The effect of single-sex wards in mental health

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- Staff views on the success of implementing single-sex wards
- Details of the effects on staff and patients

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Abstract

Background
The need for single-sex accommodation in mental health trusts has been widely expressed in documents from the NHS Executive and in national and local policies. This case study describes the effects of changing two mixed-sex wards into single-sex wards.

Methods
Two mixed-sex inpatient wards were reorganised into two single-sex wards. Qualitative data on staff views was gained from semi-structured interviews and collected.

Results
Staff and patients appear to have made the transition from mixed to single-sex wards with relatively few problems. Staff described differences emerging between the male and female wards, with the male ward becoming calmer, while the female ward became more disruptive.

Conclusions
Overall, the implementation was successful. We suggest that in general single-sex wards are just as effective as mixed-sex wards and, in some respects, may be better.

Keywords: Inpatients/Mental health/Single sex/Service management

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better option for staff and patients. The mental health unit studied here was comprised of two mixed-sex general psychiatric wards on a general hospital site. The requirements of EMSA needed to be met by reorganising the wards so that one would become male and the other female.

To undertake a service evaluation of this rapidly implemented change, qualitative interviews were conducted with staff while the change was happening and six months later. As a routine service activity, this enquiry did not require ethical approval, although approval to release the information in this article has been obtained from the trust.

Materials and methods

The two 21-bed wards serve a population base of approximately 250,000; although this population is in the 20% least deprived of all areas in England, areas of deep deprivation exist within it (Oxford Consultants for Social Inclusion, 2005). Approximately 50% of admissions to these wards are under section 2 or section 3 of the Mental Health Act (HM Government, 2007). Both wards had, at the time of the change, a full team of registered and non-registered nursing staff. One ward was designated to become single-sex male; the other female.

The change from MSA to SSA was made over one weekend in April 2010. A dedicated researcher conducted semistructured interviews with 22 ward staff (14 nurses, six non-registered nursing staff, two ward clerks), who were interviewed in the immediate days and weeks after the implementation of SSA and again after six months. Two consultant psychiatrists were also interviewed towards the end of the study period. The researcher was neither a clinical practitioner nor part of the managerial team implementing the changes so participants felt they could speak freely with her.

The interviews were based on semistructured prompting around certain areas of interest, such as ward rounds, time management, sex-specific aspects of care, changing levels of disturbance and general opinions about favourable or unfavourable aspects of the change. Interview data was collated and themes arising from the interviews were investigated. Patients were not interviewed directly as this would have required ethical approval, which the speed of change did not allow.

Data on the number and type of incident reports (for example, behavioural disturbance and assaults on staff) from 2009 (pre-SSA) to 2011 (post-SSA) were collected from the trust’s clinical risk department.

Results

The qualitative interviews revealed four strongly repeated themes at both time points: ward rounds and time management; sex-specific aspects of care; levels of disturbance; and transitional issues.

Ward rounds and time management

Before SSA was implemented, each ward had four consultants, meaning four full ward rounds on each ward every week; the number of ward rounds increased to seven after implementation because most doctors were now required to see patients on both wards.

This change required the clinical and managerial teams to work together to overcome key issues such as environment (availability of rooms) and staff time (availability of nursing time for ward rounds). The majority of nurse participants interviewed towards the end of the six-month period felt the increased number of ward rounds created a time-management problem that took them away from other work. The doctors, when surveyed at six months, did not see this as a problem; although the number of ward rounds had increased, the duration of each was shorter. However, the relationships the consultants have with the wards required reflection and careful management during the process of changing from MSA to SSA.

Sex-specific aspects of care

Staff commented on the pressure on same-sex members of ward staff (that is the female staff on the female ward). Male participants felt more pressure to “protect” female staff, particularly when working on the male ward at night, when patients were most likely to exhibit behaviour problems, and some voiced concerns about their physical vulnerability on an all-male ward. However, male staff also described how they could work much more confidently with male patients, as they did not have the worry about allegations of sexual abuse from female patients.

On the female ward, women participants reported being more able to discuss “female issues” and better manage instances of inappropriate attire or nakedness. Many male participants, however, gave the impression they felt disadvantaged and under greater pressure while working on the female ward due to fear of allegations of abuse and inappropriate behaviour against them from women patients. Overall, it appeared that, while female nurses on the male ward feared violence from the male patients, the male staff on the female ward had a much greater fear of false accusation from female patients.

Participants described receiving many complaints from male patients in the early weeks after SSA implementation, expressing that they missed female interaction. However, once newly admitted patients had replaced the previous cohort, no further comments were made. Participants attributed this to the fact that the new patients were inclined to accept things as they were and did not know that it had ever been otherwise.

Levels of disturbance

There was strong impression among participants that the male ward became a much quieter and calmer environment after the change. In general, they made sex-based interpretations of this such as: “Men would rather just watch the football on TV than chat all the while.”

They did not attribute the difference to the clinical profiles of male and female patients; for example, male patients might have more negative features of schizophrenia than the more acute female cases.

Contrary to staff expectations, the
female ward became more hectic and noisy; participants described more shouting and verbal aggression among female patients, and were of the opinion that physical aggression had decreased but verbal aggression had increased.

The data from the incident reports partly agreed with the qualitative account. The overall number of formally reported incidents on the male ward did not increase after implementation of SSA; in fact, there was a decrease of two incidents. However, incidents on the female ward had almost doubled after the change (Fig 1).

Based on the internal reports, the increase in incidents on the female ward after SSA was implemented can be attributed almost entirely to alleged physical assaults by patients (seven reports in 2009-10; 30 reports in 2010-11). Furthermore, verbal incident reports fell by two-thirds from 12 in 2009-10 to only four in 2010-11 (Fig 2). This seems to contradict the interview remarks that verbal aggression had increased on the female ward, but it is likely that staff did not see all verbal outbursts by patients as warranting formal reporting.

Implementation and transitional issues

The majority of participants stated that they understood the rationale behind SSA implementation but felt that their opinions and contributions should have been sought before the change. Most expressed a view that a formal handover should have been implemented and that the changeover happened too quickly.

Nonetheless, the implementation was considered to have gone smoothly, with no clinical problems and few complaints from patients. Some participants believed that better liaison between the wards would have been preferable so they could have provided reassurance to patients who were anxious about the change. Initially, there was no mixing between patients from different wards and this caused a feeling of “them and us”; however, with time and the admission of new patients, this stopped being the case.

Although the changeover was generally regarded as having gone well, the majority of participants had the view that the mixed-sex environment, with patients socialising with the opposite sex, is more socially typical. About one third expressed strong opposition to SSA at the point of changeover; at six months the balance of opinion was that SSA was a satisfactory arrangement for inpatient care or at least not inferior to MSA arrangements.

Discussion

At the start of this evaluation we hoped to collect detailed numerical data on the impact of implementing EMSA, for example whether admission rates, length of admission or the use of the Mental Health Act (2007) were affected.

However, this proved impossible as many other service changes going on at the same time also affected how the beds were being used, and it was not possible to say which factors were influenced by the effect of SSA and which were due to other external influences.

We wish to draw this to the attention of others who might embark on service evaluations or research on inpatient provision and suggest that, unless there are substantial resources backing any such enquiry narrative, descriptive and qualitative methods may be the best ones to use.

In this case study, based mainly on nursing opinion, SSA appeared to be no worse than MSA as, if anything, the balance of opinion favoured SSA over the previous arrangements. It might be argued that the question of whether men and women should be treated separately is largely an ideological one, but our case study provides some, at least tentative, evidence that SSA can be a satisfactory arrangement for both staff and patients.

Notwithstanding the favourable outcome of implementing SSA in our services, it was abundantly clear that the male and female wards came to differ from each other in their emotional registers. The male ward is typically quiet and orderly, whereas the female ward presents a continually hectic atmosphere and the number of reported incidents (predominantly attacks on staff) was close to double that of the male ward. We speculate that this is predominantly a function of case-mix rather than a sex attribute per se. In future studies, it would be valuable to collect data on the mental state characterisation of male and female patients because differences in case mix might affect how wards can be best adapted towards the types of cases they deal with most commonly.

Limitations

Patients were not surveyed at any point during the implementation of MSA and their opinions were only represented indirectly through the interviews with staff. The main reason for this was that it would not have been possible to obtain the necessary approvals for a patient survey in the time available.

However, it is doubtful whether such a survey would have been useful given that ward operations were being so heavily affected by other factors unconnected with the change from MSA to SSA. We suggest that gaining patients’ opinions about the respective merits of SSA versus MSA might be best done as a standalone project once patients have been discharged and are able to reflect at a distance about their time spent as an inpatient.

Conclusion

It appears in this case study that the move to SSA did not cause major problems and, on balance, proved successful. Due to having had some resources to make a structured evaluation, we are able to offer that view with modest conviction.

Delivery of EMSA as government policy for mental health represented a major ideological change in the way inpatient care is delivered; however, the requirements of EMSA can be met either by single-sex wards or by retaining mixed-sex wards.

Ideally, there should be some comprehensive research to work out which is better but, if that is not possible, then publishing further case reports, such as this, may at least enable reflection and provide information for debate.

Future research may consider incorporating patient interviews, while it would also be valuable to conduct further work into the mental state characterisation of male and female patients to seek explanatory variables for the differences in the level of disturbance. NT

References
