18. or 19. or 20. or 21. or 22
24. wom?n.tw.
25. female\$.tw.
26. 24. or 25.
27. 11. and 23. and 26
28. prison\$.tw.
29. correctional facilit\$.tw
30. jail\$.tw
31. gaol\$.tw
32. secure unit\$.
33. secure hospital\$.tw
34. special hospital\$.
35. security hospital\$.tw
36. 28. or 29. or 30. or 31. or 32. or 33. or 34. or 35
37. care.tw.
38. service\$.tw
39. provision.tw
40. psychiatr\$.tw
41. 37. or 38. or 39. or 40.
42. 26. and 36. and 41
43. commitment of mentally ill/
44. insanity defense/
45. violence/
46. security measures/
47. dangerous behavior/
48. 43. or 44. or 45. or 46. or 47
49. female/
50. 48. and 49.

Embase

1980-1997

Ovid On-line via BIDS

01-03 October 1997

1. offender\$.tw
2. prison\$.tw
3. criminal\$.tw
4. felon\$.tw
5. crime\$.tw.
6. remand\$.tw
7. convicted.tw
8. sentenced.tw
9. jail\$.tw
10. gaol\$.tw.
11. 1.or 2. or 3. or 4. or 5. or 6. or 7. or 8. or 9. or 10.
12. mentally ill.tw
13. mentally abnormal.tw
14. mentally disordered.tw
15. 12. or 13. or 14.
16. depression.tw.
17. psychos?s.tw.
18. psychot\$.tw.
19. schizophreni\$.tw.
20. personality disorder\$.
21. neuros?s.tw.
22. neurot\$.tw
23. 15. or 16. or 17. or 18. or 19. or 20. or 21. or 22
24. wom?n.tw.
25. female\$.tw.
26. 24. or 25.
27. 11. and 23. and 26
28. prison\$.tw.
29. correctional facilit\$.tw
30. jail\$.tw
31. gaol\$.tw
32. secure unit\$.
33. secure hospital\$.tw
34. special hospital\$.
35. security hospital\$.tw
36. 28. or 29. or 30. or 31. or 32. or 33. or 34. or 35
37. care.tw.
38. service\$.tw
39. provision.tw
40. psychiatr\$.tw
41. 37. or 38. or 39. or 40.
42. 26. and 36. and 41
43. coid j.au
44. dolan b.au
45. gunn j.au
46. maden t.au
47. maden a.au
48. exp psychopathy/
49. female/
50. 48. and 50.

Psychlit strategy

Journal articles 1972 - 6/1997

1. offender*
2. prison*
3. criminal*
4. felon*
5. crime*
6. remand*
7. convicted
8. sentenced
9. jail*
10. gaol*
11. 1 or 2. or 3. or 4. or 5. or 6. or 7. or 8. or 9. or 10.
12. mentally near ill
13. mentally near abnormal
14. mentally near disordered
15. 12. or 13. or 14.
16. depression
17. psychos?s
18. psychot*
19. schizophreni*
20. personality near disorder*
21. neuros?s
22. neurot*
23. 15. or 16. or 17. or 18. or 19. or 20. or 21. or 22.
24. wom?n
25. female*
26. 24. or 25.
27. 11. and 23. and 26
28. prison*
29. correctional near facilit*
30. jail*
31. gaol*
32. secure near unit*
33. secure near hospital*
34. special near hospital*
35. security near hospital*
36. 28. or 29. or 30. or 31. or 32. or 33. or 34. or 35
37. care
38. service*
39. provision
40. psychiatr*
41. 37. or 38. or 39. or 40.
42. 26. and 36. and 41.

Sociofile

1/1974 - 6/1997

Silver Platter CD-Rom

1. offender*
2. prison*
3. criminal*
4. felon*
5. crime*
6. remand*

7. convicted
8. sentenced
9. jail*
10. gaol*
11. 1 or 2. or 3. or 4. or 5. or 6. or 7. or 8. or 9. or 10.
12. mentally near ill
13. mentally near abnormal
14. mentally near disordered
15. 12. or 13. or 14.
16. depression
17. psychos?s
18. psychot*
19. schizophreni*
20. personality near disorder*
21. neuros?s
22. neurot*
23. 15. or 16. or 17. or 18. or 19. or 20. or 21. or 22.
24. wom?n
25. female*
26. 24. or 25.
27. 11. and 23. and 26
28. prison*
29. correctional near facilit*
30. jail*
31. gaol*
32. secure near unit*
33. secure near hospital*
34. special near hospital*
35. security near hospital*
36. 28. or 29. or 30. or 31. or 32. or 33. or 34. or 35
37. care
38. service*
39. provision
40. psychiatr*
41. 37. or 38. or 39. or 40.
42. 26. and 36. and 41.

Cochrane library

CD-Rom

1997 Issue 3

1. women
2. female
3. 1 or 2.
4. prison*
5. offender*
6. jail*
7. gaol*
8. felon*
9. crim*
10. custod*
11. 4. or 5. or 6. or 7. or 8. or 9. or 10.
12. 3. and 11.

SIGLE

Blaiseline On-line

1. mentally ill offender
2. mentally abnormal offender
3. mentally disordered offender
4. forensic psychia*
5. secure psychia*

Mental Health Abstracts

DIALOG On-line

30 September 1997

1. offender?
2. prisoner?
3. prison?
4. criminal?
5. crime?
6. remand?
7. convicted
8. sentenced
9. offender? or prisoner? or prison? or criminal? or crime? or remand? or convicted or sentenced
10. mentally
11. ill
12. abnormal
13. disordered
14. mentally()(ill or abnormal or disordered)
15. depression
16. psychos?s
17. psychot?
18. schizophren?
19. neuros?s
20. neurot?
21. depression or psychos?s or psychot? or schizophren? or neuros?s or neurot?
22. personality
23. disorder?
24. personality()disorder?
25. s14 or s21 or s24
26. wom?n
27. female?
28. wom?n or female?
29. s9 and s25 and s28
30. and py=1972:1997
31. prison?
32. gaol?
33. jail?
34. prison? or gaol? or jail?
35. correctional
36. facilit?
37. correctional()facilit?
38. maximum
39. security
40. hospital?
41. maximum()security()hospital?
42. secure
43. special
44. hospital?

45. (secure or special)()hospital?
46. forensic
47. psychiatry
48. forensic()psychiatry
49. care
50. service?
51. psychiatric()(care or service?)
52. mental
53. health
54. care
55. service?
56. mental()health()(care or service?)
57. s34 or s37 or s41 or s45
58. s48 or s51 or s56
59. s57 or s58 or s28
60. and py=1972:1997

APPENDIX E: CALLS FOR INFORMATION

(a) The following UK government departments, organisations or agencies have been identified so far:

Mental Health Act Commission
Patients' Councils at Broadmoor, Ashworth and Rampton Hospitals
Department of Health, Social Care Group
Department of Health, Research and Development Directorate
Department of Health, Planning Directorate, Mental Health & NHS Community Care
Department of Health, Health Services Directorate, Mental Health Services and Services for People with Learning Disabilities
Social Services Inspectorate
HM Chief Inspector of Prisons
Home Office Mental Health and Criminal Cases Unit
Home Office Probation Unit
Home Office Research & Statistics Directorate (Crime and Criminal Justice Unit)
Inspectorate of Probation
HM Prison Service, Directorate of Health Care, Health Strategy and Policy Group

(b) Research and campaigning organisations:

Women in Secure Hospitals (WISH)
Survivors Speak Out
MIND
National Schizophrenia Fellowship
SANE
The Zito Trust
NACRO
Civil Liberties Trust
Good Practices in Mental Health
Institute for the Study and Treatment of Delinquency (ISTD)
Mental Health Foundation
The Sainsbury Centre for Mental Health
Howard League for Penal Reform
Prison Reform Trust
Women In Prison
The Matthew Trust

(c) Professional Associations/Trade Unions:

Royal College of Psychiatrists
Royal College of Nursing
Association of Chief Officers of Probation
British Association of Social Workers
British Psychological Society
National Association of Probation Officers
Prison Officers' Association
UNISON

(d) Authors of articles relevant to women deemed in need of psychiatric care in secure settings
(selected on the basis of initial electronic searches or as known leading writers in relevant fields)

(i) Forensic Psychiatry and Relevant Research

Arboleda-Florez, J (Canada)
Aderibigbe, YA (USA)
Benezech, M (France)
Birecree, E (USA)
Bloom, J (USA)
Brownstone, D (Canada)
Burrow, S (UK)
Chaplow, D (New Zealand)
Coid, J (UK)
Crisante, A (Canada)
Curle, C (UK)
Daniel, A (USA)
Denton, B (Australia)
Derks, F (Netherlands)
D'Orban, P (UK)
Dunne, MP (Australia)
Eronen, M (Finland)
Feldbrugge, J (Netherlands)
Fenton, G (UK)
Fenwick, P (UK)
Finlay-Jones, R (Australia)
Griffin, P (USA)
Grounds, A (UK)
Grubin, D (USA)
Gunn, J (UK)
Hakola, P (Finland)
Hebert, J (Canada)
Hedderman, C (UK)
Heilbrun, A (USA)
Herrman, H (Australia)
Hodgins, S (Canada)
Hollin, C (UK)
Humphreys, M (UK)
Hurley, W (Australia)
Jones, I (Australia)
Jordan, K (USA)
Kachaeva, M (Russia)
Lumsden, J (UK)
Maden, A (UK)
Mednick, S (Denmark)
Miller, R (USA)
O'Connor, A (Eire)
O'Neill, H (Eire)
Prins, H (UK)
Rasmussen, K (Norway)
Romassenko, L (Russia)

Rosenstein, M (USA)
Seig, A (USA)
Staite, C (UK)
Steadman, H (USA)
Teplin, L (USA)
Tiihonen, J (Finland)
Wessely, S (UK)
Wong, M (UK)

(ii) Women and Offending (all UK)

Carlen, P University of Bath
Dominelli, L University of Southampton
Genders, E
Hanmer, J
Heidensohn, F University of London
Kemshall, H University of Birmingham
Liebling, A Institute of Criminology
Lloyd, A
Maynard, M
Morris, A
Padel, U
Player, E
Stevenson, P
Worrall, A University of Keele

(iii) Women and Mental Health

Allen, H
Barnes, M
Busfield, J
Chesler, P
Fawcett, B
Harrison, D
Lindow, V
Maple, N
Millet, K
Russell, D
Ussher, J

APPENDIX F: BIBLIOGRAPHIES OF PUBLISHED TEXTS

Bibliographies of the following published texts will be consulted:

- Allen H (1987) *Justice Unbalanced: Gender, Psychiatry and Judicial Decision* Buckingham, Open University Press
- Barnes M and Maple N (1992) *Women and Mental Health* Birmingham, Venture
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