Women Who Have Set Fires: Learning for Change

By

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Abstract

This study examines the learning opportunities available in the secure mental health system for women who have an index offence of arson and for women where fire setting has been significant in their mental health histories. The study questions the extent to which education and learning contribute towards their successful rehabilitation. A critique of the wider treatment options is undertaken, particularly of the Arson Treatment Group, learning and leisure activities and the accommodation for the women, to gain an accurate picture of their daily lives.

The research project gained multi-site approval from the Essex NHS Ethics Committee, as well as approval from the ethics committees of the Nottinghamshire Mental Health Trust, Rampton Hospital, Partnerships in Care and the Universities of Surrey and Portsmouth.

The study was designed and conducted over a period of approximately four years. Evidence was gathered from ten women, some living in Rampton Hospital and others accommodated in the Partnerships in Care medium and low secure mental health settings for women in the Mansfield and Newark areas. A cohort of seventeen multi-disciplinary professional workers involved in their care and treatment also participated.

The examination includes evidence from recent studies, NHS policies, Commissions and Enquiries, all of which were concerned about the lack of opportunities to learn and also point to a lack of appropriate leisure activities (The Reed Commission, 1993; The Tilt Inquiry, 2002; Women’s Mental Health: Into the Mainstream, 2002). Examples of good practice were also identified.

The main argument of this study is that learning literacy and skills leading to the development of self esteem and confidence need to be a key feature in a rehabilitation programme for women who set fires. The findings of this study are that there still remain insufficient opportunities for these to be acquired. It appears to remain the case that the longer a woman is contained in secure facilities the less she is likely to be able to live independently in the future.

The study concludes that appropriate learning opportunities are essential to the rehabilitation and well-being of the women, particularly when embedded in other leisure or therapeutic activities.

Maureen Sears
December 2007
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Women who have set fires: Learning for change – A study of the rehabilitation of women in secure mental health settings</td>
<td>1</td>
</tr>
<tr>
<td>Chapter 1</td>
<td>Setting the context for the treatment of women who have set fires: A brief critique of policies and mental health legislation</td>
<td>11</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>Women who set fires: A review of the literature</td>
<td>36</td>
</tr>
<tr>
<td>Chapter 3</td>
<td>Research methodology</td>
<td>63</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Examination of data</td>
<td>91</td>
</tr>
<tr>
<td>Chapter 5</td>
<td>The Arson Treatment Group: Learning in action</td>
<td>173</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>Women learning for change: The interconnectedness of therapy and learning</td>
<td>193</td>
</tr>
<tr>
<td>Chapter 7</td>
<td>Conclusion and findings</td>
<td>220</td>
</tr>
<tr>
<td>Bibliography</td>
<td></td>
<td>246</td>
</tr>
</tbody>
</table>
Table of Appendices

Appendix 1  University of Surrey Ethics Committee letter of approval
Appendix 2  NHS Ethics Committee letter of approval
Appendix 3  Partnerships in Care Ethics Committee approval letter
Appendix 4  NVivo 7 processed material relating to Question 4
Appendix 5  Chi Square tables calculated from the National Case Register, High Secure Service
Appendix 6  Information sheet for participants
## Index of Tables and Diagrams

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Table/Diagram</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Table 1</td>
<td>Disciplines of the professional participants to the study</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Table 2</td>
<td>Semi-structured interview format for professional participants</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Table 3</td>
<td>Semi-structured interview format for the women participants</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Table 4</td>
<td>Study map using Denscombe’s model</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Table 5</td>
<td>Study map using Layder’s model</td>
<td>87</td>
</tr>
<tr>
<td>4</td>
<td>Table 6</td>
<td>Women participants in the study</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>Table 7</td>
<td>Years spent in prison and mental health services</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Table 8</td>
<td>Age range of women participants</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>Table 9</td>
<td>Length of stay in secure mental health settings</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Table 10</td>
<td>Membership to Arson Treatment Group</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>Table 11</td>
<td>Arson Treatment Group – assessment of usefulness</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Table 12</td>
<td>Literacy skills of the women based on their own assessment</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>Table 13</td>
<td>Professional worker participants</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>Table 14</td>
<td>Reasons cited for fire setting in women matched to other studies</td>
<td>125</td>
</tr>
<tr>
<td>6</td>
<td>Diagram 1</td>
<td>Kolb’s Learning Cycle, reproduced from Jarvis (2006)</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>Diagram 2</td>
<td>The Process of Learning, reproduced from Jarvis (2006)</td>
<td>200</td>
</tr>
<tr>
<td>7</td>
<td>Table 15</td>
<td>Verification of information used in this study</td>
<td>237</td>
</tr>
<tr>
<td></td>
<td>Table 16</td>
<td>Proposed treatment model for women who set fires</td>
<td>242</td>
</tr>
</tbody>
</table>
Acknowledgements

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Maureen Sears
December 2007
<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATG</td>
<td>Arson Treatment Group</td>
</tr>
<tr>
<td>BPD</td>
<td>Borderline Personality Disorder</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behavioural Therapy</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EMSU</td>
<td>Enhanced Medium Secure Unit</td>
</tr>
<tr>
<td>HSH</td>
<td>High Secure Hospital</td>
</tr>
<tr>
<td>LSU</td>
<td>Low Secure Unit</td>
</tr>
<tr>
<td>MHT</td>
<td>Mental Health Trust</td>
</tr>
<tr>
<td>MSU</td>
<td>Medium Secure Unit</td>
</tr>
<tr>
<td>NHSHSW</td>
<td>National High Secure Health Services for Women</td>
</tr>
<tr>
<td>NIMHE</td>
<td>National Institute of Mental Health, England</td>
</tr>
<tr>
<td>NOG</td>
<td>National Oversight Group</td>
</tr>
<tr>
<td>PD</td>
<td>Personality Disorder</td>
</tr>
<tr>
<td>RMO</td>
<td>Responsible Medical Officer</td>
</tr>
<tr>
<td>RSU</td>
<td>Regional Secure Unit</td>
</tr>
<tr>
<td>SPD</td>
<td>Severe Personality Disorder</td>
</tr>
<tr>
<td>TED</td>
<td>Therapy and Education Department</td>
</tr>
<tr>
<td>WISH</td>
<td>Women in Secure Hospitals</td>
</tr>
</tbody>
</table>
Introduction

Women who have set fires:
Learning for change – A study of the rehabilitation of women in secure mental health settings

The study examines the learning opportunities for women who set fires and who are contained within the secure mental health system. The purpose in so doing, is to identify a strategy of rehabilitation, which will be relevant for many women who set fires and who are contained within secure facilities in England and Wales. This study attempts to determine what learning is necessary and how it may contribute to the successful rehabilitation of the women, enabling them to live safely back in the community. It examines recent policies and practice and reviews the literature to build a profile of women who set fires. The study then draws upon evidence obtained from women patients, and a group of professional workers from a range of disciplines involved in their care, both groups having contributed their experience and opinions in this examination.

The study explores two main questions

1) To what extent do the learning opportunities in the secure mental health system help women who have a fire setting history to be successfully rehabilitated and enabled to live in a less secure environment?

2) What other factors may facilitate their rehabilitation and what are the blocks to this achievement?

The locality

The ‘study sites’ are the ‘high secure’ Rampton Hospital, situated in Nottinghamshire, and the women only, three lower secure units in the locality,
managed by Partnerships in Care. These are, a medium secure unit of 30 beds, an 'enhanced' low secure unit of 15 beds and a low secure unit of 30 beds. This geographical area was chosen, because of the citing of the only 'high secure' unit for women in the grounds of Rampton Hospital. The hospital was designated in 2004 by the National Oversight Group, Department of Health, to undertake the responsibility of all women committed to a high secure mental health hospital residing in England and Wales. The new 50 bedded unit opened in March 2007.

The changes have important ramifications for women who set fires and who, it is estimated, will represent between 60–80% of the women who have been assigned to the newly built unit (Interview: Director of Women's Services, Rampton Hospital Feb 2007).

Why now?

As stated above, this examination is particularly pertinent now, as the secure mental health services are undergoing major changes, fuelled by the Department of Health's policy document, 'Women's Mental Health – Into the Mainstream' (2002) with the Implementation Guidance published in 2003, both documents are referred to throughout this work as 'Into the Mainstream'. This guidance identifies gender specific treatment principles, practice, living environments and options for women requiring treatment for mental health issues, and for those contained under the Mental Health Act 1983. Therefore this study is providing information from the consumer's point of view and that of those whose responsibility it is to implement the changes required.

It has proved necessary to constantly revise and update this examination, as developments and changes to the secure hospital environment overtook events and situations current at the beginning of the study, but rendering them irrelevant at its conclusion. The collection of data for the study was carried out at a time when 'Into the Mainstream' recommendations were still being
implemented within the secure mental health services. The timing offered a rich opportunity to critique the policy changes affecting the delivery of rehabilitation programmes for women who have set fires. However, on occasions, it was difficult discussing aspects of the study with participants when their own work and future responsibilities were in a state of flux. The women participants of the study were also anxious, aware of the changes and how these may affect them.

This examination identifies issues and questions concerning the lives of women who set fires. These are, the length of time spent in secure facilities, and in addition, what appears to be a lack of focus on key skills which would better equip them for living in the community. These, and related issues are interrogated in the following chapters and this constitutes an in-depth analysis of their problems together with suggestions to address them.

**Background to the study: A climate of change**

Chapter 1 informs the reader about the organisation and recent designation of secure units and investigates the policies and legal framework, in particular the Sections of the Mental Health Act 2007, which identifies the legal basis of compulsory containment, together with the Care Programme Approach which provides the structure of their treatment plan. The procedures and practices identified, to some extent, dictate the programme of treatments, educational and leisure activities, which form the daily experience of the women patients examined in later chapters.

The major changes in policies now being implemented has influenced the development and focus of the study. The two most significant reviews producing the evidence upon which changes were required and incorporated in ‘Into the Mainstream’ (2002), were the Reed Commission (Reed 1993) and the Review of Security at High Security Hospitals (Tilt 2000) referred to throughout this study as the ‘Reed Commission’ and the ‘Tilt Report’.
Both the Reed Commission and the Tilt Report asserted that approximately 75% of the women contained in high secure institutions did not need this level of containment, but those who did, approximately 50 women, would be transferred to the aforementioned new unit. Therefore, over the last eighteen months, approximately 150 women who were accommodated in the three high secure hospitals of Broadmoor, Ashworth and Rampton, have been placed in medium or low secure units throughout the UK, with those women still regarded as requiring a high secure setting, transferred to Rampton Hospital. As previously stated, it is estimated that the majority of women patients in the new unit will have a history of setting fires.

There are few policies referring directly to women who have set fires. This is identified as an under researched field by Women in Secure Hospitals, (WISH). However, as previously referred to, the most recent government paper ‘Into the Mainstream’(2002) substantially influenced developments in women’s services within the secure mental health system. Particularly the introduction of gender specific living, leisure and learning opportunities. These developments have considerable implications for the women involved and as a result, may have an affect upon their prospects of rehabilitation.

All but one of the women in this study have been transferred from the prison system to the secure mental health system. The second largest group are women who have been transferred from less secure environments, because their particular needs could not be met and they presented a danger to themselves and others. Therefore, the examination of the policy documents which influence their rehabilitation, encompasses those from the criminal justice system as well as the psychiatric division of the NHS, as discussed in Chapter 1.
The review of the literature

Chapter 2 examines and critiques the literature from which the study questions were formulated. It relates in particular to the previous chapter and to the examination of the major reviews, reports, enquiries, commissions and other research studies, which set the context of this study.

Literature spanning the social sciences has been used to inform as well as search for meaning concerning the actions of the women participants to the study. The body of literature concerning theories of learning is applied to the accounts given by both the women and the staff in an attempt to understand the reasons for some of the women's reluctance to learn, or develop skills which may enhance their opportunities for rehabilitation in Chapter 6.

The literature review examines in detail the studies which give a general profile of women who set fires, identifying their history of trauma and abuse and gives some explanations as to their fire setting behaviour. The profiles gathered from this information help to identify the issues and obstacles to be overcome by the women themselves if they are to live independently within the community.

The research strategy

In Chapter 3 the structure of the study and in particular the strategies for data collection, together with methods of data analysis are examined in detail. This study uses research models that draw upon both quantitative and qualitative paradigms. The advice offered by Denscombe (2003) and Layder (1993) in particular are analysed and form the basic research plan, providing answers to the questions posed by them concerning the construction of a research study.
Three sets of data have been used: The first is policy documents relevant to the organisation of the women's lives within the secure mental health system. Without an understanding of the way in which the environment is structured, it is impossible to evaluate the programmes, which are its essential components.

The second data set is designed to illuminate the women's own experiences of attending groups as a part of the rehabilitation process. This information is gained from semi-structured interviews with a cohort of 10 women, three of whom are now patients in the new unit, (the remaining seven are dispersed between the three smaller units, operated by Partnerships In Care, a private mental health company). Partnerships in Care have a contractual arrangement with the regional mental health trust and has specialised in the provision of women only secure mental health services.

The third data set is drawn from discussions with professional colleagues working within the different disciplines involved in the care and treatment of the women in each of the units. The data from this group of 17 participants were also obtained through semi-structured interviews.

From these three different sets of data it is possible to answer the questions posed in this study. The first question, concerning the contribution of learning in the rehabilitation process, and also the second, identifying the measures, which enhance the women's prospects of rehabilitation and the potential blocks to their success. It was also possible to formulate an outline treatment strategy for women who set fires from the examination of the material collected for this study.

Also found in this chapter is a critique of the research methodology, which has highlighted some of the issues involved in undertaking research in this area of work. The various pitfalls that blocked the research design and the strategies involved in finding solutions to the problems encountered are discussed.
The collection of data

Chapter 4 examines the data collected from the interviews with the two cohorts and analyses the information used to answer the study questions. It is this chapter which brings into sharp relief the experiences of the ten women participants, their views on aspects of treatment, educational, leisure activities and their wishes and hopes for the future. This together with the views and opinions of the professional participants who provide the human environment in which the women live.

It was necessary to build this profile of women who set fires using this data, identifying the difficulties they experience, in order to demonstrate the complexities of the issues that are under examination. All the women contained in the secure mental health system are placed under various sections of the Mental Health Act 1983, most of which curtail their liberty, allowing for release, sanctioned only by the Mental Health Commissioners or by the Minister of State, Ministry for Justice, formerly the Home Secretary and the Home Office.

The Arson Treatment Group

Chapter 5 contains an evaluation of the Arson Treatment Group. As the only specific treatment directly concerned with fire setting behaviours, it provides data essential to this study. There has been no systematic review of treatment programmes aimed specifically at patients who set fires, since the study by Swaffer, Haggert and Oxley (2001). As far as I am aware there has been no evaluation of Arson Treatment Programmes for women since they were first introduced, approximately four years ago. Therefore this study attempts to provide a comprehensive examination of therapies, combined with the skills development and social activities, available to women in the settings identified above. The identification of what works, and the barriers to rehabilitation, provide an essential basis for the formulation of a treatment plan for women who set fires.
Learning as therapy

Chapter 6 examines principles and theories of learning which apply to the experience of the women. This examination spans from childhood to their experience of treatments, leisure and learning activities within the secure settings.

The arguments give weight to the assertion made within this study that learning is an integral part of the rehabilitation process. The therapeutic treatments or approaches used in the care and treatment of women who set fires cannot be as effective unless the recipient is able to assimilate ideas, reflect, and change their thoughts and actions. It is argued that as a result of learning about themselves and their responses to others around them, builds their confidence. They are more likely then to be receptive to the range of education and skills development, available within the secure setting, which can contribute to the process of developing the whole person. However, this needs to be provided consistently and to be overtly threaded through the various treatment groups and learning activities, reinforcing the importance of their acquisition.

Conclusions of the study

Chapter 7 examines the data relevant to the study questions and summarises the main findings. The data are discussed in relation to the research questions and draw together the main points made by the interviewees who contributed to the study set within the framework of the research studies and policy documents which formed the basis of this study.

Chapter 7 discusses the strengths and weaknesses of the study and outline a treatment proposal for women who set fires. This is based upon the evidence found concerning their experiences of learning contributing to their rehabilitation and the blocks encountered, both personal and institutional. The
study also concludes with recommendations for further research to explore the areas to be examined in greater depth using the benefits of hindsight to avoid some of the difficulties encountered in conducting this research.

**Summary**

The study has drawn upon a wide range of policies, theories and research to support its arguments. The data have been presented in different formats, from tables and diagrams and by quoting the participants' responses to the questions posed. Hopefully, the data will be regarded as providing firm support for the conclusions.
Chapter 1

Setting the context for the treatment of women who have set fires: A brief critique of policies and mental health legislation

Introduction

This chapter examines policies and mental health legislation, which has shaped the secure provision for all women who have been accommodated within it over the last quarter of a century and in so doing, sets the context for this study. This examination of the reports, policies and studies contained within this chapter contributes to an understanding of the environments women who set fires live in. Policies provide the template, the purpose and the guidance, which initiate change. Women’s Mental Health, Into the Mainstream (2002) is the most important document to come from the Department of Health in respect of women with mental health issues and has produced major changes over the last five years for women in secure mental health settings.

Recent changes

Frequently, documents examining mental health services make no reference to the particular needs of women accessing mental health services. They often contain only a passing acknowledgement that women’s needs are different to that of men, in the later and more recent documents reviewed (Crassiati, Horne and Taylor, Department of Health, ‘Ten Years On’ 2002). The aforementioned Department of Health document ‘Women’s Mental Health, Into the Mainstream’ (2002) is the only publication dealing specifically with women with mental health issues.

This document was the result of a long campaign by professionals, including those working with women in secure mental health services, arguing for
resources and facilities that recognise the special and essential needs of women patients in mental health services (NIMHE Women’s Reference Group 2000). Women who set fires and their particular needs are rarely mentioned in the policy documents or enquiries held in recent years despite the fact that approximately 50% of women currently contained in the ‘secure system’ have either an index offence of ‘Arson’ or their records identify arson behaviour. ‘Into the Mainstream’ (2002) contains only one reference to ‘arson’ and recommends specific treatments focussed upon this activity (Section 11).

There is a tendency, for women regardless of mental health diagnosis, race, age or social classification to be grouped together in secure mental health units, but even though this may be the case there are different outcomes for women who set fires. These specific issues will be identified in the detail of this chapter and its significance for the rehabilitation of women who set fires will be made apparent.

As stated in the introduction, this study only examines women patients from Rampton Hospital and women accommodated in the three women only, lower secure units, operated by Partnerships In Care. In England and Wales, there are three ‘high secure’ hospitals, Ashworth, Broadmoor and Rampton. The latter is the only hospital now that has provision for women, with a recently built ‘high secure’ unit for women within its grounds. The women from Ashworth were relocated in 2005, the majority to regional secure facilities or to Rampton. The women in Broadmoor were similarly relocated, some to the new facility on the Rampton Hospital site in the Spring and Summer of 2007.

Broadmoor has now dismantled its resources and facilities for women patients. Accommodation for 45 women is now provided in an ‘enhanced’ Medium Secure Unit. This unit is the joint responsibility of Broadmoor and the London Borough of Ealing Mental Health Trust on the St Bernard’s Hospital site, Middlesex.
The definition of ‘enhanced’ as a designation for a medium secure unit remains unclear, as the criteria appears remarkably similar to the one used to identify a high secure unit and the women to be contained therein. This anomaly is relevant to the women in this study, as to who is referred to high secure and who to medium secure provision seems to be a lottery.

As previously mentioned, the new 50 bed high secure unit, built within the grounds of Rampton, for all women in England and Wales, needing to be in a ‘high secure’ unit, was operational from March 2007. The unit contains all of the women in the Directorate which claims to have the resources and facilities for their treatment, education and social life, in accordance with the recommendations specified in the ‘Into the Mainstream’ (2002) document. This aspect is scrutinised in Chapter 4, and contributes to the findings of the second question asked in this study.

The legal framework

Historically, treatment and containment policies were formulated, and resources allocated, as knowledge and understanding of mental illness and the intellectual capacities of individuals developed, allowing for the legal framework which contained or supported them to change. From the Lunacy Acts at the turn of the 19th Century to the Mental Health Act 1959, there have been major changes in how individuals with mental health issues have been treated (Pilgrim and Rogers 2001).

The Mental Health Act (1959) legislation confirmed the dominance of the medical profession in terms of diagnosis and treatment of people exhibiting behaviours associated with mental illness. The power of the judiciary to maintain the rights of individuals was curbed, according to the argument put forward by Pilgrim and Rogers (2001). The new drugs used to treat a wide range of mental health problems from depression to psychosis enabled people to be maintained in the community, often in their own homes rather
than requiring hospitalisation. The burgeoning costs of maintaining large Victorian institutions became prohibitive and care in the community with short term smaller units emerged as the favoured course of management for those with mental health issues.

The changing regimes of treatment are again reflected in the Mental Health Act of 1983. This legislation acknowledged the importance of the move towards ‘care in the community’ and more importantly, the responsibilities carried by other professions in the assessment and treatment of mental illness.

**Mental Health Act 1983, revised 2007**

The significant changes made in the Mental Health Act of 1983 according to (Pilgrim and Rogers 2001) were attributed by policy makers to the emergence of neuroleptic drugs. They also assert that there was a challenge to the domination of a medical approach to the treatment of people with mental illness by advocating a multi-disciplinary approach, together with the pressure to deliver supportive care in the community. However, Pilgrim and Rogers argue that the move to care in the community and the emergence of other professional groups involved in care and treatment was influenced more by financial issues than professional decisions (Pilgrim and Rogers 2001).

As the law has changed so have the rights of patients under the different sections of the legislation. The 1983 Mental Health Act, recognising the expertise of other professions in the treatment of mental illness, assigned a major role to the emerging profession of social work in the ‘sectioning’ of patients reluctant to undergo assessment or treatment.

The revised Mental Health Act 2007 which now supercedes but incorporates much of the 1983 Act and in doing so subsumes the Mental Capacity Act, 2005, and the Domestic Violence, Crimes and Victims Act, 2004. The revised...
legislation does not affect the legal position as it relates to the current detention of women who set fires. There are however, some changes to terminology, which may affect future admission under the 2007 Act. For example, the all encompassing term of 'mental disorder' replaces mental illness definitions. Responsible Mental Health Practitioner replaces Responsible Medical Officer, and no longer is there an 'approved social worker' but an 'appropriate mental health professional'.

It may be helpful to identify and examine the specific sections within the Mental Health Act 1983, as this remains the legal basis for containment within the secure hospital system of the women participants in this study. There are four ways by which, in legal terms, women are detained in secure accommodation.

1) **Remanded by Crown Court (may be compulsorily treated):**
   *Section 36/57/58 MHA 1983*

Women in this study have been detained under this section. Section 36, enables a judge to remand the patient to a hospital, instead of prison. This section is time limited to six months with renewal for six months and thereafter renewal on an annual basis. Sections 57 and 58 refer to compulsory treatment on one of two conditions, a) the consent of the patient, b) a medical practitioner in consultation with two health practitioner, for example, a doctor and a qualified nurse.

2) **Referred by Magistrates Court/Crown Court:**
   *Section 37/41 MHA 1983*

50% of women are contained on what are called 'restriction orders', on the direction of the Magistrates Court or Crown Court, under Section 37/41 of the Mental Health Act 1983, on the grounds that the individual presents a risk to the public. These orders are not time limited, and can only be discharged by the Secretary of State, Ministry of Justice. This means that individuals who
have committed offences are brought to trial, and if the Court is satisfied by
two psychiatric opinions that the defendant requires treatment for a mental
health condition, the individual can then be admitted to a secure hospital for
an indefinite period of time.

This section was assigned to five of the women in the study.

3) Transfer from prison to hospital (convicted offenders):
Section 47/49 MHA 1983

Approximately 17% of women in secure hospitals are transferred from the
prison system and placed on Section 47/49 MHA 1983 or as remanded
prisoners, on Section 48 WISH Report (2002–03). These patients are
transferred on the assessment of two doctors, one a qualified psychiatrist who
has assessed the prisoner as having a specific mental illness. Release is only
by a Mental Health Review Tribunal or the Secretary of State, as above. This
means that a prisoner who has been handed a sentence from the Courts,
once detained on a Mental Health Section, can be detained for an unlimited
amount of time. This route of containment is also noted at the end of the term
of imprisonment served, where prisoners are placed upon Section 47/49 of
the Mental Health Act 1983 immediately prior to their release from prison.
Should a patient be discharged before the end of their sentence, they are
returned, to serve the remainder of their sentence.

One of the women in the study related how the day prior to her release from
prison, two doctors interviewed her; this resulted in her transfer to Rampton
Hospital the next day, where currently, she has lived for twice the term of her
initial sentence. Two other women in this study were admitted to the secure
mental health system on this Section.
4) Transfer from prison to hospital (remanded prisoners):
   Section 48/49 MHA 1983

An increasing number of women are entering the secure hospital system prior to being processed through the criminal justice system via Section 48 MHA 1983. The route of transfer is similar to the one used above, and again, patients can be released only by permission of the Secretary of State, Ministry for Justice, or the Mental Health Review Tribunal.

Two women in the study accessed the secure mental health system via this route.

The Corston Review (2007) regarded the waiting period for women prisoners to be transferred to mental health provision which could sometimes be as long as three months was unacceptable. The Review also expressed concern over the reluctance of the authorities to refer a prisoner for psychiatric treatment on the basis of lack of bed space.

The criteria for admission to secure mental health settings

Initial detention must have a legal basis; there must be a legal basis, too, when women are referred by other mental health units (treatment/compulsory detention sections, as specified above and embedded in the 2007 Act, usually apply). They can 'escalate' up the tariff from low secure unit to high secure hospital.

However, concern was raised by the Forensic Faculty, Royal College of Psychiatry about the assessment of individuals for admission to secure mental health facilities Seminar Report (2003). They noted that the three criteria of 'security' is defined differently in the high secure 'estate' following the recommendations of the Tilt Enquiry (2000). 'Physical security', according to the aforementioned Report is predominantly assessed as 'safety of the
public'. The two other definitions of security are 'relational security' meaning the security which comes from the development of trust between health care workers and patients, and 'procedural security' which is promoted through policies and practice guidelines which are tailored to form the environment of the unit and which also determines the level of security required.

The assessment of each woman referred to the admission team must review her needs in relation to these three aspects of security. The Report (ibid.), recorded concern about admission to a high secure facility which they considered to be based more on the issues of public safety rather than the needs of the individual patient. The forensic faculty referred again to the Reed Commission (1993) which stated that an individual should be detained in an institution with no greater security than required.

However, confusion must exist concerning referral to secure provision as Rutherford and Duggan (2007) give criteria for admission to the different levels of secure provision which is solely based upon safety of the public. In the case of admission to 'high secure' the criterion they cite, 'pose an grave and immediate danger to the public'; admission to medium secure units based upon the criterion of 'a serious danger to the public'; admission to a low secure unit; 'pose a significant danger to themselves or others' (Rutherford and Duggan 2007, p. 6).

1) Admission to high secure hospital

The following criteria was given in discussion with the Medical Director of Rampton Hospital (April 2005):

In order to be admitted to a HSH, the woman's behaviour must pose a risk to the safety of herself and others. She will usually be admitted with a diagnosis of severe or dangerous personality disorder, but it is not uncommon to be admitted with a less serious personality disorder, for example, personality
disorder, or borderline personality disorder. All of the women in the study have been assigned the diagnosis of 'borderline personality disorder'. The relevance of this is discussed in Chapter 4.

A recent trend for women patients is for a greater number to be 'scaled up' the tariff from other psychiatric units or from the community 'Into the Mainstream Sec.11. (2002) usually on the grounds of assault to staff. Ten years ago transfer from the criminal justice system was the more usual route (interview with Medical Director, April 2005).

2) Admission to enhanced medium secure unit

The criteria is that the woman does not need 'high secure' which is 'Category B' prison type security, as referred to by Tilt (2000). How this is assessed appears to be idiocyncratic and reliant on the professionals involved (Interview: Medical Director Rampton Hospital, April 2005). One of the professional interviewees for this study, pointed to cases where women have been admitted to the hospital with the same offence and back ground history as women for whom requests for a medium secure placement have been made, from a neighbouring area. This supports the findings of Rutherford and Duggan (2007), that categorisation is a lottery.

3) Admission to medium secure unit

The criteria for admission to a medium secure unit is that the woman's behaviour must pose a threat to the safety of herself and others. She is usually admitted with a diagnosis of borderline personality disorder, and as noted above, this criteria is remarkably similar to that used for admission to high secure provision.
4) Admission to enhanced low secure unit

The risk status of requiring a medium secure facility.

5) Admission to low secure unit

The woman is not manageable within a general psychiatric community
(Interview: Medical Director Rampton Hospital, April 2005.)

Not only does there appear to be confusion concerning criteria for admission, but that the grounds for admission to the different levels are interpreted differently by different groups of professionals. However, concern has been recorded in all of the documents and reports referred to above about inappropriate admission of women to high secure provision, including the Medical Director. In previous research I have undertaken WISH (2003), women ex-patients commented on the stigma attached to their stay in a high secure hospital, thinking that they suffered more with the psychiatric label acquired than their term spent in prison.

Community provision under the Mental Health Act 1983, incorporated into the 2007 Act

An important addition to the Mental Health Act, 1983, was the inclusion of Section 117 under which patients who have received in-patient treatment for more than a six-week period are entitled to receive support in the community. This Section remains unchanged under the Mental Health Act 2007. A care plan is formulated in consultation with the Responsible Medical Officer (Responsible Health Professional, 2007 Act) and the unit care team who are responsible for the discharge of the patient into the community, together with the Community Psychiatric Outreach Team who will be implementing the care plan, under the Care Programme Approach regulations, (discussed below).
A designated worker from the multi-disciplinary team is allocated to the patient, usually a community psychiatric nurse or social worker. They are usually the link professionals to the rest of the multi-disciplinary team and also to the resources in the community which are often organised and run by UK wide charities such as MIND, RETHINK or local charities focussed upon meeting local needs.

Women discharged from the secure system receive support in the community by virtue of their eligibility for Section 117. A previous study of ex-patients from secure units found the support varied, but that Women in Secure Hospitals (WISH) performed a vital role in their support network, Evaluation Study, WISH (2003).

WISH is a charity set up for women in secure mental health accommodation and also supports those who are being resettled in the community. WISH workers play an important role in supporting the individual woman and also members of the community care team. WISH offers support and advice to women throughout greater London and also from regional offices in the North West with workers available to the women in the secure environments. A WISH representative will accompany a woman to a Mental Health Review Tribunal and will advocate on her behalf when asked to do so. This occurs both within residential treatment units and with women living in the community.

WISH have long since recognised the need for women to learn skills, and in recent months, WISH has been involved with the Open College Network, helping women to gain qualifications and skills fitting them for work or to gain more from their leisure interests. Much of their work is carried out under the umbrella of Section 117 Mental Health Act, 1983 and links with other community resources providing support for vulnerable women living in the community (WISH Annual Reports 2000–2003). Most of the women in the
study have had contact with WISH through the charity’s representatives located locally.

The above background information is relevant in that the knowledge of what support can be available within different communities affects decisions made by professionals regarding the stage of rehabilitation, where a woman may be able to live in an ‘open’ unit or hostel within the community. WISH has been contracted by several local mental health trusts to provide resources to women who have been discharged into the community.

The Mental Health Act 2007 (Section 17a) sets legal boundaries for ‘treatment in the community’ and re-defines the responsibilities of mental health care professionals. The Act is too new and as yet untried in terms of women who set fires, to make useful predictions, but it is important to be aware of the future implications of the 2007 Act. It is difficult to estimate the numbers of women who may be directly affected by the sections relating to ‘compulsory treatment orders’ within the new legislation, or how the criteria will be interpreted and applied.

There was much opposition to the original revision of the 1983 Act, particularly to the sections related to containment on an assessment as to ‘potential dangerousness’. This was seen to be in direct conflict to the Human Rights Act, 2001. The government argued that it is primarily concerned with public safety and advocated containment together with treatment, despite the misgivings of professionals who advised against such measures. These more contentious areas of balancing threats to public safety against individual liberty were diluted in the final paper which received the Royal Assent in July 2007.

The issues of balancing rights and risks are the everyday concerns of the health care professionals working with the women who are the focus of this study. The debate is not just an emphasis on the safety of the individual and
the community but the wellbeing of the woman should she be faced with situations she is ill equipped to manage.

**Women offenders with mental health issues**

As previously noted many young women who have been graduates of the care system find their way into the mental health system, often via the prison system. Young women in care have limited resources to fend for themselves in the community. At sixteen, young people in care were expected to be able to live independently, to manage their finances, to be employed or to be participating in further education, ‘Me, Survive, Out There’ (1999). This report by the National Association of Young People In Care (NAYPIC), was used in their campaign for additional support for care leavers. This resulted in the Children Act 2000, which designated support for care leavers to achieve further education, gain employment and be settled in accommodation relevant to their needs. Many of the women currently in the secure mental health system found themselves homeless, without support and unable to cope, having left the care home or foster carers, with no other means of guidance or support Jones (1999).

The Corston Review (2007) also refers to the situation noted above that many women prisoners experience homelessness prior to their offence and sentence. The Review noted the number of women who are imprisoned with serious mental health issues and the length of time between referral to secure mental health services and their admission.

A woman interviewee in this study said that she waited six months before she was transferred from prison to hospital. On her arrival she was horrified to see bars at the windows, which she had not experienced in her prison sentence.

The Wish Report identified that substantially more women than men under the age of 24 years of age were admitted to high secure hospitals; 41.1% of
women patients were admitted before the age of 24 years, with 10% of these admitted as teenagers, in contrast, only 29.1% of men had been admitted to high secure hospitals on or before their 24th birthday WISH Report (1996–1997).

One of the younger women in the sample left the care of social services at sixteen without the support of her foster carers. She developed drug and alcohol dependency problems, which in part, led to her setting a fire in order to obtain help and remove her from her current situation. She was admitted to a medium secure unit, aged 19 years, from the local magistrate’s court. Most of the women in the study however, were admitted to the secure mental health service through the above means, or through a transfer from the prison system, either midway through their sentence or at the point of completion.

Young people in care and their lack of educational attainment was also the subject of a major governmental review by the Commission for Social Care Inspection (2006). According to the aforementioned review, a substantial number of young people are still leaving care without the necessary skills or support in place, to live independently. This problem has been noted in this study.

The estimate for women prisoners with psychiatric problems is approximately 70% according to Women in Prison (2007). 4% of women prisoners who have a history of mental health issues are transferred from the prison system to high secure hospitals, but of these 4%, less than 0.5% are women from different ethnic minority backgrounds WISH Report (2000). The figures show that a questionably small number of black, Asian or women from other ethnic minorities are transferred from prison to hospital. All of the women in this study were white and from the UK.

Whilst up until the mid-nineties, prison transfer was the most used route through to the secure hospital system for women, now it is progression from
local mental health resources, where a woman’s containment is problematic. Into the Mainstream (2002). This means that the patient is either physically dangerous or has set fires in institutional settings and possibly endangered life (Interview: Medical Director Rampton Hospital, April 2005). Although Stewart (1993), Frances (2002) confirm that the majority of women who set fires mainly do so to damage property and not with the intention of harming others, or endangering life.

It is estimated that 50% of the women who were contained in Broadmoor who are in the process of admission to the Women's Directorate, Rampton Hospital have a history of setting fires, (Interview with Medical Director, Rampton Hospital, April 2005). All of the women contained and restricted have been placed upon one of the aforementioned Sections of the MHA 1983, and can only be released from that Section by the Mental Health Review Tribunal or by the Secretary of State, Ministry of Justice. Their containment upon a Section of the Mental Health Act, 1983 is regardless of where they are accommodated, whether it is the high secure hospital or a medium secure unit.

Usually women who are transferred as part of their rehabilitation from the secure hospital to a medium secure unit still remain on the section of the Mental Health Act 1983 they were first contained upon. If and when a woman is able to live in the community, she still remains on ‘section’ but is ‘out on licence.’ These women still come under the jurisdiction of the secure hospital until their discharge from the relevant Section of the MHA 1983. This means that a small number of women who have set fires and who are living successfully and independently in the community are not ‘discharged’ from the Mental Health Act 1983. They could be recalled to the secure hospital in the event of any further misdemeanour or what is assessed or interpreted as a relapse in respect of their mental health by the community mental health team who should be regularly supporting and assessing the individual.
Most women with an 'index offence' of arson have been convicted of the crime known as 'arson with an intent to endanger life', (Interview: Medical Director 2. May 2005). Many of the women are handed life sentences for this conviction, even though only a small minority of women have inflicted or intended to inflict injury or death in the commissioning of the offence, (Interview: Professional Colleague June 2006).

A number of these women complete a prison sentence of anything between 4–6 years and are then placed upon Section 31/47 of the Mental Health Act and transferred to either high secure hospital or a medium secure unit. There is no limit on the time they can be detained and they can only be moved to another facility or released with permission of the Secretary for State, Ministry for Justice. The records from the (National Data Base, 2004) show that one woman was contained in Rampton Hospital for over twenty years in addition to the time spent in prison. No injury or loss of life is recorded for this patient’s offence.

**Policies into practice**

The most influential reports affecting the lives of women patients within the secure hospital system have been the Reed Report (1994), the Fallon Enquiry (1998), the Tilt Report (2000), and the recent Department of Health document, Women’s Mental Health: Into the Mainstream (2002).

The Reed Report conducted by Dr John Reed in the early 1990's, spans 11 volumes. Volume No. 3 is entitled ‘Patients with Special Needs, Women and Older Patients’. The Reed Commission referred to women patients as a 'specialist group' with only one reference to fire setting in women. However, Reed emphasised education within a rehabilitation programme for women. He also recommended that resources specifically targeted at women should be available, making the observation that services and facilities were those most relevant to male patients. His famous dictate, for which his entire report is
known, is that no patient should be contained at a level of security beyond their need.

The Tilt Report was commissioned in 1999 and reported in February 2000, after the Fallon Report, 1998, which indicated security failures and severe issues of misconduct of a number of staff in Ashworth Hospital. Tilt, the former Head of the Prison service, was primarily asked to inspect the security and 'relational activities' (Tilt Report 2000, p7) and a range of practices in all three of the special hospitals. Tilt, like Reed before him, identified the lack of learning opportunities and leisure activities as insufficient to meet the needs of the patients.

In terms of the provision of medium and low secure accommodation, it was the Butler Report of 1975 which first recommended the use of smaller secure units in addition to the secure hospitals, offering scaled down security, more befitting the needs of the individuals but still contained within a secure environment. Although the findings and recommendations of the Butler Report (1975) were accepted, the appearance of these smaller regional units were slow to develop during the 1980’s, though the numbers of beds in the medium and low secure units has doubled during the last ten years. Rutherford and Duggan (2007).

Added to this, the management of the three special hospitals was devolved from the NHS Special Hospital Commission to local Mental Health Trusts creating major administrative problems as the hospitals contained patients from the whole of England and Wales. This made financial responsibility a major issue when looking at the rehabilitation of patients assessed as able to live in less secure accommodation.

Many of the local authorities from where the patients had originated were reluctant to take on the financial responsibility of their care. Very often patients did not wish to return to their home territory, but local authorities in
their preferred location were also not prepared to allocate resources to patients from outside their area (Bartlett 2003). One of the participants in the study complained that she was moved from a medium secure unit where she felt that she made good progress. She had developed a network of friends in the locality and engaged in activities both inside and outside of the unit. Her enforced move to one of the units in Nottinghamshire on the insistence of her mental health trust funding her care, on the grounds that she had family in the locality, although she had no contact with them, caused her great distress.

The rationale for the transfer of the three hospitals to local Mental Health Trusts was to ensure ‘better integration’ (Tilt Report 2000, p12) of the hospitals within the range of local provision and mental health resources available within the community. Tilt also recommended a budget of 25 million to be spent between 2000–2003 on ensuring adequate places for patients being moved from the special hospitals to less secure environments (Tilt Report 2000, p13).

Medium secure and low secure provision in the community over the last ten years has proliferated. One of the most important organisations involved in the development of community resources is Partnerships in Care. This organisation set up medium secure units, and units known as ‘low secure’ within existing Mental Health Trusts. Regionally located close to Rampton and Broadmoor, Partnerships in Care have set up women only, secure mental health resources for women who have graduated from the two secure hospitals, for those carrying a psychiatric diagnosis, transferred from the prison system and women ‘scaled up’ from community psychiatric provision.

Partnerships in Care is a “lead organisation” in working with women who have set fires. They have developed women only specialist units and have promoted a women only Arson Treatment Group (ATG) in a Medium Secure Unit within the Nottinghamshire Mental Health Trust. Women who have been transferred from Rampton Hospital to these units can access the ATG. The
ATG forms a major plank in the rehabilitative prospects of women who set fires. The work of Partnerships in Care feature prominently in this study, as both patients and staff participated in this examination of rehabilitation.

**Women's Mental Health: Into the Mainstream 2002**

The Department of Health first published ‘Women's Mental Health: Into the Mainstream’ as a consultation document in 2002. It recognised, and furthermore, emphasised the need for “gender sensitive and gender specific services ... to ensure that gender is embedded in every aspect of mental health and social care” (Into the Mainstream p.5 2002). It has been the responsibility of the National Institute for Mental Health, England, to ensure its implementation in all of the residential and community resources throughout England and Wales. Into the Mainstream (2002) was the first consultative document addressing issues of inequality and discrimination of women within mental health services.

The second, published in 2003 entitled ‘Inside Outside’ set out the issues and concerns of black and ethnic minority mental health users, recognising that not only must the mental health resources be gender sensitive but also racially aware, respecting and recognising difference rather than interpreting other cultural norms as mental health issues. This has relevance for the secure mental health services in the provision of gender and racially aware services, which are now receiving long overdue attention (Inside Outside Department of Health 2003).

**Care Programme Approach**

It is not only the physical resources and growing network of less secure accommodation that has been responsible for creating more rehabilitative resources and opportunities enabling progression from high secure settings. The range of treatment options within a structured care plan, identifying
treatment pathways and treatment goals agreed by a multi-disciplinary team within set time scales, has revolutionised psychiatry countrywide.

The Care Programme Approach was advocated by the Department of Health for Mental Health Trusts and establishments in the early 1990's. The level relevant to this examination is the 'enhanced' approach. This has established an assessment and treatment plan in use in all secure mental health provision and this format is the basis of care and support within the community for patients released from secure hospitals and units. (www.hyperguide.co.uk/mha/cpa/htm) (Accessed January 2005).

Prior to admission to a secure unit or hospital, an assessment of the individual is carried out. This includes a 'risk assessment' to determine risk to the person or others. The assessment is carried out within a multi-disciplinary team, usually led by the designated 'responsible medical officer' assigned to the patient. The team records an initial assessment and outlines an interim treatment plan. At this time a 'key worker' is assigned to the patient and regular reviews are held by the care team which monitor her treatment and progress.

The Care Programme Approach sets out the treatment and social regime to be offered to the patient and detailed records are kept of the patient’s daily activities and progress within the various treatments, educational and social groups they are expected to attend. The Care Programme Approach featured prominently in the data collected from both the women cohort and also the professional workers group.

**Treatment options**

The physical treatments, drug regimes or electro convulsive therapies are not the subject of this study although it is recognised that they do have an effect on the women in the study group. It is not within my professional competence
to examine this area of their experience, only to comment on what I perceive to be their effects in my interviews with the women in the study. The range of therapies and treatments used in the treatment of women who set fires, is closely examined in chapters 4, 5 and 6.

Aspects of rehabilitation

Prior to the latest report (Into the Mainstream 2002) it was known that many women were contained in high security, not because this was necessary but because there was nowhere else which could offer the services the patient required. Recently there has been a more stringent policy regarding admission to high secure accommodation with a resistance to it being used as a ‘dumping ground’ for women patients who are ‘difficult’ to treat. (Interview: Director of Women’s Services Rampton Hospital, February 2005). The primary criterion for a woman to be referred to high secure is based upon an assessment of her level of danger to others, as identified earlier in this chapter.

As previously stated, over the last ten years, there has been substantial growth in the commissioning and building of regional secure units designated as ‘medium secure’ and ‘low secure’ units for patients who are in the final phase of rehabilitation and who are likely to return to the community (Royal College of Psychiatrists 2003). Places in low secure units are also used for women who are not able to live independently but who do not require the more secure services. The problem already emerging is that there is insufficient movement within this population for the number of places required, if the targets for ‘stepping down’ women who are unnecessarily contained in higher secure units are to be met. Two of the women in the study fall into this category, they do not expect to leave the low secure unit in which they currently live.
The managers in secure mental health services are required to balance the pressure for placements within their units with the need to ensure that the rehabilitative goals of their current residents can be met. The assessment of women's needs is also complex and potentially 'political'. An example of this is the closure of the women's services at Ashworth Special Hospital. A programme of movement was imposed on a population of 40 women. The initial assessment of the women's history and progress indicated that the majority of them could be moved safely to less secure accommodation. An inspection of their needs by the Home Office led to a request for Rampton Hospital to accommodate eight of these women. At that time, Rampton Hospital had a total of 40 beds in the women's services, all of which were occupied (Interview: Medical Director Rampton Hospital, April 2005).

This problem was further compounded by the 'accelerated discharge' strategy, implemented in 2003 again to comply with the 'Tilt' recommendations which resulted in approximately 100 women from the three secure hospitals being moved to less secure accommodation over a two year period. The accelerated discharge programme has resulted in the occupation of less secure accommodation over a longer period of time, with pressure to increase accommodation in medium and low secure units throughout England and Wales (Interview: Consultant Psychiatrist, April 2006).

Only one patient of that initial cohort who was moved from Rampton to a medium secure unit has been re-admitted. The response to the problem of insufficient lower secure accommodation brings into sharp focus the needs of women who have been accommodated in a high security hospital for a number of years. Reed in 1993 claimed that possibly as many as 50% of the women contained in high secure hospitals did not need such levels of security. The Tilt Report published seven years later in 2000 stated similar concerns.
Thomas et al. (2005) studied the records of women in the three high secure hospitals in 1999. The total population of women at that time was 190. They estimated that 75 (39%) continued to need 'high secure' provision but 63 (33%) needed a lower level of security. For 52 (27%) there was disagreement on the level of security required. The women for whom there was disagreement were more likely to be diagnosed with a personality disorder or mood affective disorder, more likely to have an arson offence or one of violence, compared with the women for whom there was agreement over placement. The group of women not needing the high secure service were significantly older and had recorded longer stays in one or more of the secure hospitals. They were less likely to have an index offence of homicide.

The survey by Thomas (ibid.) was undertaken before the accelerated discharge policy came into effect. Of the total group, just under half of the women in the high secure group and over a third in the low secure group were rated as having 'ongoing needs' in relation to Arson.

The current situation

The pressure to move women out of high security hospitals has escalated over the last three years, brought about by changes of policy regarding their containment. The rehabilitative programmes have been intensified and their timescales reduced. In the twelve months leading to the opening of the one high secure unit for women at Rampton Hospital, fewer than one hundred women were contained within Rampton and Broadmoor Hospitals.

The Rampton Women’s Directorate with a total of 50 beds in operation since March 2007 is now the only high secure facility for women. The rest of the population are accommodated in the range of less secure units dispersed throughout England and Wales. Given the fact that 50% of the women patients have a history of setting fires and that there appears to be a greater reluctance allowing them to embark upon courses of rehabilitation at
approximately similar times to their non-fire setting counterparts, the residual population contained within the new unit at Rampton Hospital is likely to contain a greater proportion of women who have set fires. One professional interviewee asserted that women who have set fires are contained in 'high secure' for almost double the time of non-fire setting women. The records kept on admission and discharge rates indicate that an additional eighteen months is the average extension of their stay, with the Tilt Report (2000) estimating that patients are in high secure hospitals for an average of 7–8 years.

Examining the data gathered in this current study, it appears that the longer the woman is contained in a secure setting the more difficult her eventual rehabilitation to independent living. The issues concerning the length of stay for women who have set fires and their future prospects of rehabilitation are examined in Chapters 4 and 6.

The policies shaping the secure mental health system for women, and the legal framework, form the context of this study in which treatment and learning strategies are analysed. Many of the issues identified below stem from those raised in this chapter. These include the prediction that women with fire setting histories will be contained in the highest level of security and possibly for longer periods of containment.

Included in the analysis are the experiences and opinions of a group of women patients, and a group of professionals drawn from a range of disciplines involved in their care. The concerns they raise, in particular about treatment strategies and learning opportunities, are the focus of this study, and are examined in the chapters which follow the review of the literature.
Chapter 2

Women Who Set Fires: A Review of the Literature

This chapter contains a review of material used to examine each of the areas which contribute to the formulation of the study questions with a summary, drawing together the most interesting, novel and important contributions to the questions overall. These are the policy and legal framework issues, discussed in the previous chapter, aspects of treatment in current use, the literature concerning research methodology, and theories of learning.

More importantly the review identifies research studies and articles which give a profile of women who set fires and explores some of the background factors and circumstances in which fire setting behaviours occur. It is essential that an understanding of the reasons and motivation to set fires is understood to appreciate the relevance of the questions posed in this study.

I have previously suggested that there is a paucity of research specific to the problems and particular needs of women who set fires. However, there is a growing body of research, as yet unpublished, concerning women in secure mental health resources (www.phrm.nhs.co.uk, accessed Aug.2007). Equally important is the recent requirement to develop gender specific treatment and containment since the publication of the Department of Health Review: 'Into the Mainstream' (2002).

The policies examined in Chapter 1 to a large extent explain the structure of the services, and influence much of the practice, looking at the treatment approaches to women who set fires. In particular the policies contribute towards answers to the second question of the study, which concerns the measures emanating from the policy documents which are seen to either facilitate or block progression for the women through the secure mental health system.
I have drawn upon enquiries and reports from the Department of Health and Women in Secure Hospitals (WISH) reports, together with research and journal articles relating mainly to the UK system. In general material which relates to the mental health and criminal justice systems in the US and in some European countries does not have sufficient similarity to permit a comparison of experiences and attribution of their findings to the population of women fire setters here in the UK. There are, however, one or two exceptions which will be noted in the discussion below.

The previous chapter reviewed the history of the policies, practice and legislation, which have shaped the current services and the resources available to women who have set fires. Their progression through the mental health secure system differs from non-fire-setting women in three respects: their access to the Arson Treatment Group; the length of time contained in the secure system; the additional assessment of risk which is undertaken prior to changes in their treatment or at the point of making a visit outside the institution or unit in which they live.

It was the Butler Review (1976) which set out the need for less secure accommodation to be made available through an increase in medium and low secure units across the UK. However, 17 years later, slow progress was criticised in the Reed Report Vol.3 (1993) and then nine years later, lack of progression was again highlighted in the Tilt Report (2000). All three Reports advocate less secure environments being made available for those patients who are not in need of high levels of security.

Madden (1996) was also critical of the lack of progress in addressing the problems noted by Butler and then Reed within the secure system, and together with the government reports, pressure was mounting to make available additional places in medium and low secure units. In terms of where women are contained, women have experienced major change over the last
two years. The only available high secure accommodation is the aforementioned 50-bedded unit within Rampton Hospital NHS SW (2006).

Also noted, there has been a steady increase in the numbers of medium secure units and low secure units within the urban areas of most major towns and cities throughout the UK within the last five years. In terms of recent progression, in the last two years approximately 150 women have been moved from the three high secure hospitals in England and Wales to less secure units (Medical Director, Women’s Services, November 2006). This number is in addition to those transferred through the ‘accelerated discharge’ policy implemented after the Tilt Report (2000).

Two years following the Tilt Report, Bartlett and Hassell (2002) asked the question ‘do women need special secure services?’. They provided evidence from a number of studies identifying the different routes to secure settings taken by male and female patients. The admission ratio of one woman to five men has been stable over a number of years. Women are admitted to secure settings because of offences such as damage to property, including arson, ‘self harm or aggression to hospital staff’ (Women in Secure Hospitals (1999). They tend to commit less serious offences, with 13% of the population being transferred from prison. The women are more likely to receive a label of ‘psychopathic disorder’ whilst men are assessed as having a ‘mental illness’ Bartlett and Hassell (2002), and Rutherford and Duggan (2004). Lart, Payne, Beaumont, Macdonald, Mistry (1999) claim there is a lack of gender sensitive treatment, and that little differentiation is made between treatment options between the sexes; however, women are more likely to receive drug treatments than ‘talking therapies. Lart et al. (1999) consider that treatment models are under-researched.

Opportunities for learning

The information required to answer Question 1 of the study, concerns the opportunities to make changes through therapy and the range of educational
and leisure activities available to the women. Very little information is available about models of practice involved in rehabilitation through the secure system. Mostly, this is seen by the professionals involved as including controlling symptoms of mental illness through medication, talking treatments, working in groups for either therapy, educational activities or in developing skills and interests.

Increasingly, many units operate in conjunction with local FE colleges in providing the education and specialist skills required to enable their residents to operate more comfortably in the community (WISH Report 2002). Despite the current culture of 'evidence based practice' there is little information on what works in terms of treatment of the women in secure settings (Lart, et al., 1999). No evaluation of treatment models for women who set fires could be found.

An important strategy in monitoring and measuring the daily experience of women in the 'secure system' has been the introduction of the Care Programme Approach in 1991, (Health and Social Services) Circular HC (90) 23/ (LASSL(90)11). This brought about the requirement for all mental health resources working with adults between the ages of sixteen and sixty-five to develop structured care plans for each patient and appoint a key worker (since 1999 re-designated as a Care Programme Co-ordinator) to meet targets of care with and for their patients. This included a multi-disciplinary treatment plan, regularly assessed and reviewed. For patients within the secure system, this is carried out formally by the local mental health commissioners every six months and includes ‘funders’ every twelve months.

The funders are representatives of the mental health trusts who hold financial responsibility for the individual and who foot the bill for the patient’s treatment, wherever that may be. The funders play a vital role in the rehabilitative process, as they can dictate what happens to the patient in terms of what and
where they are prepared to fund, despite the assessment of the patient’s care team, recommended via the responsible medical officer (RMO).

The objective is to ensure a regular review of patients requiring specialist mental health services with the aim of preventing, as far as possible, situations of self-harm or harm to others in the community. Within mental health institutions, the Care Programme Approach (CPA) through the regular reviews allows members of the care programme meeting to question the treatment and progress of the patient under review, to be party to decisions regarding rehabilitation strategies, and the potential release of patients. The six monthly CPA meeting is seen by some patients as a forum for them to participate and have their say concerning their treatment, whilst others take a passive position and do not contribute. However the reviews where all disciplines involved with the patient can contribute and arrive at decisions relating to treatment and rehabilitation plans is seen as significant progress, made over the last ten years (Turner, 1996) www.hyperlink.co.uk.mhs/cpa.htm (accessed April 2006).

The Care Programme Approach ensures that all the women patients in both the secure hospital and the medium and low secure units have access to their care plans and that these have been discussed with them and signed by them. They have a named co-ordinator, usually the responsible medical officer (RMO) assigned to them and responsible for them. In addition they have a ‘named nurse’ who is available to them when on duty and others who are available when he or she is not. The patient attends the six monthly CPA review meeting and they see this as a significant point in their treatment regime. The Care Programme Approach is the basis for their treatment and the monitoring process essential to their progression and movement through the secure system. Both the women in the sample and the professional workers were able to explain how the CPA helped the patients achieve their agreed goals and how these were monitored by the care teams.
Profile of Women Who Set Fires

Searching for studies which deal specifically with the causes of fire-setting for women exposes the paucity of such material. The studies of Arson mainly focus upon the activities of men. The criminal use of fire is mainly considered a male tool of aggression (Prins 2001). The explanations for its use for criminal activities are many. Some include setting fire as a means to murder, or for revenge, to cause damage, to cover another crime or for fraudulent gain. Fires can be set under the influence of drugs or alcohol, by both men and women (Stewart 1993).

Psychiatric assessment in some cases detect underlying mental illness revealing either psychopathic, psychotic reasoning or a condition which mainly affects men, Pyromania (Prins 2001). This is not to say that women do not set fires for any of the reasons cited above, but that it is unusual for a woman to do so. More women than men are assessed as having a personality disorder, men typically are assigned a mental health problem (Rutherford & Duggan 2007). (www.scmh.org.uk accessed October 2007).

The assessment process begins before the woman enters the hospital or medium secure unit when she is referred from a mental health resource, the criminal justice or the prison system. Often the reason why the woman resorted to fire-setting is obscure or is accounted for by a number of traumatic experiences. Operating under the Care Programme Approach (Department of Health 1991), and examined in Chapter 1, a multi-disciplinary care team is therefore assembled. Their duties include an examination of the woman’s history, to consider the best options for care, prepare treatment regimes and to embark upon the strategies of rehabilitation, offering the best pathway for the prospective patient.

Fire setting is located within the spectrum of self-harming behaviour. Coid, Wilkins, Coid (1999) studied seventy-four remanded women prisoners over an eight-week period. They found that fire setting behaviours were relevant with
34% of the women who self-mutilated, approximately one third of the population studied. They also noted that women with fire-setting histories acted impulsively, that their offending behaviour began in their early adolescence, that they had lived in damaging environments and that they were assessed as having an anti-social personality disorder. The importance of the connection between self-harm and fire-setting is its significance in terms of treatment strategies. Self-harm is a particularly difficult to behaviour to eradicate in patients and a connection between the two behaviours may mean that one ‘feeds’ on the other, or that one is a substitute for the other, making it very difficult to predict the risk factors of either behaviour.

The opinion expressed by some of the professional participants confirms the results of Coid, Wilkins, Coid (1999) study, in that fire-setting behaviour is set within the range of self-harming behaviours. In terms of treatment, Dialectical Cognitive Therapy (Linehan 1993) approaches are found to be useful and have been integrated into the Arson Treatment Group programme.

Bland, Mezey and Dolan (1999) extracted histories from 87 female patients in Broadmoor, who were between 22 and 88 years old. They discovered that histories of ‘sexual victimization and physical abuse’ were prevalent in a substantial number of the cohort. Self-harm was admitted by 94% of the women. Offences on admission were 71% for aggression towards others and 47% for arson. Again the numbers of women exhibiting the dual behaviours of self-harm and arson are broadly similar in both of the aforementioned studies.

Examining transfers from prison to the prison mental health system, Gorsuch (1998) studied the case notes of 44 women referred to the psychiatric wing of a prison with an average age of 30 years. Half of the sample were ‘difficult to place’ and had been refused admission to the secure mental health system, previously. Gorsuch noted their history of offending, self-harm, diagnosis and medication. The comparison group gained places with no difficulty. The ‘difficult to place’ had suffered childhood trauma and sexual abuse. They had
committed violent crimes and arson and had previously been contained in a secure mental health environment. They were also considered a management problem and a danger to themselves. They were assessed as having a personality disorder and not considered suitable for a community sentence or treatment under the Mental Health Act 1983.

This may be an area for change within the 2007 Mental Health Act, as the term 'mental disorder' replaces specific diagnostic labels, which may have mitigated against their admission to a secure mental health unit on grounds of 'untreatability'. Again, this study noted that women who set fires were contained in high secure hospital units longer than their counterparts without this history Gorsuch, (1998). Three years later, this fact was also noted by Bartlett and Hassell (2001).

Taking the figures from the above studies, the estimation of the numbers of women who have set fires range approximately from 30% to 48% of the women contained overall in the secure mental health system. However, the number of women with fire-setting histories from March 2007 would be between 60 and 80% of the population of women to be admitted to the new Rampton Hospital high secure unit (interview with Women's Director Rampton Hospital, October 2006).

The link between self-harm and fire-setting corresponds to the view that women set fires to harm themselves rather than others (Stewart 1993). Many women who have set fires carry the label of personality disorder. These are divided into three categories, (a) borderline personality disorder, (b) personality disorder, (c) severe and dangerous personality disorder, according to Bowers (2002) who uses the measurement set out by the DSM iii American Psychiatric Association categories.

Women who have persistently used fire-setting are likely to attract the label of 'severe and dangerous personality disorder' in the absence of psychotic
thought patterns (Interview: Psychiatrist MSU June 2006). Others who have used fire-setting less frequently are likely to be assessed as ‘borderline personality disorder’. Most women who are, or who have been contained within the secure hospitals, are assessed as being in this category. In Stewart’s study, 41% of women in her sample experienced psychotic thought patterns. These women would be subjected to the range of drug and talking therapies, focussed upon their mental health possibly more than their fire-setting behaviour. In this current study, similar evidence is found. All of the women in the sample were assessed as having a ‘borderline personality disorder’ often in conjunction with other psychiatric diagnosis, such as depression, or psychotic thought patterns (Interview: Psychiatrist MSU, June 2006).

Women tend more often to set fires to punish themselves rather than others. Stewart (1993) found that 69% of her study group attempted to destroy either themselves or their property. This connects to the theory of fire-setting being an extension of self-harming behaviours. All of the ten women who formed the research study group self-harmed in addition to their fire-setting activities. Only two women set a fire to seek revenge on a third party. As noted above, the majority of women who set fires are assessed as having mental health issues, linked to a personality disorder Rutherford and Taylor (2004).

It is a fallacy that fires are set by people who are obsessed with fire. Those who are may carry the psychiatric diagnosis of pyromania. Pyromania, is a rare condition which gives rise to pathological excitement and possibly sexual arousal in setting the fire, fascination with the fire itself, attending the scene and calling the emergency services. Pleasure, gratification or relief at the fire being dealt with, are emotions commonly reported by male fire-setters but seldom by women (Prins 2001). However, because women who set fires are very often contained in either prison or within the secure mental health system in concentrated numbers, it is more likely that women who do exhibit features associated with pyromania will be found in both populations (Coid 1991).
Many studies that include women in their sample analyse their findings using a set of criteria that fit the underlying causes for men and not women (Smith and Short 1995). Although it is recognised that women set fires for different reasons, few studies have examined these in detail. Reliance on assessment and treatment for women has been based mainly upon a psychodynamic interpretation of their underlying motives (Stewart 1993).

In terms of prevalence, studies point to more men than women setting fires, but an increase in the incidence of women fire-setting has been noted. According to Soothill, Ackerley and Francis (2004), one in five convicted arsonists are women. The average age for beginning a fire-setting career was estimated to be between 14 and 18 years of age (Soothill et al. 2004). However, Soothill et al. assert that this age range appears to be extending to women up to their 30’s, who are now known to begin their fire-setting careers later. One of the women in this current study falls into category.

Non-psychologically motivated fire-setting for profit, or concealment, or to facilitate another crime, extortion or political motivation, as previously noted, are largely male prerogatives. Women are more likely to be psychologically disturbed than their male counterparts, according to Herjanic (1977) and Tennent et al. (1971). Rider (1980) asserts that women have more destructive tendencies. Tennent et al. (1971) gives a characteristic profile of women who set fires, claiming unsatisfactory early upbringing, disruptive schooling, parental separation or disturbed sexual relationships. Tennent and colleagues' study estimates 51.8% of arsonists experience psychotic episodes, with higher rates of self-mutilation and attempted suicide. Tennent’s study also claims that ‘arsonists’ exhibit inadequate controls over tension and anxiety and externalise their frustration in fire-setting. According to Tennent (1971) the women also appear unable to apply more socially acceptable modes of expression.
None, according to Bradford (1982), set fires for sexual satisfaction. Although the Tennent study was conducted in 1971, the profile the authors describe also applied to the group studied by Stewart some twenty-four years later. Similar numbers have limited literacy skills. Stewart talks of her researchers helping the women who participated, to complete inventories and questionnaires.

However, a major proviso in the comparison between the two studies is the reference by the former study to women's sexuality. Tennent records that women fire-setters in comparison with non-fire-setters are 'promiscuous' and that they have more convictions for prostitution. Her study claimed that more of the women are likely to have children. Stewart talks of 'disinhibited' sexual behaviour and refers to Tennent's study. Caution, I think, needs to be exercised in claiming validity, by referring to studies dated over 35 years ago, as society's attitudes concerning sexual behaviour have relaxed over the years. Labels of 'promiscuous' or 'disinhibited' are contentious when assessing the behaviours of women today.

However, women who set fires may be seen to operate beyond the boundaries of cultural and social norms of the community in which they live, may account for the interpretation of their sexual behaviour as being 'disinhibited'. A possible cause for this 'disinhibition' may stem from their experience of sexual and emotional abuse, often beginning in childhood. Such experiences were reported by some of the women in my study, confirming the high number of women who have experienced sexual abuse, reported in most of the studies previously cited.

Geller (1985) looks at a phenomenon he calls 'communicative' arson. He describes this as being an activity designed to bring about a specific outcome for an individual. The case study he examined was one where patients were to be moved from an institution to a community facility. Reluctance to make such changes resulted in the women setting fires, in the knowledge that this
would be seen as a contra-indication to a move to a less secure environment. In the face of their fire-setting behaviours the patients remained in the institution.

A more recent study from Bristol (Smith and Short 1995) examines a similar phenomenon. A mental health community residential resource experienced six incidents of fire-setting over a five week period. These were fires and set by six women patients who were resident over that period of time. All of the women either knew each other or knew of the fire-setting events. These were described as copycat fires, but the original intention by the first one was to change the decision made concerning her discharge from the psychiatric setting where the fires took place.

The other women were deemed to have set fires as a means of communicating their feelings about the disruption in the Unit of a temporary move for refurbishment and the retirement of the medical director. Therefore all of the fires could have been set as a means of communication, as described in Geller’s study.

Geller (1985) and Stewart (1993) use the term ‘contained’ fires which refer to the fire having been set in a ‘safe’ place (for example, a stair well or dustbin). Whilst clearly these can have dangerous consequences, the original siting was to limit danger.

The incidence of copycat behaviour within psychiatric institutions is a well known phenomenon (Smith and Short 1995). The most common form of copycat behaviour is self-harm, in the form of cutting, or self-mutilation. As noted above, women damage themselves as an outward expression of inner distress and claim to find emotional release from the activity. As fire-setting is largely seen as a behaviour which fits the spectrum of self-harm it is easy to note the comparison.
The profile of women who set fires drawn from the research cited above provides a picture of women from childhood through to their thirties. They have often been known to the education authorities for truanting behaviour, and to the police and probation for petty crimes (e.g. shoplifting). They have often had a disrupted family life, been in care before the age of thirteen years with one or more parent absent and a high reporting rate of sexual and physical abuse perpetrated by a family member or close friend (Stewart 1993; WISH Report 1998–99).

According to Stewart's study more women who set fires reported having friends whilst the control group were more likely to describe themselves as 'loners'. More women in the control group were or had been married and had children than the women who set fires. More women who set fires reported sexual abuse and dysfunctional parenting. It also appears that even though for many of the women their education suffered serious disruption, more women fire-setters were employed than their non-fire-setting counterparts (Stewart 1993).

Stewart's sample when matched for their criminal behaviour profile, did not differ except in fire-setting: half of the twenty six women had come to the attention of educational authorities or mental health services prior to leaving school age. 71% of the sample admitted to having been sexually abused – significantly more than among the control sample. 77% of the sample had not completed education, but surprisingly more arsonists had been employed than among the control group. 25% indicated that fire predominated in their fantasies. Women destroyed mainly their own property or that of partners and relatives. There were several accounts of this from the women in this present study.

Other fires were set in safe, 'contained' targets in that they were set in abandoned buildings, cars, dustbins, disused hospital wards and an empty post office (Stewart 1993). The motives for fire-setting were described in
Stewart's study as self hate, primarily followed by revenge. Stewart's study, claiming a quarter of her sample fantasised about fire setting, conflicts with the previous studies noted, where this was not considered significant for women Prins (2001).

Stewart (1993) suggests the areas to be targeted for treatment are low self esteem, a focus on attaining social skills, work on assertiveness techniques, dealing with depression and para-suicidal behaviour and gaining a competent level of literacy. Stewart's research is one of the only ones which suggest options for treatment.

Levels of literacy

Several studies refer to the fact that women fire-setters did not complete their education (Stewart 1993; WISH 1998–1999). However, the statistics from the National Data Base that records details for all individuals admitted to one of the three high secure hospitals, suggest that women were registered as attending education for the legally required period National Data Base (1972–2004, accessed May 2005). This may not relate to the actual experience of the women, many of whom report absconding, and absenteeism as early as from junior school through to their senior education. Stewart (1993) estimates that 77% of her sample did not complete their education. Several women in my study admitted to years of non-attendance in senior school, with one woman reporting that she had not attended school since the age of twelve.

In answering the study questions it was necessary to get to grips with the complexities of the issues faced by women who set fires. Many clinical papers concerned with fire setting attest to the fact that substantially more men than women engage in this activity. Only one in five convicted arsonists is a woman, according to the study by Soothill, Ackerley and Francis (2004). Their paper goes on to examine the trends of women convicted of arson, and records a substantial increase in the conviction rates for women from 1951 of
4.1% of the total conviction rate for arson, rising to 14.2% of women convicted of arson in 2001. Soothill et al. (2004) then identifies that the age of women at the time of offence has also risen significantly.

The profile for women fire setters indicates that it is an offence committed predominantly by women under 30. However, Soothill et al. (2004) point to an increase in the age of women recently entering the secure system because of an arson conviction in their 40’s. Their study concludes that no women were convicted of fire setting at age 70 or more, whilst this was still a fairly common occurrence for men. This issue of age is important for further research into the problems of fire setting. However, all but one of the women involved in this current study were in their teens and twenties when they began their fire setting careers, the exception being a woman in her thirties when she commenced. The way in which the sample was selected is discussed in the following chapter.

An enduring criticism of all of the research located that examines mental health and arson, is that very few studies differentiate between the sexes. This is despite recognition that women may use fire setting for very different reasons to that of men and that these reasons may have implications for their treatment and eventual rehabilitation.

To summarise the profile of women who set fires

The studies identified above, examining the histories of women who set fires, claim that many of the women refer to their childhood experience of sexual abuse from a family member or friend. Among the research studies and policy papers, there are estimates as low as 50% and as high as 80% of women who have been sexually abused as children and that this is noted in the studies reviewed as an important factor that may be significant in the causation of the women’s fire setting histories.
They also claim that the women often left school or were excluded from school before the age of sixteen, that many of them have experienced teenage pregnancies, most spent time in local authority care, that they were mainly unemployed, and many also known to the psychiatric services as an adolescent. The majority of the women accumulated a psychiatric history as well as a criminal one. Because they are perceived as dangerous, they spend longer in secure mental health resources (WISH 2000). This aspect was an important feature in the data collection for this study.

Some of the studies above looked at the incidence of fire setting and the antecedents to fire setting actions, but as previously noted, only Stewart (1993) identifies what needs to be considered in terms of treatment. She advocates skills classes in literacy, creative writing and assertiveness work.

Both the Reed Commission (1993) and the Tilt Report (2002) refer to the need to create opportunities for women to engage in the aforementioned activities, as does 'Into the Mainstream' some years later. This study also identifies gaps in learning opportunities and activities that the women have requested.

In general terms, Lart, Payne, Beaumont, Macdonald, Mistry (1999) also identify the problems noted above: that the studies often did not differentiate between men and women and more importantly, that there was no acknowledgement that women’s issues of abuse needed to be specifically addressed and that a 'one size fits all' approach does not work. It is also noteworthy that models of practice have not been evaluated in terms of their efficacy. A further problem noted was the terminology with regard to diagnosis. Some studies refer to 'borderline personality disorder,' others to 'personality disorder', and others to 'anti-social personality disorder'. Given that there were no definitions of the terms used, it cannot be assumed that we are examining 'like for like'.
Bartlett and Hassell (2001) advocate the need for qualitative studies examining the lives and experiences of women in secure settings in order to identify treatments targeted on their needs and to help them to deal with their histories of abuse, discrimination and isolation. This current study is an attempt to consider treatment and practice models for women who set fires, who form at a minimum over 50% of the population of women in secure mental health settings.

The research methodology

In putting together a research strategy, a rich seam of literature examining qualitative methodologies was available, enabling the study to be structured upon a foundation of reports, enquires and research into the care of women in high secure mental health settings. Bryman (2004), and Layder (1995) helped in the choices of structure and planning of the different stages. Thus giving sufficient scope to make changes, as the preparation stage progressed. Cresswell (1998) was influential in confirming the choices made.

Bryman (2004) offered a useful resource that distilled many of the key researchers contributions to the field of qualitative analysis. Among these, the work of Alston and Bowles (2003), who suggest a requirement for extensive detective work, and Denscombe (2003) in providing a checklist to ensure that considerations of ‘relevance’ and ‘feasibility,’ were taken into account in the construction of this study proved particularly valuable. The writings of Knight (2002) and Gomm (2004) supported a pragmatic approach in order to find a balance between what is considered ideal and what is realistic in the commissioning of research. In considering the arguments between a quantitative and a qualitative analysis, Hammersley (1994) talks of ‘social realism’ where the gathering of information, opinions or perceptions from the perspective of the individuals gives meaning and form to statistical data. This approach is in evidence in this current study where the contributions from the interviewees are intended to bring to life the information gained from other sources.
The formation of the study was shaped significantly by what would be permitted within the secure mental health system. This is strictly regulated and controlled by the Ministry of Justice (formerly the Home Office) and the Department of Health. This left some of the options considered imperative in qualitative analysis unavailable to me. Many of the studies using interviews to obtain data expound the virtues of the taped interview. Unfortunately this was not a method available to me as no recording equipment is allowed in secure mental health settings. However, as Kvale (1996) argues, the emphasis on recording of interviews may be excessive; he suggests that an interview recorded in note form also has many advantages. I use his arguments to consider the quality of the data collected and stored in note form from the interviews with the two cohorts.

The present study relies heavily on description where analysis or comparison with other studies is not possible. As previously noted there is a paucity of material examining similar issues. Silverman (1997) and Denzin (1997) acknowledge that 'thick description' has an essential role in qualitative research design. Silverman cites numerous examples of qualitative research where vital information would have been lost had it not been for a narrative describing events or observations about specific relationships which added an important dimension to the studies he discussed.

The area of data analysis was rather more contentious in that there is a myriad of systems and software packages advocated in the literature. Bryman (2004) gives a detailed account of the use of NVivo 2, whilst some of the older literature does not specify a particular system, but takes the reader through 'handmade' allocation of categories, methods of cross-referencing and strategies of triangulation. Having reviewed the packages available I finally chose NVivo 7 as the qualitative software package most likely to demonstrate a useful analysis of the data gathered.
Unfortunately the application of NVivo7 proved disappointing, in that it contributed nothing that had not been achieved by 'eyeballing' the data. I therefore abandoned computerised technology and instead analysed the data 'by hand.' This is explored in the following chapter, together with a discussion of the recruitment of specialist reviewers who examined and verified the accuracy of various sections of the study.

A criticism of many of the studies examined was that they did not specify their method of data collection, or analysis. This made it difficult to assess their claims, or to apply their methods to this study. However, sufficient studies, including Stewart (1993) Coid (1991), and WISH (2000), gave background details of women who set fires to build a useful profile of them. This has been used to argue for particular aspects of rehabilitative strategies in answer to the first question of the study, in the final chapters.

A detailed justification for the study, its methods and application is required to demonstrate why the study was formulated as it was. In spite of the approval of the five Ethics Committees, I was unable to proceed as planned because of the blocks to the research at institutional level. This was particularly in the case of the identification of interviewees. Therefore, I had to construct the study around what was possible, not what was desirable. These issues are examined in the following chapter, which discusses in detail the methodology utilised in this study.

Treatment groups and programmed activities

Two groundbreaking innovations in the treatment of women who set fires have been the Arson Treatment Group modelled and implemented within the Medium Secure Unit, and the Meaningful Day Programme modelled within the secure hospital. Both provide valuable avenues for further examination at a later date.
As previously indicated, the only specified treatment strategy for patients who set fires is the Arson Treatment Group (ATG). Into the Mainstream (2002), advocates the ATG as a major treatment strategy for women in this category.

Unfortunately, this study revealed the lack of opportunities for women to undertake an ATG, particularly in the high secure hospital, although this is now being addressed. This study revealed an impasse between two departments within the hospital which led to the women being denied this opportunity for approximately eighteen months.

There is only one study that looks at the application of an ATG (Swaffer, Haggert and Oxley 1999). This is a descriptive account, which does not differentiate between the sexes but advocates the ATG as an important treatment tool for ‘arsonists’. A recent unpublished MA study, Gill (2006), examines issues of self-esteem, confidence and patterns of thought affecting the way women learn and how they can potentially benefit from the treatment group. Both of these studies are used in evidence to support the central argument of this study, suggesting that greater integration between the two camps of therapy and learning could prove an important factor in the rehabilitation of women who set fires.

An observation of the novel pattern of group work revealed in the ATG, and the different aspects of learning that are focussed upon are examined in Chapters 5 and 6. They are seen as being an integral treatment tool for women who set fires and used as evidence to answer question one of the study, in measuring the extent that learning opportunities contribute towards the women’s progression through the secure system.

Stewart (1993) identified issues of self-esteem and lack of confidence as extremely important in the treatment of women, and particularly women who set fires. On the basis of this study, together with the knowledge of the abuse experienced by so many women who set fires, it has been possible to critique
the ATG currently in progress with women in the medium-secure setting in Chapter 5. A number of women in this study talked of their experience of this group.

The lack of research concerning treatment models has been noted above. It is therefore important to evaluate the ATG learning as described by the women in the study, within a theoretical framework giving it a context and rationale for its development. At this point measurements such as self-esteem ratings, assessment of confidence, appraisal of risk assessments, prevention of harm and an ability to adopt ‘keeping safe’ strategies are indicators of whether the current configuration of the ATG yields positive results.

This present study spanned a time of considerable change, which formed part of the analysis and is central to the second research question exploring what helped to facilitate, and what were the blocks to rehabilitation. The physical environment and the ethos of treatment are examined. The study returns to the recommendations of Reed (1993) and Tilt (2002), culminating in ‘Into the Mainstream’ which forms the basis of the rationale for the development of the unit for the number of women estimated as needing to be in a high secure environment.

The new unit attempts to address, within the Meaningful Day Programme, criticisms of the lack of activity for all women contained (Tilt, 2002; ‘Into the Mainstream’ 2003). The Programme is to have a clearly structured timetable, breaking down the daily activities into meaningful tasks with goals, identified and assessed for each of the women. However, significant gaps exist in the programme, resulting in women not engaged in tasks or activities for between 3-4 hours in each day. Another omission was the ATG which was not included in the initial Meaningful Day Programme. I understand that despite this, it began in June 2007 for the women fire setters deemed ready for this intervention.
The Meaningful Day Programme within the high secure hospital is new and has only been implemented since March 2007. Partnerships in Care, medium secure unit, have in place a system of tracking the daily activities of each of the women within their three units, overseen by the Director of Programmes. As yet, no studies have been instituted to evaluate the daily activities of women contained in these environments.

Also discussed in this analysis are some of the difficulties in conducting research and adhering to a protocol of openness and sharing of findings with key personnel during the study period. The tension between research uncovering unacceptable truths, and the institution's need to justify aspects of its operation led to difficulties which are discussed later in the study.

Learning and therapy

I have examined some of the reasons why a substantial number of women who set fires have limited skills in literacy and search for the clues to this deficit in a sociological review of educational studies, including Bourdieu (1998 cited in Giddens 2006) and Goleman (1996 cited in Jarvis 2006). I attempt to substantiate claims that literacy plays an important part in the rehabilitation of the women.

I further examine the relationship between theories of learning used in primary education, notably Piaget (1926) and Erikson (1963). The reasons for reviewing literature of this period are because the majority of the women in the study would have been of school age at this time these theories of learning were translated into practice in the classroom. I argue that women with experiences of trauma and family breakdown are impaired in their ability to learn literacy skills at an appropriate age because of their emotional state rather than their lack of intellectual capacity for learning.
The interviews with some of the women talked about their inability to think about learning because of their anxiety and fear of what was happening to them and or other members of their family. For some of the women in the sample, when exposed to formal learning opportunities, the feelings associated with their school days are relived.

In the light of this, I revisit Jackson and Marsden’s study (1962) of education and the working class, and later studies Bonney (1998) who examines the concept ‘working class’ and identifies issues of race, ethnicity and poverty in a critique of poor educational attainment by children in industrial societies. I also revisited Holt (1964) and his groundbreaking work on how children fail, the title of his study in the mid-sixties, particularly his examination of how humiliation and fear contribute to lack of attainment. I suspect that Holt’s children’s experience of education would have been moulded by the recognition of their social class, ethnicity and the educational aspirations of their parents. The accounts of the women confirm that their personal traumas went unrecognised in the class-room.

I have returned to the seminal works of social psychology to construct the arguments concerning the inter-relationship between adult learning and therapeutic interventions, particularly focussing upon women’s experience of both. Belenkey et al. (1986), Rogers, C (1961) and Rogers, A (2004) contribute to this understanding.

Jarvis (2006) integrates much of his earlier work into this text, which is the first of three, drawing together a very far-ranging scope of ideas from philosophy, educational theories and the social sciences to re-formulate an all-encompassing theory of human learning. This work provides a useful platform for an analysis of the process of learning, which maps the progress of some women through the system of rehabilitation.
I have used studies in self-esteem and confidence building (Rogers and Freiberg, 1994), in this chapter to argue that the acquisition of literacy is also a tool to make good use of therapeutic interventions. This is demonstrated in the diagram constructed by Jarvis (2006) who models the relationship between intellectual and emotional learning and making changes to perceptions, feelings and actions.

The seminal work of Freire (1972) who recognised the importance of learning for individuals as a necessary foundation for survival if reintegration with the community is to be achieved was also valuable. Freire’s work with groups of learners shows many similarities with the women contained in secure accommodation. He identifies knowledge as power that can be utilised by the individual to gain an understanding of their situation and to determine actions, which can either maintain or change the situation, giving the individual choices, which were not available prior to their acquisition of literacy. Freire coined the term ‘conscientisation’ which was also adopted by feminist writers, and adult community educators from the 1970’s onwards, meaning a consciousness about the relation of power between those in possession of knowledge and those without.

A major theme for Freire was education through a dialogue between equals, that learning can only take place if it resonates with the lived experience of the learner. I draw upon the interviews with the women and professional workers to argue the relevance of Freire’s work and how learning for the women has not and cannot take place without respect and understanding of their experiences Gill (2006).

By using the work of Freire (1972), I also seek to emphasise that literacy is essential to the women in their progression through the treatment system. They need to be able to use language and thought to evaluate and legitimate their own experience. They need literacy to read reports and to challenge or explore the detail pertaining to them. They need to be able to access literature
to learn other ways of dealing with thoughts, feelings and actions. Finally they need literacy skills to manage their daily lives in and outside of institutional settings. Other writers also in adult literacy hold the same view, but my preference for Friere is because his writing expresses with clarity his theories and the descriptions he uses of his work fires the imagination.

Theories of learning lead to an understanding of how the goals and aspirations of some of the women have to be measured against one of the major blocks to their achievement, that of institutionalisation. Here the seminal works of Goffman (1961) and Foucault (1988) bring a damning account of its effects, not only on the patients contained but also on the staff who work with them. This work is central to the examination of the blocks preventing progression and rehabilitation, which is the second question of the study. Some of the accounts of the daily lives of the women and staff demonstrate the insidiousness of the effects of institutionalisation and how difficult it becomes to think outside of practices, which are woven into the daily routines of the institution.

Conventional group work used in both therapy and learning are explored in respect of the first question about learning for change. The literature used to support the arguments in the way in which learning is acquired comes mainly from studies of group work, Douglas (2000); Whittaker (2000), adult learning, Jarvis, (2006); Rogers, A (2004) and social psychological theories concerning human learning, Rogers and Freiberg (1994). In terms of Assertiveness work which is introduced as a component to many of the learning activities, draws upon the work of Dickson (1983) and Lindenfield (1993).

The final part of the study is an examination of the data collection process. It refers back to Chapter 3, which examines research methodology. The conclusions and recommendations, which draw together the answers to the study questions, make reference again to the literature identified in the chapters above.
Conclusion

This review has identified the main themes and issues that need to be addressed in this study of rehabilitation through the secure mental health system. An examination of the main treatment model, the ATG is linked to the theories underpinning its rationale and focus for women who set fires. The approaches used to capture the views of women who set fires and whose lives are lived in secure settings have been identified, together with an identification of the many blocks to their progression. Finally, because of the speed of implementation of policies and strategies over the last two years affecting the lives of women in secure settings, this study has been constantly updated.

This study has taken into account many contributions across the literature of the social sciences, of learning theory, reports and policies to provide answers to the study questions. The main points noted for examination and discussion are contained within the discussion identified above and in the conclusions of this study.
Chapter 3

Research methodology

Introduction

This chapter examines the methodological framework for the study and considers in detail a range of theories from recent writers of research whose advice has influenced the construction of this work. Bryman (2003) and Layder (1995) have been particularly influential in the creation of research maps that helped clarify the issues, categorise sets of data for collection and utilise the relevant tools for analysis. Contained in this chapter is also an account of the problems faced and the way the study changed shape to deal with the different issues encountered.

To remind the reader, the study questions are as follows:

1) To what extent do the learning opportunities for women fire setters in secure mental health settings contribute towards their successful rehabilitation into the community?

2) What are the factors that facilitate rehabilitation and what are the blocks to this achievement?

This study was formulated on the hypothesis that women who set fires have a more problematic route through rehabilitation within the secure mental health system than non-fire-setting women. The preliminary examination of the process of rehabilitation, and the statistics gathered through the National Case Register, confirm that there are serious blocks to their progress through the system, particularly their movement to less secure environments. Stewart (1993) found a high proportion of literacy problems amongst the women in her study. Therefore this study examines the question of literacy and other
learning in an attempt to measure its significance for the women in their progression through the secure mental health system. This first question of this study, explores literacy and the learning of skills, hitherto denied them.

The second question, looking for other factors, which may aid their rehabilitation, and indeed the blocks to rehabilitation. One of the blocks, referred to above, and confirmed by (Rice 2005) as well as some of the professional workers who participated in this study, is that women who set fires are contained longer within the secure system, and that the surveillance to which they are subjected reduces opportunities for their rehabilitation.

Returning to the first question, a key feature of the study is to establish the use of learning opportunities offered within the rehabilitation programmes for women. The evidence from studies of education for women who have lived with disadvantage point to improvements in self esteem, and confidence when skills of literacy are acquired. These attributes enhance their abilities to manage their problems more effectively (Thompson 1983). Self-esteem and confidence are considered positive indicators in an assessment of the mental health for women Lindenfield (1993), Showalter (1986) Whittaker (2000).

The questions evolved during the preliminary stage of the study, which involved talking with mental health professionals to discover more about the lives of women who set fires, their treatment and their opportunities for rehabilitation back into the community. The questions allowed for a broad range of research methodologies, these included a critique of policies and procedures, a statistical examination of the numbers of women who are contained within the secure system, who have a history of fire setting and a qualitative enquiry, searching for facts and opinions from a sample of women patients and professionals, involved in their care.

Prior to embarking upon a study and the construction of a methodology to achieve answers to the questions set, Bryman (1995) and Alston and Bowles
Constructing the study

I have relied heavily on Denscombe (2003) as his work enables the researcher to provide the answers to his set of questions which aid the structure of a study. This can then form a framework which can clearly identify the potential strengths of the data gathered and its analysis as well as pointing to the difficulties which may be found as a consequence of the earlier choices made. His approach to research encourages the researcher to question each aspect of a potential study in terms of its value, meaning and ethics, leading towards the creation of an interesting and hopefully useful study. Figure 4 below, provides a table illustrating the stages proposed by Denscombe applied to this study.

Denscombe (2003, p5) lists ‘Relevance’ as the first measure, the question being ‘does it matter? In the case of this study, this can be affirmed without hesitation. There is little research about women who set fires and no independent assessment of the rehabilitative process could be found through the literature search. This study will hopefully provide a timely contribution, particularly as there is significant change in the containment of women in the secure mental health system, previously noted in Chapters 1 and 2.

Denscombe (2003, p6) second question is ‘Feasibility’, “can the research be done?” For a professional to undertake a study concerning individuals, either workers or patients, within the secure mental health service, without being part of the service is difficult for two main reasons. The first reason is that the secure mental health system works with extremely vulnerable and sometimes, dangerous individuals; without such background experience, the researcher could in ignorance cause distress, which could have far reaching repercussions. The second reason is that operating outside the system, regulations and protocols of protection for both the patients and the
researcher make it extremely difficult to gain access to material, data and participants. This posed a major problem for me following approval by the NHS Ethics Committee. It was expected that I would attend a two week programme at Rampton Hospital to initiate me into the security measures to be observed. Fortunately this was waived by a decision made by the Rampton Hospital Ethics Committee.

The reason for such blocks to be put in the path of researchers may in part be because the secure hospital system has still maintained some of the characteristics evidenced in Goffman (1961). Although his study of total institutions was carried out in the late 1950's, some of his findings are relevant today. In particular, the apparent reluctance to expose working practices to scrutiny, especially by outsiders, who are considered to have few credentials in the field of forensic mental health.

I have a history of work associated with the secure mental health system, and this association enabled initial discussions to take place. Even with this level of experience, however, progressing this study has been a long and arduous process, with many blocks and obstacles needing to be negotiated. The positive aspect of this experience is that the research structure, design and methodology has been closely scrutinised, which led to changes that have strengthened the study. It is also hoped that because so many individuals now have a stake in the study, it stands a better chance of being considered ‘valid’ by the people who are in a position to instigate changes.

I was fortunate that the study was supported by the former Medical Director of Rampton who allowed the Senior Psychologist to act as ‘in house’ research supervisor. In the month we worked together she provided valuable advice on promoting the research within the institution and also negotiated the involvement of key people. Unfortunately both the Medical Director and the Senior Psychologist left within the following month, and although tentative
plans had been made to transfer support to another member of staff, this did not materialise.

As the study progressed I realised just how necessary it was to have 'inside' assistance. However, the support I received from staff who were behind the research was invaluable and enabled me to continue to complete the data collection, although ongoing discussions and access to personnel during the last few months of the study were discontinued.

Writers such as Knight (2002) and Gomm (2004) discuss the fact that much research has to be shaped around what is feasible. The study had to be designed, taking account of local conditions and regulations, enabling the collection of data relevant to the questions to be addressed. The approaches used, in turn affect the analysis and assessment of data collected. The decisions taken determine, whether at the conclusion of the study data have been generated that effectively answer the study questions, and indeed, whether the results will still have relevance, as Denscombe’s first question asked.

This study has undergone fairly major transformations, partly in response to the recommendations by the various Ethics Committees and partly because of knowing what would be feasible in terms of data collection. Originally I wished to conduct the study over a wider geographical area, circulating a questionnaire to approximately 20 medium and lower secure units, but despite having gained ‘multi-site’ approval from the NHS Ethics Committee I would still have been required to submit to each mental health trust a fresh proposal to their ethics committee. This was not considered feasible at this stage as to the point of gaining permission to contact staff employed by the Trust had taken me eighteen months and submission to five ethics committees, the Nottinghamshire Mental Health Trust, Rampton Hospital, Partnerships in Care and the Universities of Portsmouth and Surrey.
It was also known that it would be extremely unlikely that access to patient files would be allowed for what is designated a study primarily undertaken for a post-graduate degree. Therefore it was recognised that the interviews with patients and staff would be crucial. I anticipated that only limited documentary evidence in the form of policies or written practices, not in the public arena, would be made available.

The women participants

I had expected to be able to choose the women to participate, which would have provided a sample locating a similar number of women across the units, and cross matched for age, length of time in a secure setting. This was not allowed. The women were chosen by their Responsible Medical Officer (RMO), and some of these women refused to participate. I corresponded with all of the potential participants setting out the purpose of the study, their role in participation and offered reassurances concerning their anonymity and confidentiality.

In terms of the women in this study, they compared highly with the profile of what appeared to be the total population of women contained within the high secure hospitals at the time Parry-Crooke (2000). This showed that many women had been treated within the mental health system since they were sixteen, many had been in the care of the local social service departments, few had achieved GCSE’s, with the majority having very rudimentary literacy and numeracy skills.

The majority of women who were put forward for this study have life events that match the profile given in the WISH Report (ibid.) and also the previous WISH Report 1998-99, discussed in the literature review. These events include, all manner of abuse from an early age, educational under-achievement, received into the care of the local authority, had been juvenile offenders, and received psychiatric treatment. There are some grounds
therefore, for presuming that the sample identified are fairly representative of the total population of women in secure mental health services.

A further frustrating aspect of the recruitment of volunteers for the professional cohort, was that despite posters advertising the study, and presentations about the research conducted to the professional groups employed in this field, volunteers were few. Although a substantial number agreed to participate, which would have given adequate representation of their professional group, they were very difficult to 'pin down' to an agreed time and date. Therefore, it was not possible to recruit a cross matched sample of participants to the study.

The following table shows the disciplines of each of the professional participants:

<table>
<thead>
<tr>
<th>Discipline</th>
<th>High secure hospital</th>
<th>Medium/low secure units</th>
<th>Independent consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Directors of women's services</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Arson Group Leaders</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Educators</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Programme leader</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adult literacy advisor</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Community Literacy tutor</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Table 1. Disciplines of the professional participants to the study
Another example of shaping the study around what is feasible, is the fact that interviews could not be recorded because of the Home Office regulations. Therefore no transcriptions of interviews could be made. This results in a significant loss of actual verbal responses. However this can be balanced against the fact that I, as the interviewer and a trained and experienced mental health worker, have been used to listening and recording information from both verbal and non-verbal communications.

Kvale (1996 p. 32) takes issue with the practice of transcription of oral interviews and suggests that much is lost through the transcription of a live event, an interaction between two people and its representation in the written form. He asserts that note taking and the writing of notes after the interview is valid as the interviewer can capture the essential meaning and also interpret responses which lend a richness to the exchange otherwise lost. Kvale comments that if Freud had not worked in this way he doubts that the theory of psychodynamics and psychoanalysis would have emerged from Freud’s work.

To return to Knight (2002) and Gomm’s (2004) initial examination of what is feasible, choices of what a researcher may want to do and what they are allowed to do are often not the same. This point was clearly made in the process of carrying out this study. Knight (2002) recommends that the researcher engage participants in the study by involving them in a review of the data collected. He also emphasises that interpretation is the territory of the researcher, but that useful insights and reflections can enhance an understanding of the data at this stage.

In the spirit of involvement and engagement as well as ‘triangulation’ of the accuracy of the data collected, I invited some of the participants and the sponsor to the study to discuss the accuracy of various chapters, particularly the policy and legal framework section, the ATG, and the Meaningful Day Programme, examined in the following chapters. Whilst there was no
argument about the accuracy of the work, issue was taken with interpretation (despite Knight’s protestations). I was required to remove certain passages, if my access to the research site was to continue.

Another example of the difficulties in undertaking this research was the occasion when interviewing a woman patient in the presence of a member of staff, a query was raised that my questions to the participant were not about ‘arson’ but about ‘what goes on here’. This was despite a presentation about the study to the staff group, and recognising the staff member as one of the attendees. Fortunately, the Director of the Unit dismissed the person’s objections and supported the study.

Data gained through interview

Denscombe’s (2003, p6) third question relates to ‘Coverage’. Will the questions asked provide the information required? In this study, the structured interview schedule was the subject of rigorous examination by the Ethics Committees of the NHS and of the independent sector residential services and is discussed later in this chapter. The second point relating to coverage is whether the method used, or the formulation of the questions, would provide the information required. Questions familiar to the researcher might be interpreted differently by the respondent and thereby fail to produce relevant data.

The process of questionnaire design and the format for semi-structured interviews was examined against the guidelines discussed in Bryman (2004), Layder (1995), and Kvale (1996). The format for the interview schedule was tested amongst colleagues working with women within the secure mental health system. They were interviewed using the schedule and invited to give comments about it. Similarly two women from a WISH project also agreed to be interviewed and to comment on the process. As a result of piloting the semi structured interview schedule for the women participants, changes were
made to the introductory questions. This aspect is examined in detail later in this chapter.

However, in retrospect, the questions relied upon the ability of the participants to expand and engage in a free flow of ideas, reminiscences and exploration of thought. This was not forthcoming with the majority of the women participants. Several of the women in the sample offered only monosyllabic responses to the questions asked. Others went off on tangents that bore little relationship to the questions asked. Therefore the questions should have been more direct, and specific in requiring detail of learning enabling me to link more closely the process of learning to the route of rehabilitation.

However, returning to the advice offered by Kvale (1996), I was able to make some interpretations, linking their responses to theories concerning the way in which we learn. It was also possible to identify the effects of institutionalisation that I believe affected a number of the women participants.

The fourth question concerns ‘Accuracy’ (Denscombe 2003 p7). There are two elements to this measurement, one is the potential for obtaining information that is not entirely accurate, and the other is ensuring that the data obtained can answer the questions posed. Concerning the first point, I believe the professional cohort took the opportunity to reflect on their work, in ways that possibly have not been expected in other evaluations or studies. I believe this resulted in genuine and honest contributions concerning their work from their point of view. The material gained from the professional cohort, provided data, which together with the other elements of the study, provided answers to the study questions.

**Semi-structured interview schedule for the professional cohort**

Table 3.2 below sets out the semi-structured interview schedule for the professional cohort, together with some reflections on their rationale and
application. The preamble included restating the purpose of the research, assurance of confidentiality, and estimated time for the interview together with written information and the request to sign a statement confirming their consent to participate in the study. Each of the participants were sent a 'thank you' letter and the written notes of the interview together with a stamped addressed envelope to make any amendments they thought were necessary.

Whilst the core questions are listed below, supplementary 'prod' questions regarding literacy were interspersed in appropriate places so as not to interrupt the flow of thought or to fragment the interview. Participants from occupational therapy and the education centre were asked in greater detail questions concerning literacy.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Are you aware of women with fire setting histories within the Centre?</td>
<td>This turned out to be a redundant question, as all of the participants were made aware of the patient’s background.</td>
</tr>
<tr>
<td>2.</td>
<td>If so, are there any characteristics, which you think, make them 'stand out'? If Yes, can you describe them.</td>
<td>The reason for this question was to see what, if any, characteristics separated women who set fires from those who did not, were taken into account in terms of treatments or access to activities. The question also served to compare the characteristics in the current cohort of women with those identified in the other aforementioned studies.</td>
</tr>
<tr>
<td>3.</td>
<td>Do you work with the Arson Group?</td>
<td>This question was not applicable to all participants. This would have been known if access to a preliminary discussion could have taken place.</td>
</tr>
<tr>
<td>4.</td>
<td>Do issues of fire setting come up in the other groups?</td>
<td>This question was asked to determine if there was a consistent theme relating to their offence throughout the treatment groups.</td>
</tr>
</tbody>
</table>
5. Please tell me about your work and the particular role you play?  
   This question was designed to map the settings and specific support for the women.

6. What is your role within the Care Planning Team?  
   The role of the individual professional is important in understanding how decisions regarding treatment and progression related to rehabilitation are determined.

7. Do you think your views are heard when it comes to the assessment of progress for the women?  
   This question relates to the different roles of professionals within the Care Planning Team and was asked in order to assess what levels of influence the participants individually thought they possessed in the decision making process.

8. What are the most interesting aspects of your work?  
   This question was deliberately placed in this position, to enable the participant to reflect on their own unique contribution to the work.

9. Is there an activity, which is most popular with, all or most of the women?  
   I wanted to gain a picture of the activities of the women from the professional participant's point of view. If an activity is viewed as positive, then this may have a more beneficial effect for the women and can be explored in terms of its usefulness with the women participants.

10. What are the most difficult or unpopular activities for them?  
    As a mirror opposite of the previous question, and again to explore with the women from their perspective.

11. What do you think have been the best achievements over the last 10 years?  
    This question was posed to determine the effects of policy either national or local which may have affected their work, providing evidence to answer Q2.

12. What in your opinion remains to be done to enhance the opportunities for women with fire setting histories within the Unit/Hospital?  
    The purpose of this question was to allow a 'free rein' to the participants to identify other areas remaining to be explored.

Table 2. Semi-structured Interview format for professional participants

Further comment regarding the first question asked. It was unknown at the construction stage of the study that all participants would have been aware of a fire setting history, presenting a problem which could have been avoided if
the proposal of the study could have been provided to the ethics committees in two stages. The first stage of outline approval could have been given with permission to present the detail at a later stage before final approval. This would give researchers permission to gain access and explore in more detail the nature of the task, avoiding the potential hazard of asking inappropriate questions.

The semi-structured interview schedule for the women patient cohort

The interviews were started with introductions, restating the purpose of the study, confirmation of confidentiality unless information given could lead to the harm of the interviewee or other persons, including children. The respondent was told that the appropriate authorities would need to be informed in the event of such a disclosure. The participants were given written notes concerning the study and their participation in it. A form for them to sign or mark, confirming their consent to participate in the study. 'Thank you' letters were sent with a modest token, together with the notes taken, for them to amend if necessary. Correspondence with the women participants was through the WISH London Office.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Tell me as much or as little as you want to about your life prior to the events that led to your admission to...........?</td>
<td>See notes below.</td>
</tr>
<tr>
<td>2.</td>
<td>Were you assigned to an Arson Group whilst in hospital or another unit?</td>
<td>This question was deliberately a closed question, to give the participants a chance to settle into the interview and to gain factual data. From this question came an exploration of the circumstances of their invitation or not depending upon their circumstances.</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>What was your experience of being a member of the AT group?</td>
<td>The response to this question led to other questions relevant to the interviewee concerning their experience focused on aspects of learning, managing the written homework and how undertaking this treatment had affected them.</td>
</tr>
<tr>
<td>4</td>
<td>What other education/learning groups did you attend?</td>
<td>This question was to build a picture of what the participant had been able to do in their time in the unit or hospital. To know what opportunities they had been given and what they had taken.</td>
</tr>
<tr>
<td>5</td>
<td>What was your experience of the other groups you attended?</td>
<td>This was thought to be a useful question that led to the type of evidence upon which the rationale for change to women only environments was based. It was also thought possible to discuss with individual participants their thoughts and feelings about what they had learned.</td>
</tr>
<tr>
<td>6</td>
<td>How could they have been improved?</td>
<td>This question was asked to explore from their point of view the ideas they may have about the activities offered.</td>
</tr>
<tr>
<td>7</td>
<td>Who were the people who were most helpful to you?</td>
<td>This question was to explore supportive relationships and to map the different disciplines in terms of their perceived helpfulness to the women interviewees.</td>
</tr>
<tr>
<td>8</td>
<td>How would you describe yourself to me?</td>
<td>This question was asked following discussion with Director of WISH, her experience of the women who set fires was that their self esteem was at zero level to the point that they did not have a concept of 'self'.</td>
</tr>
<tr>
<td>9</td>
<td>What plans do you have for your future?</td>
<td>This question was to gauge if the women did think about life in the future and of living outside of the institution.</td>
</tr>
</tbody>
</table>

Table 3. Semi-structured interview format for the women participants

The first question was added following a small pilot of the interview questions. The women 'pilots' commented that the interview began with a question that gave no 'lead in' and therefore nothing to make the interviewee feel that they had any control over any of the questions. They also commented that even
though the participants would know what the study was about, but without an introductory question to set the context of the interview they would find it hard to focus on the following questions. I had to seek approval for the first question from the women's directorate, as I had given assurance that questions would not be asked directly concerned with their index offence, or questions that may sabotage their current therapeutic relationship. The conversation following the first question was aimed at putting the participant at their ease and usually referred to some detail they had mentioned.

The data derived from the interviews is discussed throughout the remainder of this examination of the overall study questions. Whilst the above questions steered the interview for each of the participants, supplementary questions appropriate to the flow of discussion were introduced.

**Accuracy and truthfulness**

Turning briefly to the data gained through the semi-structured interviews with the women participants, much of this has to be described. The study relies on substantial description of the life events and experiences before and whilst in secure mental health facilities. These descriptions are taken from the semi-structured interview notes and are important because they tell the story of the women's experience through their narrative. They are also important for the reader to gain a good understanding of the process of rehabilitation and the subtleties of institutional life that explain some women's actions, attitudes and insights. Denzin (1997) asserts the right of the qualitative study to rely heavily on description as part of the analytical framework. Silverman (1997) refers to this process as 'thick description' and confirms its essential place in qualitative research design.

For the patients, each story was unique to that individual and to some extent it is not a matter of what can be substantiated in terms of truthfulness Bryman (2004). It is necessary to see the telling of the experiences as the individual's
perception of their experience and thereby accurate to the participant. The study cannot guarantee the factual truth of all respondents. This is a known problem with qualitative research. Bryman and others refer to 'interview bias' where the participant may shape their response to what they think the researcher wants to hear. Bryman (2004) and Kvale (1996), also note that researchers will unwittingly give clues, by their non-verbal, if not their verbal, encouragement of particular comments.

A further problem for the participants of this study is that on several occasions a member of staff 'sat in' on the interviews. Although the women agreed to this happening, it undoubtedly affected their answers to the questions.

The second aspect of accuracy is likened to validity in that the researcher must be vigilant to ensure that the data collected in response to the questions asked, answer the core research questions. To systematically return to the core questions avoids the researcher going off on tangents and asking questions which may be interesting but which do not focus on the main purpose of the study.

A third point is that when wanting to gain information about events or situations which may induce feelings of guilt or embarrassment, then the participant may wish to explain these events in ways which make them feel more comfortable. Therefore, there may be omissions or embellishments to their story which may not coincide with records of the event, but then, it is also the case that accuracy cannot be guaranteed in written documentation either (Ovreviet 1986).

Cross-checking the Data

Another positive aspect of constructing a multi-approach study is that the results generated can be cross-checked. Triangulation gives the opportunity
to evaluate the data collected from different sources and by different methods to assess the accuracy of the results and thereby, to some extent, test the validity of the study.

It was intended to triangulate the data by comparing the statistical data with the information gained by interview of the cohort of professionals and the cohort of women who have set fires. Knight (2002) discusses triangulation as a necessary activity to ensure that the analysis of the components of data, particularly in small-scale projects, present as accurate a picture as possible.

With fairly small samples, the data collected in interviews can be analysed by the researcher, who can confirm or disconfirm the study hypothesis. By using qualitative analytical software such as NVivo packages, it is possible to add a further dimension to the data analysis. NVivo7 was tried as a small experiment with the responses to question four, for women participants. The answers were processed through the NVivo7 software and produced tables corresponding closely to the assessment made by analysing the responses manually.

Using NVivo7 categories of words used to describe or give meaning to particular questions were listed to identify themes relating to either actions, feelings or opinions voiced by the women participants. The tables generated by using NVivo 7 software are shown in Appendix 4. As previously stated NVivo 7 was tried on Question four, but was not applied to the other questions, as it was found that this application did not enhance the study conclusions.

The lesson learned from attempting to use NVivo 7 software is that it has to be applied and incorporated at the beginning of the study and not at the point of analysis. This then begs the question of whether or not the research is shaped by the tools of analysis rather than the questions being generated from previous studies and research of the issues.
The fifth question is that of ‘Objectivity’ (Denscombe 2003; Bryman 2004; Silverman 1999; and Denscombe 2003) emphasise that whether the study is primarily one conducted within a quantitative or a qualitative methodology, the influence of the individual researcher is to be noted. Bryman refers to the researcher as an actor within the research study. Layder (1995) considers a research map, similar to the one constructed by Bryman, but for Layder this involves the research participant, and could be seen to include the influence of the researcher upon the other sets of data collected and assessed. The researcher makes decisions about the direction of the research, the methods of data collection, and justifies attempts at validity and reliability within an ethical framework.

This work is influenced by my own knowledge, experience, preferences and also the skills and resources available. The facilitation of a multi-strategy research design demands not only rigour and perseverance, but also commitment and confidence that the study will provide valid and reliable results. The formulation of the research questions and the methods used to provide answers will therefore be influenced by the above considerations.

The study was designed with the intention of examining the data gathered by applying three different approaches. It is expected that using different formats will reduce researcher bias, although this may be an element in the study, this has to be made apparent throughout the analysis. To some extent, researcher bias is evident in the decisions made regarding the methodological approaches and also the underpinning philosophical basis on which the qualitative components of the study are formulated. Returning to the earlier point concerning triangulation, by employing this approach the study should be able to demonstrate both accuracy and objectivity.
Validity, transferability and dependability are all questions raised in the assessment of qualitative research. Again Bryman (2004) and Kvale (1996) consider the trap noted by exponents of qualitative research, that of measuring qualitative studies against the yardstick of quantitative methodology and their ensuing claims of validity and reliability. Trends in social science research appear to accept the place of qualitative research as offering important data which takes us beyond the positivist approach, Hammersley (1994) refers to this focus of research as 'social realism'.

This study benefits from these debates in that it is deemed no longer necessary to justify the methods used by positivist standards. This freed me to concentrate on ensuring that the study meets the previously agreed criteria for a credible multi-approach methodology.

**Approaches to analysis**

Kvale (1996) discusses the meta-theories of Marx, Freud and Watson and raises questions of their validity in addressing issues found in today's society. Post-modernist thought moves away from the idea of meta-theories, and recognises that these may not aid our understanding of the minutiae.

The meta-theories of Freud and those of the behaviourists may be the foundations of the rationale for the way in which mental health care practice has developed, but are not particularly useful in helping us uncover the layers of thought and practice which have resulted in the treatments used today. In particular, when considering the 'hybrid' psycho-social approaches favoured in modern psychiatry such as cognitive behavioural therapy Sheldon (1995), dialectical behavioural therapy Linehan (1993), anger and anxiety management techniques Lindenfield (1993). These rely upon a combination of insight, reflection, ability to express ideas upon worksheets, in an ethos of joint responsibility of the patient and the professional in the maintenance of a treatment or rehabilitative programme.
This is a phenomenological analysis because it is recognised that factors affecting the ability of an adult to learn are sometimes reliant upon the individual interactions between teacher and learner. Phenomenology is concerned with seeing the world through the eyes of the subjects (Moustakas, 1994). This approach has much in common with ethno-methodology, (Garfinkel 1984) where the research aim is to understand the meaning of social events and life experiences of different individuals, groups or communities. Using these two approaches rids us of pre or misconceptions that we may have concerning the population being studied.

Inherent in the phenomenological and ethnographic approaches is the necessity to be non-judgemental and to have respect for the subject under scrutiny. This is a central requirement for a study grounded in feminist principles.

This study is rooted in a feminist perspective because of the recognition that gender differences in the development of the services and resources allocated to women has been different to that of men. Feminist research has been most influential in identifying inequalities in many areas of sociological and psychological study. A feminist perspective therefore not only examines gender, but race, class, age and disability (Oakley 1981); (Stanley and Wise 1990).

It is possible to extract data that identifies race and class and these may be determining factors in who is placed within secure services. In terms of the Mental Health Act 1983, the more restrictive sections appear to be placed upon women from working-class backgrounds and those belonging to Afro-Caribbean ethnic groups Parry-Crooke (2000).

Feminist approaches to research pioneered the participation of the individuals or groups who are the focus of the research and transformed them from passive subjects to active stakeholders. By doing this, a voice was given to
those who are not normally heard. Instead of research being done to them, feminist research is conducted with them. In this study, it is attempted by inviting a dialogue between myself and the participants. This was not without its problems which have been identified above and are discussed later in this study.

Turning now to grounded theory that emerged around the same time as feminist approaches to research (Strauss and Glaser 1967) who first coined the term ‘stakeholder’. They recognised that participants involved in research had an interest in its outcome. Grounded theory concerns itself with the generation of theories through qualitative analysis. There are elements of grounded theory in the approach to this study and in the use of analytical tools. However, this study is primarily concerned with identifying ways in which improvements may be made to an established system, whereas grounded research that can generate theories is more likely to instigate a fresh approach, or to begin a process.

As can be seen, the structure of the study is drawn from a range of qualitative strategies suited to the environment. This includes ideas of ethnomethodology and phenomenology, practices from grounded theory and ethics of feminist research in an attempt to address the many restrictions that I as the researcher faced.

Other strategies were considered, for example a case study or biographical study. This was discarded as not appropriate as it may not have yielded sufficient data to be representative of the population. Neither would a case study approach be allowed by the medical directorates as this may have been seen as interfering with the therapeutic alliance between professional and patient.

An observation study was initially considered, but this would also not have been allowed on the grounds that my presence would create a distraction to
the routine of the unit. This approach would not have been appropriate for the task. However, much was gained from the opportunities I did have to observe the interactions between staff and patients which are discussed later.

The last strategy considered was that of a focus group. Initial discussions did take place regarding the feasibility of this, but the logistics of ensuring that groups of women or groups of professional participants could be available to participate in this would not have been a possibility.

**Ethics of research**

The final question Denscombe (2003) asks is that of ‘Ethics’. This relates to the four questions of all research involving human participants. Informed consent requires the following questions to be answered:

- Do the participants know what part they will play in the study, its purpose and how it may affect them?

- Confidentiality: can the information given be traced to the individual participant, institution or unit?

- Is it possible participants could be harmed by taking part?

- How can they benefit from participating? (pp. 134–141).

All the above questions were central to my concerns and subject to rigorous assessment by all of the ethics committees previously mentioned. As a result, the study was strengthened to ensure that these issues were addressed in great detail. An information sheet setting out the research with the role of the participant clearly stated, together with the procedures to ensure safety of the
participant and support should they be affected in any way by the information they chose to disclose (see Appendix 6).

Follow-up procedures were also put in place to ensure support from key staff should any participant experience distress. The questions were designed to minimise information being divulged which related to their fire-setting behaviour, the emphasis being on what could be learned to enhance their prospects of rehabilitation, and using strategies to keep them safe from fire setting activities.

Much writing in the field of research is devoted to the adherence of ethical principles (Denscombe 2003); (Bryman 2004); (Silverman 1997); (Creswell 1998); (Richardson 1998) and (May 1997). These principles basically argue that research subjects should be treated with respect and dignity, that the purpose of the research should be explained in full and that they should know precisely what is expected of them should they choose to participate in the study. The criteria used to measure the ethical position of any study involving other individuals or groups is that of beneficence, that no harm comes to them as a result of their participation and this incorporates the aforementioned four questions by Denscombe (2003).

As previously noted, this study has been scrutinised by five ethics committees, each one requiring, in essence, most of the same material, but with emphasis on different aspects of the overall study. Whilst all emphasise beneficence, some have queried methodologies and this has involved time consuming correspondence and re-assessment leading to extended time scales, which then presented problems for potential participants engaging with the study.
Framework of the study

So far, using Denscombe's (2003) questions and drawing into the examination the study map, the stages of the investigation can be depicted can be as follows:

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Analysis/critique of mental health policies, legislation, history of treatment and rehabilitation</th>
<th>Review and critique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>Analysis of statistical data from 1993–2004, National Case Register, Rampton Hospital</td>
<td>Quantitative analysis</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Semi structured interviews with professionals and women patients in the 3 levels of secure MH facilities</td>
<td>Qualitative analysis</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Triangulation of the 4 sets of data obtained</td>
<td>Qualitative and quantitative analysis</td>
</tr>
</tbody>
</table>

Table 4. Study map using Denscombe's model.

Examining Layder's (1995) work, he talks of a research map which plots the different areas for examination citing context, setting, situated activity and self, each possibly requiring a different methodological approach as identified above, but which then sets out a map in greater detail. This proved to be a useful tool in terms of drilling down within the different aspects of the study and also ensuring that the linking across the sets of data cover every aspect. In terms of Layder's map, the aforementioned enquiries, research papers, insurance and risk assessments form the 'context'.

An examination of the setting leads to the acquisition of substantial knowledge about how the mental health secure system operates from an organisational structure to everyday decision-making and operational activities. It also involves an understanding of the roles of the individuals involved and what influences their thinking and their decision-making.

The 'situated activity' requires an understanding of what constitutes 'rehabilitation'. The activities which come under this umbrella, how and when...
it operates, what activities are on offer, how they are assessed, who determines progress within the rehabilitation process, what are the criteria by which it is measured?

The last point on the map, 'self' means the individual who is experiencing the above procedures. The individual who is living in the secure system and who is regulated by institutional policies, laws and treatments, influenced by research which may or may not be relevant. This includes the thoughts and feelings of the individual living their everyday lives within the institution.

The following table sets out the study using Layder's categories:

<table>
<thead>
<tr>
<th>Context</th>
<th>Admission and discharge data, legislation, policies, understanding of history of institutional living, current practices, enquiries, risk assessment policies</th>
<th>Quantitative and qualitative analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Institutional knowledge, rehabilitation processes, discussion with staff and questionnaires, arson group programmes</td>
<td>Quantitative and qualitative analysis</td>
</tr>
<tr>
<td>Situational Activity</td>
<td>Interviews with respondents, knowledge through their eyes, understanding of their needs</td>
<td>Mainly qualitative, some quantitative analysis</td>
</tr>
<tr>
<td>Self</td>
<td>The meanings for people and the emotional experience for them, and for the researcher</td>
<td>Qualitative analysis</td>
</tr>
<tr>
<td>Triangulation</td>
<td>Data from quantitative data, qualitative data and analysis of policy documents</td>
<td></td>
</tr>
</tbody>
</table>

Table 5. Study map using Layder's model

**Analysis of qualitative data**

The questions and categories that Layder and Bryman discuss lend themselves primarily to a qualitative research analysis. For the analysis of
data gained in interviews both with the women patients and professional colleagues I have drawn upon the work of Knight (2002). He asserts that some of the techniques discussed in Glaser and Strauss's grounded theory work of the sixties have influenced his work, which demonstrates the wide influence and appeal of grounded theory research approaches.

Knight (2002, p.185) suggests that categories and 'boxes' in which to assign the information needs to be accomplished early on in the process of the analysis. Once the data from interviews is categorised under headings the researcher creates, then the comparison across the sets of data is made possible. This ensures that the researcher can engage in the strategy of triangulation with the three data sets, leading to a credible and worthwhile study. Whilst some of Knight's advice was carried through in this study, because of the small numbers involved, much of the analysis was accomplished purely by 'eyeballing' the data collated under the headings devised.

Conclusion and Summary

This examination of the theories, principles and approaches to research design has helped determine the structure of the study and the methods of analysis to be used to answer the two research questions. However Knight (2002) in his discussion of feasibility has been a major concern throughout the construction and execution of this work.

This study was in no small way steered by the 'stakeholders' in that ground rules were set by them with little room for negotiation. As discussed above, this led to constrictions on questions to be asked and subsequent interpretations of the data challenged and continued access threatened. Some of the issues encountered and identified above were that the women were chosen by their medical officer which did not allow for balancing characteristics across the sample. Potential professional subjects were
uncontactable, despite telephone calls and correspondence which remained unanswered. A major set back was the allocation of a supervisor who resigned her post within weeks of the beginning of the data collection phase leaving me without an advocate. Finally, powerlessness to affect decisions made concerning control of information available to the study. All of these events required tenacity, ingenuity and good humour to stay the course.

However, the study was structured and the research questions formulated taking into account the above questions and issues. This process then determined the various methods used to examine the questions and form conclusions that led to recommendations regarding aspects of rehabilitation for women who have set fires.

The following chapter discusses the data from the two sets of interviews and examines it in relation to the policy documents, reviews and research identified in the literature review.
Chapter 4

Examination and Analysis of Data

This chapter examines the data collected from the two cohorts, the women participants and the professional group. The salient points from the interview questions are discussed in relation to the two research questions and linked to the previous discussions on policies and practice which determine the overall experience of the women who set fires and who are contained within the secure mental health system.

Profile of the women participants

In this study, the ten women with a history of fire-setting were recruited from each of the levels of the secure system, alongside seventeen professional workers involved in their care.

Despite the fact that the sample was recruited by RMO’s, the profile of the participants did not vary from the characteristics known through other studies (Stewart 1993; Parry Crooke 2000; Gorsuch 1999) of women who set fires. Therefore, it is claimed that the participants to this study were representative of the population of women who set fires.

<table>
<thead>
<tr>
<th>Hospital or unit</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>High secure hospital</td>
<td>3</td>
</tr>
<tr>
<td>Medium secure unit</td>
<td>2</td>
</tr>
<tr>
<td>Enhanced low secure unit</td>
<td>3</td>
</tr>
<tr>
<td>Low secure unit</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 6. Women participants in the study
The length of stay in secure care ranged from three to over twenty years. In addition to this time, the majority of the women have served prison sentences or had been on remand for at least three months, the longest time served in prison was 4 years for any one sentence. Most women were found guilty of the offence, 'arson with the intent to endanger life'. However in describing the circumstances of their fire-setting it would appear that most related to empty buildings, or contained fires set in places of relative safety which accords with the findings of the Stewart (1993) study. Three of the women in the sample were contained on Sections 31 to 41 MHA 1983 and seven of the women were contained on Sections 47 to 49.

An additional factor for the women in this study is that six of the ten women informed me that they were handed life sentences by the Court, the maximum sentence for the index offence. Only one of the women admitted to me that she set a fire knowing that the target of her crime was present in the building.

<table>
<thead>
<tr>
<th>Total time spent in prison for the group</th>
<th>19.9 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total time spent in high secure hospitals</td>
<td>17.2 years</td>
</tr>
<tr>
<td>Total time spent in medium secure units</td>
<td>19.8 years</td>
</tr>
<tr>
<td>Total time spent in low secure units</td>
<td>7.0 years</td>
</tr>
<tr>
<td>Overall time spent in secure MH services</td>
<td>43 years 10 months</td>
</tr>
</tbody>
</table>

Table 7. Years spent in prison and mental health services

Age of women in the sample

<table>
<thead>
<tr>
<th>Age of women in the sample</th>
<th>Number of women</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29 years</td>
<td>3 women</td>
<td>1 high secure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1MSU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 ELSU</td>
</tr>
<tr>
<td>30–39 years</td>
<td>4 women</td>
<td>1 high secure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1MSU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 ELSU</td>
</tr>
</tbody>
</table>
The majority of the women who set fires did not complete their education, or gain educational qualifications. Therefore particular attention is paid to the weakness of literacy skills and how this can affect their treatment and rehabilitation which is the primary question of this study.

The main treatment for women who set fires is the Arson Treatment Group which requires limited literacy skills as many of the exercises or worksheets, ask the participant to describe thoughts or feelings. The more able the woman is in reflecting on her thoughts and feelings, the more she is likely to gain from the work of the Arson Treatment Group and indeed other groups requiring similar skills, for example, Anger Management work.

The evidence gained from the women who are developing their literacy skills is that they are more confident and have enhanced levels of self esteem. The skills gained in developing literacy helps the woman’s progression as she is ‘stepped down’ through the secure mental health system. This often entails a transfer to a medium secure unit after leaving the secure hospital. The table below shows the data on numbers of women discharged from the three high secure hospitals of Ashworth, Broadmoor and Rampton to lower levels of secure care in 2002–2003, the most recent record available. Unfortunately their levels of literacy are unknown.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage</th>
<th>Number of Women</th>
<th>Years Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>40–49 years</td>
<td>3 women</td>
<td>1 high secure</td>
<td>2 LSU</td>
</tr>
<tr>
<td>Under 2 years</td>
<td>17.95%</td>
<td>28 women</td>
<td>2 high secure</td>
</tr>
<tr>
<td>2–5 years</td>
<td>24.36%</td>
<td>38 women</td>
<td>2 high secure</td>
</tr>
<tr>
<td>5–10 years</td>
<td>33.33%</td>
<td>52 women</td>
<td>2 high secure</td>
</tr>
<tr>
<td>10–20 years</td>
<td>18.59%</td>
<td>29 women</td>
<td>2 high secure</td>
</tr>
</tbody>
</table>

As the table shows, the greatest number of women discharged from the high secure hospitals were patients who had been accommodated within the system for between 5 and 10 years. The average length of stay within the secure mental health system is approximately 8 years, according to Rice (2005). Some of the women are assessed as ‘fit’ to live independently in the community, having graduated from both the secure hospital and the regional or medium secure units. Unfortunately, for some a combination of their life experiences, their mental health and their treatment making the prospect of living independently virtually non-existent.

In the methodology chapter it is explained that the women were interviewed using a semi-structured interview schedule. The questions were subject to scrutiny and agreed by the staff prior to the women being put forward by their Responsible Medical Officer (RMO) for the project. No questions relating to the women’s conviction or previous history were to be asked as this was thought to potentially jeopardise, or to interfere with the ‘therapeutic’ process.

Whilst participation in the study was voluntary, it is possible that some of the women felt that it was ‘in their interests’ to participate. If it had been possible to build some rapport with the women prior to the interview, I may have gained more or better data. My first contact was by letter and although this was designed to be as friendly as possible, not all of the women would have been able to read it.

I knew from my experiences of conducting another study with a similar cohort, that the attention of the women would be unlikely to be held for more than 30-45 minutes. Therefore the interview schedule was constructed with these limitations in mind.
As previously discussed in Chapter 3, it became evident early on, in the first two pilot interviews, that the women participants were unable to make sense of the questions because the introductory question offered no context in which to anchor the interview. The women expected to be asked about their history as a means of focussing on the task. Asking questions about how they were helped to overcome their experiences without the questions being linked to their previous experience, were meaningless. The initial steps taken to overcome this potential problem was to ensure that they received information sheets prior to interview about their contribution and again, at interview, the purpose of the study was explained, but even so, this proved inadequate for all the reasons identified above.

It was agreed that an introductory question could be inserted which asked them to tell me as much or as little as they wanted, about how they came to be where they were. This seemed to work, I think because the women were able to take control of the interview, as they were invited to tell me what they wanted me to know. I recognised that their account may differ from the notes and records on file, but I thought it important to hear how they accounted for their situation and what were for them the important details. The possibility of viewing patient’s records was considered, but then discounted as I was warned not to expect permission to be granted by the various Ethics Committees as a researcher and outsider to the forensic services, to view confidential documents.

The ones who did talk about their experiences prior to entering the prison or secure mental health system during the interview gave harrowing accounts of their treatment within their families, the child-care system and their school experiences. These details have not been attributed to the individual participant but given as general information, so that the identity of the participants is obscured as far as possible to maintain the condition of confidentiality. Some of the women’s experiences are portrayed in the discussion, which concludes this chapter. Their accounts accord with the evidence from Stewart (1993) and Bartlet and Hassell (2001).
The second question asked whether the participant has been or is currently a member of an Arson Treatment Group. The learning skills examined in this question contribute significant evidence to address the first question asked in this study. In the following table, the participants are grouped according to their secure setting.

<table>
<thead>
<tr>
<th>Participant</th>
<th>HS or Unit</th>
<th>Not offered ATG</th>
<th>Waiting to join</th>
<th>Currently participating</th>
<th>Completed ATG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HS</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HS</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>HS</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MSU</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>MSU</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ELSU</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>7</td>
<td>ELSU</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>ELSU</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>LSU</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>LSU</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

Table 10. Membership to Arson Treatment Group (ATG)

Four of the sample had completed an Arson Treatment Group, a further two women are currently members, two are awaiting a group and two have not been offered this facility. Two of the women stated that they were moved to a lower secure environment because of their membership to an ATG. One of the women from the high secure hospital waiting to join an ATG is very aware of the necessity of attendance in enhancing her prospects of moving through the system.
It is increasingly the case that without the opportunity to join an ATG a woman with a fire setting history will be delayed in ‘stepping down’ through the secure system. Membership to the ATG is a factor in an assessment of the woman’s readiness to be moved to a less secure environment, viewed by both their care team and the Ministry of Justice.

The two women in the high secure hospital who had been assessed as ‘ready’ have been unable to access an ATG for approximately eighteen months, delaying their progression through the ‘secure system’. This was because of the move to single sex activities within the hospital and a further delay in agreeing a revised ATG programme for the women.

One of the women spoke of her experience of intimidation whilst a member of a mixed sex group within the hospital. This lends further weight to the necessity of providing a women only group within the hospital.

In contrast, two direct entrants to the MSU were undertaking the ATG within 8–12 months of their admission. However one of the women left the group very shortly after the interview.

It was clear in one interview with a woman who had spent many years in the secure system, and who had progressed to the low secure unit that her work in the ATG had not successfully erased fire setting as a possible option. It was also probable that she would spend the rest of her life in some kind of institutional care, possibly by virtue of the length of time already spent in prison and then the secure hospital system. She entered firstly the criminal justice system and then transferred to mental health facilities whilst in her late teens having had a limited experience of work, or of developing relationships, or indeed of having positive experiences that may have influenced her view of the world outside.
The third question asked what was their experience of the Arson Treatment Group.

I have used a Likert type scale to assess usefulness of the ATG to give the range of answers from the cohort followed by a discussion of the results.

Code:

A: 'Very useful' indicates that the participant commented and described the way in which the experience helped her.

B: 'Useful' where the participant felt that the ATG was useful in parts, but perhaps not in others. The different reasons for assigning 'useful' are recorded in the notes of their interview.

C: 'Not sure' is used, where the participant is unable to say what was useful and what was not.

D: 'Not useful' is used where the participant has given examples as to why the experience was negative.

E: 'Useless' negative in every aspect.

O: Treatment ongoing.

DP: Participant dropped out.

N/A: Question not applicable.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Setting</th>
<th>Very useful</th>
<th>Useful</th>
<th>Not sure</th>
<th>Not useful</th>
<th>Useless</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>1</td>
<td>HSH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HSH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>HSH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Table 11. Arson Treatment Group – assessment of usefulness

<table>
<thead>
<tr>
<th></th>
<th>MSU</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>MSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>MSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ELSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>ELSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>ELSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>LSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>LSU</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

One of the participants who attributed an A for the group, said that she was “dead against it”, did not want to do it and had no intention of co-operating. A session early on in the programme made her think and this triggered other thoughts about her fire setting, which she had not done before. As a result of this, she became engaged in the treatment and used the staff and group members to as she put it, “turn her life around”. This particular participant was an ‘informal’ leader, other members tended to follow her. Her ‘conversion’ also dissipated other negativity in the group, leading to a successful outcome for most of the other members.

A participant from the LSU could not remember anything about the work undertaken, but said she felt uncomfortable being one of the only women in the group. As an afterthought she commented that it must have been ‘OK’ as she was moved soon after completion of the group.

The participant who indicated ‘B’ felt that a lot of things went on in the group that she did not like, but still felt that she got a lot from it. Further prompting of what she didn’t like was a ‘throw away’ reference to the ‘homework’ which would have involved writing diaries and worksheets.

One of the participants currently attending the MSU ATG group said that she found it very hard, in terms of being challenged in ways that she had not been
before and that she had no means to cope with it, (she dropped out six weeks later). The other woman attending the same group said that she was coping because she had a lot of support from her link nurse and therapist.

The range of work is intensive and expectations on the women who undertake the ATG is high. A high level of motivation is required to stick with difficult issues in a way that the women have not been confronted before, over such an extended period of time. One woman said how she felt exposed by her lack of literacy which she had previously concealed and which did not match her verbal skills. Whilst the ATG team asked the women to express themselves how they saw fit and that they were not looking for 'Booker Prize' levels of literacy, nonetheless some women were clearly embarrassed by this lack of skill. The drop out rate from an ATG tends to be small, as the support available to the members is extensive and reaches beyond the usual confines of traditional groupwork as discussed in the following chapter.

The fourth question asked of the women was about other therapy, education, learning and leisure groups they attended.

The reason for this question was to identify what groups were available to the participants and how significant were they to their progress. There was a wide range of answers given to this question, although some women needed prompting in order to discover the range of their activities. Some women emphasised the therapeutic groups and others the skills groups.

The summary of answers will be grouped according to the setting, as the womens experience in each unit differed according to what was available within the programme offered.
High secure hospital

The three participants from the high secure hospital were affected by the policy changes required by Into the Mainstream (2002). Access to classes were barred when the segregation policy was put into place. This effectively prevented access to the IT programmes, Maths and English. Craft and cooking groups were still available but only on one day per week from the education centre. Whilst craft and art activities could still be accessed from the women's craft centre.

In terms of therapy groups, it was generally agreed that they were useful, “I learned a lot about myself”, “could cope better”, “can help others”. However it was difficult for two of them who described themselves as “not good in groups” and one participant as a “bit of a loner”. The groups attended were mainly alcohol and drug group, cognitive behavioural therapy (CBT) and dialectical behaviourial therapy (DBT). All three participants agreed that they benefitted from attendance even though grudgingly.

Medium Secure Unit

There were two participants from this unit, both had belonged to the alcohol and drug group and then gained membership to the second ATG group made available in the unit. The first participant gave an A to the alcohol and drug group saying that she benefitted from this. Both she and the other participant were only six weeks into the ATG programme having just completed Module 1 and beginning Module 2. The first participant said that she found it hard as she did not like the paperwork, similar to her experience in the DBT group. This participant felt that she got on better in “one to one” work.

In terms of education groups, she was attending ‘one to one’ sessions on literacy which she said at the time she enjoyed. She had given up on the Maths group, which was working with others, saying that it was ‘boring’.
The leisure groups she attended were ‘Cleaning Your Room’ which was “about clearing rubbish from your head not just keeping your room tidy” This participant also enjoyed cooking, “fun when this happens” crafts was also good, but not good at Art. In music she was learning to play drums. The cooking group was re-scheduled so that the participant could attend the ATG.

The second participant had joined the DBT group and Relaxation. She found the DBT group very stimulating, but found difficulty in relaxing. She joined the ATG programme and said that she found it very difficult, at a later visit to the unit I discovered that she had subsequently withdrawn.

As far as education was concerned this participant did not think she needed English and had also given up on Maths. She enjoyed the computing lessons when available, although she felt that she was not that good at it but was “getting on with it”. This participant also liked the craft sessions and art. She said that she had always cooked, but learning about calorie control which she realised was very important for her general health. The activities she most enjoys apart from trips outside of the unit is making presents for her family, she finds this a good and therapeutic activity, keeping her in touch with her family.

Enhanced low secure unit

There were three participants from this unit which was geographically close to the medium secure unit and so there was regular traffic of staff and patients between the two units enabling them to access the different therapeutic groups and other social and learning activities.

The first participant interviewed in this unit had completed Arson Treatment Group in the medium secure unit, and had been moved to the enhanced lower secure unit. She was excited about her progress, although still feeling a little unsettled in her new unit.
She joined a DBT group and finds this quite interesting, although she has
done this before, she feels it is different now. This participant is also engaged
in one-to-one therapy, which is something that could not have been
approached before her completion of the ATG and her progress to date.

Her view of education was that it was uninteresting. She can read magazines,
but not interested in books and will not attempt Maths although she said she
would try computing if it was on offer. She also thought that craft is boring and
not at an advanced enough level. This participant now wants to do drama and
singing which is currently being explored with a local college. She won an
award in prison for video work. Her preference is to occupy herself either
reading magazines or watching TV in the ward open area.

The second participant had rather different views of the therapeutic groups
and also the education classes. She did not like DBT as she finds “listening to
other people is boring” This participant achieved English and Maths Key Skills
Grade 2. This level of accomplishment is virtually unheard of in the unit and
she is seen as quite a star by the other women and the staff. She feels good
about her achievements, from having no literacy or numeracy skills to gaining
these certificates. This participant also enjoys Crafts and one-to-one work,
likes all leisure group activities, but not interested in therapeutic groups.

The third participant in the study from the enhanced lower secure unit was a
new resident and is still being assessed. As yet not attending therapy,
educational or craft groups. This participant was difficult to engage as she
was very unhappy about her move to this unit from her placement in the south
of England.

She prefers one-to-one therapy, she does not feel comfortable in groups, as
she has difficulty in trusting people. This participant wants to attend college to
do literacy, and thinks she can be anonymous in college, but would feel
exposed to undertake it in the unit setting. Literacy teaching is not currently available within this unit.

This participant told me that she had been moved against her wishes on the recommendation of her funders, so that she could be near her family. Apparently her family have no contact with her and she had made good friends with the women in her previous placement. She compares her situation with where she was in the past and talked about all the things she has done in the past but doing nothing now. Bartlet and Hassell (2002) discuss the detrimental effects of decisions by funders to move patients on a cost cutting basis rather than a consideration of the needs of the woman involved.

Low secure unit

The final two participants were from the low secure unit and both had attended an ATG within the secure hospital. Both of these women were difficult to engage and did not talk in detail of other groups despite the question being asked several times and in different ways.

The first participant interviewed attends craft sessions and enjoys music. She has no literacy skills and is not interested in learning. She also sees no future for herself outside of the Mental Health system,

The final participant of the study explained that she had attended the ATG group in the ‘big hospital.’ It was a mixed group with only herself and another woman present, “didn't like it much.” She likes one-to-one sessions with her key worker but does not attend any other group. “I go to Education for something to do and Crafts”. She also enjoys Art, Health and Hygiene. This participant commented several times throughout the interview that she wants more things to do as she spends much of her time doing nothing. She commented that more structure to the day and going out more would be good
for her. This participant expressed no interest in developing literacy, and possesses limited literacy skills.

To summarise

Membership to the ATG clearly demonstrated rewards for several of the members of the preceding groups. Recently this appears to accelerate 'stepping down' to lower secure units. Even when attendance did not yield significant results for one participant who felt that it made little difference to her actions concerning arson. A member of the current group decided to withdraw despite ongoing support.

There was a mixed response to the work carried out in the DBT groups. Some saying it was interesting; one participant was 'bored'; another, too much paperwork.

Arts and crafts carried a mixed response. It appears that different activities were offered in the different settings. The level of craft activities was varied with most complaining that these were of a low level.

English and Maths are not on offer in all of the units, with limited access to IT in all settings.

Maths taught in groups, where only one appeared to progress whilst the others gave up.

All of the women who took English, did so in a one-to-one relationship, but even so, some gave up.

One was hoping to attend college outside of the unit.
Clearly the women did not like their lack of skills exposed. It would appear difficult for some women to be motivated, possibly due to their medication, or their mental health well-being. The craft groups were criticised by some of the women as being beneath their level of skill development. The criticisms evidenced indicates some of the blocks to progress, which is section (b) of the second question asked in this study.

The fifth question asked the participants for their experience of the groups attended. I tried to drill more in depth about their experience of membership to the different groups attended. Asking the participants for their experience, how useful was the work or activity for them. This question together with Question six which asked them how the situation could be improved, yielded limited but useful additional data providing the evidence for the second question of the study.

Observations concerning the different education and leisure activities available in all four settings were useful. The leisure groups differed considerably between the units. A wider range of activities was offered in the high secure hospital setting. Trips outside of the high secure hospital were not an option, trips were seen to be an important activity to the residents in lower secure environments.

The experience of therapy was mixed, particularly DBT which was mainly disliked. It seemed that the participants seemed to prefer one to one discussions with their key worker or designated therapist.

**Q6. How could group work be improved?**

This question was asked because of previous knowledge of mixed gender groups and how difficult these were for women on occasions. I also wanted to know if the women preferred women therapists.
With hindsight I realised that the women had little else with which to compare these experiences. Some of the participants tended only to consider the ‘therapy’ groups and others only the leisure or craft groups.

The comments from the women in the high secure hospital tended to consider therapeutic groups and commented upon the CBT and Alcohol and Drug groups. One participant felt that she was not listened to and that more help in understanding the group process would have been helpful at the beginning. One other said that she thought that she would not have been helped without the support of the CBT group.

In the medium secure unit, it was felt by some of the participants that more outdoor activities could be found. There were comments of boredom over the same old craft activities which they felt were not appropriate to their level of skills. One participant would have liked a gardening group. Another commented that it was like living in a hot house and that it was very tense and difficult sometimes. One participant would have liked more things to do, “too much time on our hands” she commented.

The three participants in the enhanced low secure unit echoed the sentiments of those in the medium secure unit, in that there was too little to do, although they liked the activities they did do. One commented that “Some groups are run in the evenings and I think I am just too tired to really give it much energy. Better if it could be run in the daytime’.

The third participant who was undergoing an assessment, felt that she was slipping back as there was nothing for her to do.

The two participants from the low secure unit also wished there was more to do. One would have preferred to have been able to go out more.
The last participant reflected on her therapy and commented that "Drugs helped me, not so keen on psychiatrist, didn't feel listened to. I would like to go out more, shopping and things like that would be good"

There was a wide range of answers to Q6. Several participants referred to 'time on their hands', 'little to do'. This is a general problem in each of the units, struggling with the provision of meaningful activities. This is partly because of funding issues, but also because the focus of treatment. The impression created was that it was in 'therapy' that the work was done and the educational and leisure activities were of lesser importance. Others wished for outside activities, particularly shopping trips, feasible only to those in the medium to low secure units. Some commented on the need for outdoor activities.

Several participants referred to initial help, in supporting the women to understand what was happening to them. The provision of pre-therapy groups is no longer available. This need could have been addressed by the provision of 'pre-therapy groups which are designed to prepare the women for the different forms of therapy to which they may be assigned.

There were no comments concerning the gender of the professionals who were available to them or who were involved in any of their activities. It seemed that this was taken as read, with no choice in the matter.

Q7. This question asked: Who were the people most helpful to you?

This question was asked in an attempt to see if a particular professional discipline was identified. It would also help to build a picture of the involvement of the different disciplines from the participant's point of view.

Examining the responses to this question led to a pattern of answers where the women in the high secure hospital and medium secure units, tend to
identify the nursing members of staff, as their support. One participant commented that “they are there all the time and you can always talk to one of them.” Another participant identified the ATG staff as being the most supportive. trailing were the psychiatrists and social workers, who possibly would not have been seen as key to their treatment unless there was a particular involvement for a specific issue. The psychologists were mainly treated with suspicion and the work with them in DBT and CBT groups, uncomfortable. It was interesting that the participants in the lower secure units identify family members. There may be several reasons for this.

One is that for those women in high and medium secure units, they are mainly younger and they appeared to be actively involved in a range of treatment programmes which create a greater reliance and alliance with professional staff. These relationships were not so obvious in the lower secure units. Particularly for the women in the high secure hospital, their homes were not within an accessible geographical range. It is also possible that their offences or behaviour are still ‘raw’ and that they are alienated from their family, or that they have distanced themselves from trauma experienced within their home. Either way, they may have limited or no access to their family members.

The women in the lower secure unit, identified their sisters’ as their main support. This may be because there is more access for family. For both of these participants family were on relatively direct train routes. Although it was not at all clear that regular visits were undertaken, and in the case of one woman, she had no memory of a visit, but of receiving a card. These women had also spent the longest time in institutions, so it is also possible that their ‘trigger’ behaviour is fairly ancient history. They did not appear to be in active treatment groups other than ward group meetings which happen daily from Mondays to Fridays for one hour in the morning.

It was at this point I asked the question: How would you describe yourself to another person? This question was asked as a supplementary question.
When the questionnaire was piloted, the discussion focussed upon the way in which women in secure mental health settings may see themselves. This was thought to be mostly negative and without giving themselves credit for the way in which they have progressed or been able to deal with their living environments. The question was asked in an attempt to gain an impression of the level of their self-esteem.

As discussed in Chapter 6, self-esteem is linked to developing confidence and a belief in oneself. It is also a component in the motivation to engage in educational activities. This is seen as a key strength in determining those who can be rehabilitated with a degree of success and those who may not (discussion with Social Worker High Secure Hospital, April 2006).

Mainly the participants offered comments such as “well I have been very ill and did terrible things.” “I hope people won’t think too badly of me.” Others suggested that they were “loners’ and “get depressed at times.” Another participant said that she hides her true self as she has hated herself and wished herself dead, but puts on a bright and breezy face. Several of the participants particularly those in the low secure unit did not answer the question saying that they just did not understand it.

In responding to this question there was much resistance, long pauses and asking for clarification of the question. I think the level of discomfort signified that the women did not think well of themselves despite some of them being asked to look at their progress over the years. Several of the participants had begun to talk with me about their achievements, particularly one, in gaining certificates for English and Maths, only to look down and feel unable to say anything positive about themselves.

The reasons, and also the theories underpinning the women’s inability to talk well of themselves is identified and a discussion of this is to be found in Chapter 6. The evidence gained from the participants bears out the theories
relating to the acquisition and maintenance of self esteem, examined in the aforementioned chapter.

**Q 8. The final question asked the women participants: What are your plans for the future?**

This question was asked to gain some idea of what the women felt they were working towards, in terms of how they saw their rehabilitation and future prospects of release.

The women participants in the high secure hospital with potentially a longer period in secure mental health settings ahead of them seemed to be the most positive and also realistic. One woman said that she still had a long way to go, but hoped to gain a place in a unit close to where her XXXXX lived. Another knew she was soon to be moved to a medium secure unit at some distance from the hospital and said it was “scary’ but sure it would be OK once the move was made. The third participant wanted to go to a local medium secure unit, but if this was not possible to one nearer her home. These women were only looking as far as the next step which seems realistic given their circumstances.

The two women in the medium secure unit were also realistic about their options, with one indicating that even though her life with her family had been traumatic, she still wanted to be closer to them. The second participant was concentrating on the immediate and indicated that she needed to finish her treatment before thinking further into the future.

The participants in the endahanced low secure unit each had clear views of what they saw as their next step. One participant said she would like to go to a warden assisted hostel, either in the vicinity or back to her home town saying “I don’t want to waste any more of my life now”.

111
The next participant said that she wanted to progress to a low secure unit as she could not live in the community without being in trouble again.

The last participant said that she hoped to live in a hostel in the community as she could not live on her own. “I spent too long living with people, it would scare me, it’s frightening to think of being on your own”

The two participants in the low secure unit were the least realistic in their ambitions. One said that she wanted to go and live with her boyfriend. When asked about this, she said that she did not know where he was at the moment, they met in the hospital and telephone each other sometimes.

The final participant indicated that she wanted to live in a flat near her sister, but then reflected that she didn’t think she could live on her own and her sister could not have her to live with her. She was at a loss to know what the future held for her.

The responses to the above question were more realistic for the women in the secure hospital and medium secure unit, with increasingly unclear pictures of what the women’s likely options were the longer the participant had been contained within the secure system. It appears from the data that the length of time spent living in close proximity to others has an effect on some of the participant’s ability to consider themselves capable of independent living, thereby restricting their opportunities for rehabilitation. The participants have all lived for extended periods of time in different institutions including prisons. For some, their responses indicate levels of institutionalisation making it extremely difficult for any one of them to survive in the external community in the short term, and some are destined to remain in some kind of group living, probably for the rest of their lives.

The interviews with several of the women were difficult and stilted. Although ‘open’ questions were asked, often the responses were monosyllabic, and
supplementary questions were asked. At times, I felt I was dangerously close to 'putting words into their mouths.'

The more difficult interviews took place in the low secure unit where I thought that the women would be more responsive, having accomplished much of their treatment and would be looking to leaving the secure mental health system. These participants tended not to expand upon their answers and without prompting would have only offered one or two words, for example, I suppose so,' 'not really,' 'couldn't say for sure.' They also appeared to be the most unrealistic about their future.

It also appeared that the effects of medication was in greater evidence in the low secure unit than in units designated high or medium secure facilities. The participants in the high secure hospital seemed more confident and able to reflect on their situations, and were able to employ a broader vocabulary to express their thoughts and feelings. The years spent in institutional living were less than the women in the low secure unit. There was a sense that the women in high secure felt that they had a future.

The less literate women also seemed to be residing in the medium and low secure units. Clearly the women in the medium secure unit where an Arson Treatment Group was available to them was a major factor in their securing a place in the enhanced low secure unit, this seemed a positive motivation for them. They also appeared more realistic in terms of their future rehabilitation and what they needed to do to fulfil their ambitions.

The experience of finding the less able women in the low secure unit possibly reflects the hiatus in the development of residential resources for women from institutions. The movement through of women from high secure environments to low secure and then to community resources is blocked by occupancy over long periods of time, where the women are not able to move on partly through lack of alternative provision, but also because they are too vulnerable to live in
a less secure environment. Into the Mainstream (2002) document in examining the progress of women through the secure system estimates that women in low secure environments should not stay longer than two years, but this is clearly not a realistic aim at the moment, given the lack of alternative support units.

**Arson Treatment Groups**

The key role played by the ATG in enabling women who set fires to step down through the secure mental health system is examined in Chapter 5. The data from the women participants revealed the difficulties for them in accessing the ATG in the high secure hospital. Whilst the participants who had undertaken the first ATG devised for women in the MSU had benefitted from it, in that they had been moved quite swiftly to the enhanced low secure unit in the region. Discussions about their activities identified that most women in each of the settings felt that more could be done in terms of leisure and craft activities. It was also possible to identify gaps in educational provision in each of the settings. This is a moving picture as I was aware that a literacy specialist had been available to women in the MSU and neighbouring ELSU. Literacy was taught in one to one sessions whilst Maths was taught in groups when available. The Maths appeared to have a higher drop out rate than literacy. Some women commented on the fact that they did not like to feel exposed in a group and felt 'stupid'.

Some participants when talking about the education groups of literacy, Maths and IT, said that they attended because there were plenty of 'fag breaks'. Some thought that some of the sessions were 'good fun' and interesting, especially when they had talks and demonstrations from people outside. They also found this was a good opportunity just to chat to people outside the ward environment.

Rampton Hospital offered programmes for women in mixed groups, these were abandoned following the implementation of 'Into the Mainstream'.
Rampton Hospital, accommodating 400 men and 40 women did not have the resources to offer parallel activities. However, the picture is not as bleak as the unpublished Rampton Hospital Education Unit Report (2005) suggests. Since segregation in 2005, more women have enrolled in classes. The educators have also adopted a 'learning by stealth' strategy. In effect, this means that whilst the women may be engaged on one task, leading to a skill, for example cooking, they are also learning another alongside it. Maths may be used to weigh ingredients, whilst some science is involved in learning about electricity and gas. Literacy skills are being developed in their ability to follow a recipe, other opportunities are constantly seized upon by the education staff.

Two of the women in the study possessed very limited skills of literacy and this affected their progress, both in therapeutic interventions and their response to educational opportunities. Four women possessed usable literacy skills with one enjoying creative writing amongst her interests and another proud of her achievements in gaining certificates in English and Maths. Two of the remaining five were attending literacy classes, another woman was making good progress, whilst the remaining two had basic skills, enabling them to complete tasks relating to their therapy and examining their care plans with difficulty.

Below is the table showing the self-reported literacy skills of the women in the study.

<table>
<thead>
<tr>
<th>Women</th>
<th>No literacy</th>
<th>Basic literacy</th>
<th>Usable literacy</th>
<th>Good literacy</th>
<th>Attending literacy classes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - 1 HS, 1 MSU, 1 ELSU,</td>
<td>#</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

115
Table 12. Literacy skills of the women based on their own assessment

| 1LSU | | |
| 2 - 1HS | | # |
| 1LSU | | |
| 1 - ELSU | | # |
| 2 - 1HS | | # |
| 1MSU | | |
| 1 - MSU | | # |

The experience of being ‘in care’ and having to leave the protection and support of either foster parents or a care home is an event experienced by all young care leavers. The Children Act 2000 has made more provision for care leavers, but unfortunately, none of the arrangements, however poor, were available to the participants when they were faced with leaving care.

Most of the women could not cope, living on their own and being unable to return to their families, some became dependent upon drugs and alcohol. One
woman said that she ‘became very ill’, and although allocated a place in a hostel, quickly became homeless. At seventeen she made her first attempt at suicide. Another woman said “No one listened to me, I had to do something drastic so that I could be rescued”……. “I told the police what I was doing but it was only when the house was on fire that anyone came”. Again this experience was not uncommon for the participants who did discuss their histories.

As shown above, many of the women fire setters have histories of sexual, emotional and (for some) physical abuse from a young age, some before the age of seven. Belenkey et al. (1986) evidences the fact that women who have been abused experience powerlessness through not being believed or heard.

The profile of women who set fires gleaned from the studies referred to in the literature review and in the interviews with the women participants in this study, are as follows:

a) A women is likely to have aquired a diagnosis of borderline personality disorder

b) Be contained in the secure mental health services for approximately 8 years

c) Set a fire in a ‘contained’ area

d) Destroy property belonging to herself, family member or someone with whom she had a close relationship

e) Have experienced some period of employment
f) Be a parent

g) Set a fire to make a statement

h) Have limited educational achievements

i) Spent time in care before the age of 16

j) Have been treated for other mental health issues

Whilst the therapy and drug treatments focus upon their psychiatric and emotional needs, the deficits caused by the loss of learning opportunities when young still go largely unattended.

The Arson Treatment Group, examined in the next chapter, goes some way to encourage women to explore literacy and to see the reasons why this may be helpful to them in their progression through the secure system.

Some of the women feel that they are at a stage where they are stronger and more able to cope, can see a future for themselves, but for others, they see no future for themselves outside of the mental health system. Other women did not appear realistic in terms of what they thought the future could hold for them.

The data from the professional cohort is examined below and will be concluded with a comparison of data from the women cohort, identifying the similarities and differences in how each group perceive the programme of rehabilitation. What is offered and how it is received?
The data from the professional cohort

<table>
<thead>
<tr>
<th>Professional group</th>
<th>High secure hospital</th>
<th>Medium secure, HLSU, LSU</th>
<th>Independent consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists/RMO's</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Directors of women' services</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Arson Group Leaders</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Educators</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adult literacy advisor</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adult literacy tutor</td>
<td></td>
<td>1</td>
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</tbody>
</table>

Table 13. Professional worker participants

Seven participants were from Rampton Hospital, nine from the Partnerships in Care medium and low secure care units, all of participants to the study have direct contact with patients, with the exception of the Director of Women’s Services in Rampton Hospital. The Medical Director of Partnerships in Care, contributed to the examination of mental health policy examined in Chapter 1, and the two consultants in adult literacy examined policy and practice, together with the arguments concerning the inter-relationship between therapy and learning, presented in Chapter 6.

The data gained from the meeting with the Director of Women’s Services concludes the data examination at the end of this chapter.
It was not possible to match discipline for discipline across the two settings, therefore there are no psychologists or occupational therapists from the secure hospital and within the medium secure settings, no educators. The educators in the secure hospital took on some of the roles of the occupational therapists, and in the medium secure units the occupational therapist also acted as an educator.

In fact, although there was a positive response at the presentations to the two sets of professionals with offers to support and encourage women participants as well as themselves to participate, there was a poor response to the request for volunteers. This made the main source of recruitment 'word of mouth,' what Glaser (1986) called 'snowballing.' A criticism of this means of recruitment is that the researcher is likely to attract like minded participants to engage in a study as volunteers will suggest others who are likely to share their opinions and perceptions of the work. I suspect that to some extent this was the case in this study.

The recruitment process was exceedingly slow, often there was from a month to six weeks time lapse from request to meeting. I attempted to interview at least two participants on each visit, to lessen the amount of travelling and also to give me an opportunity to spend longer in each of the environments, observing and chatting informally to staff. This proved to be an effective method of recruitment to the study. It was sometimes possible to meet with a colleague who was recommended to participate by a volunteer previously interviewed. The questions all related to the participant's work and knowledge of women who set fires. No information was asked about individual women participants.

The data is examined for each question identifying information from each professional group and compared with the contributions from the other disciplines.
Q1. Do you know the background offence, particularly whether a woman has set fires?

As previously noted the first question, asking if the participants were aware of the women with fire-setting histories on admission to their ward or unit was redundant. It is the practice of each setting to ensure that staff working with a new admission are aware of the background of the patient.

There were added responses to the question from nurses who were allocated certain women patients as their 'key' worker. It is the nursing staff who are mainly key workers, although they may hold other responsibilities, but they are the professionals with day to day contact. Their shift system makes them accessible at different times over a seven day period. They are therefore able to observe all aspects of their charges daily living, their problems and their strengths. Unfortunately the nursing staff together with psychologists were the most difficult to recruit to the study.

One nurse commented that "I choose to get to know the person and form my impressions of them through my interactions with them rather than read someone else's assessment of them". The second nurse in the study said "You often find that when reading their notes, their actions seem horrendous, but when you get to know them, you can see behind it and why they did it. Often the offence is not as bad as how it is written," and, "day to day it makes no difference as there's no possible access to anything for them to light a fire. We do a risk assessment if we are going on a journey outside the unit."

The psychiatrists mostly commented upon the important role of the assessment and the importance of the Care Programme Approach. One said that the question asked prior to admission is "can we help this patient". All of the care team assembled for each patient will be aware of their history. This participant commented on the process of treatment indicating that every six months progress is matched to treatment goals which is part of the Care Programme Approach. A psychiatrist from the MSU estimated that at least a
third of the women in each of the lower secure care settings had a history of fire setting. Within the new unit at Rampton Hospital upwards of 70% of the women are likely to have a fire setting history.

The social worker in discussing her role confirmed that It is the social worker who compiles a social history which means visiting family, foster carers, communicating with the education system, criminal justice system and probation service as appropriate and producing a report for the admission team prior to the acceptance of the patient and to regularly update the care team regarding the home circumstances of the patient.

The other participants concurred on their role as part of either the admission team or the care team for the patient regarding this question and emphasised the importance of careful assessment prior to admission.

Q2. This second question asked if there were characteristics which the participants thought differentiate between women who set fires and those who do not. The reason for this question was to see if there were characteristics of women fire setters that have to be taken into account in any rehabilitative or educational approach to be used, other than their propensity to set fires.

The nurses were of the opinion that largely fire setting was opportunistic, impetuous, drink or drug fuelled. “They do not know how to get rid of their anger and frustration.” They also thought that fire setting was done to injure themselves or to damage their own property, not to cause harm to others. They concluded by saying that women who set fires are less in control of their feelings and thoughts. “it just occurs to them to do it and they do”. Both nurses also agreed that most women who set fires have been victims of sexual, emotional and physical abuse and that this forms the basis of their self harming behaviour and see fire setting as part of this spectrum.

In answer to this second question the three psychiatrists were mainly agreed that there is little difference between a woman who sets fire and those who do
not, “just different ways of expressing their feelings”. Another commented that it is ..."largely a question of what outlets for their anger, disempowerment, dispossession are available to the woman”. It was also considered that a minority of women, once they have done it become fascinated by fire, (pyromania). Others it is an ‘indirect’ process, a means to cause harm but indirectly. “Women fire setters have very complex problems and we need to deal with their hurt, rejection, and abuse in a holistic manner”. “I think they act on impulse, they need to bring attention to their distress, to gain help. The women’s past trauma is so great that they will do anything to bring them relief, even if it gets them into worse situations”.

The social workers from both the high secure hospital and medium secure unit were fairly uniform in their opinion as to the characteristics of women who set fires. One considered that fire setting is the sure way of bringing help and support, and said that they have often been rejected by every other support service, but that no-one cannot respond to an incident of fire setting. A social worker from the medium secure unit observed that fire setting was within the spectrum of self-harming behaviours, and she also considered that they are ‘concrete’ thinkers, unable to see other ways of solving a problem. The third social worker thought that fire setters fell into one of three categories. The first are the ‘one-offs’ who ‘cry for help’. The second group have suicidal and self harming tendencies and the third group are the women with anger problems who seek revenge. He went onto say that he thought this group probably had problems, even pre-birth.

The occupational therapist was of the view that women who set fires have difficulty in expressing themselves verbally, with poor coping skills and possibly a lower IQ than non-fire-setters. She thought that they were also under-confident, always seeking approval or reassurance before tackling anything new.
The educators did not seem to think that it mattered when they were faced with the woman in front of them, and thought that there was nothing that makes them stand out as fire setters.

Both arson group facilitators thought that there was little difference between the histories of both groups of women and considered the triggers of self harming behaviours were much the same, thinking that it is an accident that they take this route. "I don't think there is any difference in the women's histories, the triggers of self harming behaviours are pretty much the same. I think it is almost by accident that they take this route". The second ATG group facilitator thought that women see fire setting as an option after hearing about it, or seeing others doing this. She thought that it was rare that women are obsessed with fire, seeing this as mainly a male problem.

The Director of Programmes, medium secure unit concurred with most other opinions of fire setting characteristics. She thought that fire setters fall into two groups, "the calculated fire setter and those who do it on impulse. The impulsive ones are saying, I can't cope anymore, someone take charge of me. They are like frightened rabbits caught in the headlights. The calculated ones, do it largely for revenge, a means of expressing their anger, getting back at someone or something".

Lastly the psychologist, medium secure unit said that he saw no real difference between the two groups, but that there are "clusters of behaviours, thoughts and feelings which may pertain to both groups".

To summarise the views of the professional group, some considered there was no difference between women who set fires and those who do not, just opportunity and chance. Some identified what they saw to be prominent characteristics, such as under confident, unable to handle their emotions, an inability to consider other ways of dealing with problems, issues with anger management. Mainly falling into two groups, the frightened and not coping
individuals and others, angry and vengeful. There were no striking differences of opinion between the different disciplines.

Below is a table which identifies characteristics by professional group, linked to the studies of women who set fires and referred to in this work.

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Reason cited</th>
<th>Other studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>Impetuous/frustrated</td>
<td>Stewart (1993)</td>
</tr>
<tr>
<td>Nurse</td>
<td>Opportunistic related to abuse</td>
<td>Stewart (ibid.)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Anger/disempowerment, abuse</td>
<td>Stewart (ibid.)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Underlying problems the same</td>
<td>Smith &amp; Short (1995)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Impulsive, past trauma, abuse/personality disorder</td>
<td>Bowers/Coid (2002)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Desperate, tried everything else</td>
<td>Bowers (2002)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Concrete thinker, can’t visualise other solutions</td>
<td>Coid (2002)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Cry for help, suicide, anger</td>
<td>Geller (1995)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Cannot verbalise, cannot cope</td>
<td>Stewart (op cit)</td>
</tr>
<tr>
<td>Educator</td>
<td>No different from non-fire-setters</td>
<td>Coid (2002)</td>
</tr>
<tr>
<td>ATG facilitator MSU</td>
<td>Fire setting decided by accident</td>
<td>Geller (1985)</td>
</tr>
<tr>
<td>ATG Secure Hospital</td>
<td>Copy cat behaviour</td>
<td>Geller (1985)</td>
</tr>
<tr>
<td>Director progs MSU</td>
<td>Impulsive/ some for Revenge</td>
<td>Stewart (1993)</td>
</tr>
<tr>
<td>Psychologist MSU</td>
<td>Cluster of behaviours no different to non-fire-setters</td>
<td>Coid (2002)</td>
</tr>
</tbody>
</table>

Table 14. Reasons cited for fire setting in women matched to other studies.
Q3. Do you work with an Arson Treatment Group?

This question was asked primarily to calculate the range of different professional disciplines involved in the treatment of women who set fires.

One nurse from the MSU said that she would like to do the training and was hoping to do so within the next 12 months so that she could be a group co-facilitator.

This question was only relevant to the medium secure unit, as the Arson Treatment Groups are not currently available to women in the high secure hospital.

There were four workers currently involved, all from the MSU. One social worker acted as group consultant to the other professionals. The facilitators of the Arson Treatment Groups came from the professional backgrounds of nursing, psychology and social work. No educators were involved. Psychiatrists commented that their work was primarily with individuals and they had no time left to commit to group work.

All participants seemed familiar with how the Arson Treatment Group was organised and all participants with clinical responsibilities had contributed to discussions about its place in the treatment programme of the hospital or unit. The education staff were aware of the group but not of its structure or content.
Q4. Are issues of fire setting discussed in settings other than the ATG programme?

This question was asked to discover whether, when working on the rehabilitation of women who set fires, this was the general focus, or whether this issue was discussed only in the ATG, thereby confining the rehabilitative work on fire setting to this programme.

Both the nurse participants emphasised that discussion amongst the women of their offending behaviour is discouraged and they are reminded that all discussion of their experiences is only held in the confines of their treatment or therapy setting. This rule extends across all of the leisure or educational activities. The reason for this is to ensure that these discussions are directed to the appropriate forum and also to prevent the spread of awareness of different behaviours that could influence future actions. One nurse further commented that there was occasional ‘boasting’ about their actions, which was swiftly dealt with, but that she was not aware of fire setting being discussed in other therapy groups.

Both Educators commented that rarely were these issues discussed in her presence. If a woman mentioned her history, it would never be dwelt upon.

One social worker reflected that fire setting may be raised in discussion about deliberate self harm.

The second social worker said that the groups attempt to deal with the ‘here and now’ and therefore talk about past offences is not encouraged in these settings.

The social worker from the high secure hospital commented that “rarely is the subject raised by the patient, but it is raised by me using a Risk Assessment,
usually prior to a home visit or a meeting outside the hospital, which rarely happens nowadays.

The occupational therapist, from the medium secure unit was aware that risk assessments had to be made before women who set fires could attend cookery classes. She was unaware of any talking about any offences in any of the practical craft, painting or creative writing classes.

The Director of Clinical Programmes, medium secure unit, said that for the occupational groups all women are ‘risk assessed’. “This assessment involves the women themselves, enabling them to take responsibility for their behaviour”. She felt that this empowers them and helps them participate in their own treatment and progress. It would appear that this happens prior to the women’s assignment to a particular group activity, as the facilitators did not refer to this process.

The Psychologist, medium secure unit, was aware of fire setting being discussed where relevant in groups such as Anger Management and Alcohol and Drug Group. He was not aware of what happens in the occupational groups.

It would appear that for the clinical groups, there were guidelines for enabling or allowing discussion on previous offences, whether fire setting or other activities. In Dialectical Behavioural Therapy groups, which has a focus on current feelings and present behaviours, any reference to past behaviours is seen as inappropriate.

It appeared that where relevant in the educational, craft or interest groups, occasionally these experiences would be mentioned but would not be the focus of the activity nor would this be encouraged.
In terms of the women being 'risk assessed' prior to an activity, I was told that it was possible that a woman may be excluded from a certain activity until it was thought that her mental state would allow her to be included and not present a risk to herself or others. No examples of where this had happened, was given by either group of participants.

Therefore it appeared that discussion of fire setting behaviours was mainly held within the ATG sessions, some individual therapy meetings and possibly groups such as Anger Management, but not DBT or CBT sessions.

Q5. This question asked the participants to tell me about their work and the particular role they have in relation to women who set fires. This question was designed to map the settings and specific support for the women fire setters. To give a comprehensive picture of the work undertaken by the different participants I have noted the responses of each individual to this question.

Nurse 1, medium secure unit, “I have responsibility for three patients who have set fires. I try to see them individually twice a week. Sometimes it’s informal and quite ‘chatty’. Other times it’s more difficult for them to talk. The main thing is that the talks are ‘patient led’. I think they know that they can trust me and that I’ll be straight with them. I treat them with kindness and firmness so that they know where they stand at all times”.

The second nurse commented, “I do most of my work in ‘one to ones’ usually about 15 minutes with each patient when I am on duty”. There has been a change in the way the work is managed on the ward. We now have ‘nurse therapists’ who are not ward based. Whilst this is good in many ways because the nurse therapists recognise the different needs between the female and male patients, this can lead to communication problems. Some issues discussed with the nurse therapist are not relayed to us on the ward. Often if the patient suffers a reaction to the discussion we are left in the dark as to what the problem is or then how we go about helping the patient. So a lot of my work is day-to-day management of the ward and its activities and coping with difficulties as they arise. “Another problem which arises is that the nurse
therapist now does all of the assessment work before the patient arrives on the ward which means again that we have to rely on information being passed to us which does not always work well”.

Psychiatrist 1, high secure hospital, “Perhaps it is easier if I tell you what I do in relation to assessment”. We observe the women for the first two weeks in which time we set up the basic treatment plan. Within this we do a functional analysis of fire setting. We attempt to work in a holistic way with the women trying to help them come to terms with some of their experiences, and of course fire setting is included in this. Our main aim is to deal with the origins of their feelings of despair, anger about what has happened to them. “Up until now the Arson Treatment Group has only been appropriate for a few women who have benefited from it and this has usually been some 18 months to two years into their treatment plan”.

Psychiatrist 2, medium secure unit, “I deal with aspects of trauma from their childhood, plotting their experience to the diagnosis of Borderline Personality Disorder (BPD)”. I work with women to help them control their impulses, and work to regulate their moods. My work here is much more rewarding than being in the community, here ‘I feel I can make a difference to the lives of some of the women’. “Some of them of course cannot be helped, but I treat people consistently, I do not rescue or reject.”

Psychiatrist 3, medium secure unit, “I enjoy patient care, I am involved in most aspects of their treatment, not the groups of course, but I am aware of them and the individual work undertaken by my colleagues. I think the structured care plans and regular care plan meetings have made a big difference to the way in which the women are treated”. “One of the major difficulties is that the women, particularly fire setters, stay in secure facilities for too long, there are not sufficient community resources or less secure units across the country to provide for the needs of these women”. 
Social Worker 1, medium secure unit, “My main role is liaising with families and community resources. I listen to the families and try to understand what has happened to them and how the patient came to be and act as she did. I enjoy the detective work, and also I feel I am the ‘voice of worry’. ‘I ask the question, does this woman still present a risk to the community? I am the outside link for the women on my caseload, between the unit and their family’.

Social Worker 2, medium secure unit, “I am the bridge between outside contacts and the patient”. I enjoy this, the women are keen to know what is happening with their families, but of course I cannot disclose any aspects of the woman’s treatment to them. I talk with the patients and act as a back up for decisions taken about their treatment. “For example, one woman said she wasn’t interested in attending the Arson Treatment Group, but she knows that she cannot be considered for a transfer to a local low secure unit near her home without having attended. So we talked about what this meant and why she was troubled by it”. “My daily work within the unit is just this, trying to come at it from a different angle, hoping that it reinforces decisions made and helps them see the reasons behind them better”.

Social Worker 3, high secure hospital, “Much of my work is dealing with loss and separation, unresolved grief. ‘The ‘bee in my bonnet’ is about women as mothers. For some, their children were taken into care and adopted without their consent, and without them comprehending what was happening’. There is so much anger and despair for these women. It is difficult for them to see that there is light at the end of the tunnel. They have often been abused since childhood and seen as the cause of problems, not as a result of the terrible things that have happened to them, largely at the hands of men and people more powerful than them. “This work is really important to me and I have experienced over the years the opportunity to help some women resolve some of their problems and overcome them to some extent”. “Many, of course, remain extremely damaged”.

131
Occupational Therapist, medium secure unit, “I am an occupational therapist, I work mainly with Rehabilitation, concentrating on daily living skills, self care. Can they change a bed, keep a clean room, cook meals, budget”. On the community leisure groups, we assess their ability, going into shops, interacting with the public, knowledge of their surroundings, eating and drinking in public. Some of the women have not been out for twenty years, and so we devise graded exercises, monitor progress and then up the stakes. “We assess motivation, motor skills, anxiety at new situations, coping skills, asking for help, directions”.

In the groups run in xxxxx, we have groups from 9.30-4pm divided into different sessions. Usually 6 patients to 2 staff. In Education it is usually a smaller group, 3-4 patients with teachers. “Education builds the women’s self esteem, getting certificates for their achievements in English, Maths and RSA computer skills”. We try to facilitate attendance at college for different courses, sometimes this works, and sometimes not. Some women access the Learn Direct education centre. “We have very detailed assessment checklists for every skill to be developed, e.g. general social skills, self management, skills for independent living etc. computer skills courses. English, cooking for independence, lace making, are all courses run at the local adult education centre”.

Educator 1, high secure hospital. This participant had been allocated the task of Project Manager for the daily programme for the new women’s unit. Her task was to create the Meaningful Day Programme, which was to ensure that the women were able to access 5 areas of activity on each day.

Educator 2, High Secure Hospital. My work is to ensure that the women can access learning that is meaningful, anxiety free and so that they can measure their achievements at the end of the activity. With the changes taking place after ‘Into the Mainstream’ women only activities have meant that they cannot access the full programme, which includes male patients. This means that we
have to ensure that the day they can attend the unit that several learning goals are achieved for the same activity. For example, when we have a cooking morning, the women are learning maths because of weighing the ingredients, understanding temperatures, etcetera. “They are improving their literacy skills through reading recipes and writing their activity sheet. We talk about what they are learning and make the experience one which is reciprocal, conversations about what they are doing, how they could apply their skills and knowledge, helping to motivate them to achieve the goals set in their care plans”.

Arson Treatment Group Facilitator 1, medium secure unit. “I am a nurse by profession. I work on the ward and developed an interest in fire setting when I first came here. I didn’t realise how big a problem it was. Previously I worked with sex offenders”. “We have had stabs of trying an Arson Group in the past but without a lot of success. So xxx.xxx from Rampton came over and gave us some advice and also acted as supervisor for us. We developed the modular programme from his work, and shaped it to have specific relevance to the women”. His group is a mixed group and he holds to the view that the mix provides a richness of experience for the women. We have something like six facilitators on the ATG. We need this number because some are involved in Care Programme Approach meetings on a Thursday, and we have to take account of holidays and sickness. “If the group is small then we only use two facilitators but with a larger group, more staff work with the group”. I think this gives a message to the patients of the importance we place on it, and on them as women who have something to contribute.

We have just started the next group, this will be shorter than the sixteen months of the last one. “One woman said ‘what, I can’t attend for sixteen months, I may not be here then’. So although it was off putting it actually worked. But it means a long time for women who need a group if they have to wait something like a year before they can attend”. “We are working to reduce the group time to just over twelve months, by instead of allowing say, 4 weeks on ‘dangerousness’ we limit this to one session. So we are working on the
modules, hopefully it will work with fitting women into the programme as we go along”. Not sure how this will work, but it's worth trying out. “We are learning all the time and the women recognise this and are very supportive of us”.

“It is exciting to see the women develop their confidence, self esteem, self awareness, knowing for themselves that they contribute to not only their own situation but also others. They may start off feeling that they can’t talk about this or that, but soon gain confidence and trust and take off”. The development of trust is crucial, and this can happen in a long-term group. “Also of course the facilitators are assigned to each member so that they can talk with them about any aspect troubling them, in the knowledge that it is all material for the group at some stage”. This I also think is very helpful as the women mull over problems and worries that they may have, and they do not have to wait a week to see anyone, “they can contact their facilitator or any other one and can be seen usually within the day”.

Arson Treatment Group Facilitator 2, high secure hospital, “Arson treatment has been the main focus of my work for a number of years. My background is in nursing. We originally devised a group lasting for 16 months and covering 4 main modules. It was for men and women, although of course the women were in the minority. I still feel that men and women should be treated together as this is the way they learn to better cope with each other. It's more true to life on the outside”. “However the shutters came down when women had to be treated separately”. The whole institution is now divided into cost centres and instead of working together, “now I am asked to justify the expense of having a woman colleague working with me as to how this is benefiting the women’s sector”.

“I have acted as consultant to a group which has been set up along the lines of the one here, but run in an all women’s medium secure unit. I have not been asked to run one for the women once they go to the new unit here in the
Spring 2007. As far as I know there is no work being carried out specifically addressing issues of fire setting within the women’s sector”.

The group covers all aspects of fire setting, from dangerousness to safety, the possible reasons for setting a fire. “We integrate all of the group learning from other groups such as Anger Management, Drugs and Alcohol and work with fire setting as the focus rather than as a side issue. People do not see the need to consider arson as a problem here because there is no possibility of anyone setting a fire within this institution”. So it’s seen as a problem but not relevant to the patient being here.

“It is essential to address fire setting because the patient cannot move on without doing so. The Home Office want to know if a patient has attended an Arson Treatment Group before they will consider a move to a less secure environment”.

“When everything settles down, I hope that the relevance of the Arson Treatment Group for the women in the new unit will be recognised and that we will be able to work with the women. I have put forward plans, so hopefully something will be decided soon”.

Director of Programmes, medium secure unit, “I co-ordinate the therapy programmes to meet the patient’s needs together with the occupational therapy programmes, education and leisure activities. These are discussed at the Morning Communication Meeting”. I facilitate across the board from the Multi-Disciplinary Team assessments. ”There is a Therapeutic Programmes Meeting every month, this is multi-disciplinary and includes group supervisors, group consultants”. Any new proposal for an activity is discussed and agreed or not at the meeting. There is a discussion about the programme and individual progress. Each facilitator reports to the care team about their patient, particularly risk factors, but also progress.
"This is important communication because a woman may be alright in the group and immediately afterwards, but some trigger may set off a reaction much later, and if the key worker is unaware of any distress or matters raised which could cause a reaction, then it leads to miscommunication and this is unhelpful to the woman". The structure of communication and feedback works on the whole, it’s the two way communication that is important. There are sometimes breaks in communication resulting in a kind of them and us situation. "Nurses working on the ward have difficulty in maintaining continuity because if an incident arises and they cannot leave the ward, therefore it is difficult for them to co-facilitate a group".

Psychologist 1, medium secure unit, "My work is mainly ‘cognitive behavioural’. I have an emphasis on evidenced based work, I like to know “what is the evidence’ that this particular treatment or approach works”. Clinicians need to be able to justify what they do. I am eclectic in the approaches I use. I tend to work from a social learning framework, “this means that I am not tied to any one psycho-analytical, psycho-dynamic approach. I use what I need from any one approach if it fits and I have the evidence for it, to justify the approach taken with the patient”. The main points always to be made concerning the ‘integrity’ of the approach in that it has to be on a firm basis of knowledge of cause and effect, “a convincing rationale of how and why certain therapies, or approaches can be adopted. The questions I ask, is the approach relevant and appropriate”.

As can be seen by the comments extracted above in answer to the question about the professionals' work and roles in relation to women who set fires, there is a broad approach, offering a range of expertise in therapeutic, occupational and educational work across the study sites. It was not possible to reflect or compare directly work undertaken in the secure hospital with the work in the private secure mental health units, as roles were not exactly comparable. For example, within the secure hospital the education centre undertook work with patients, which was done by the occupational therapist within the medium secure unit. However, important insights and reflections
concerning the Arson Treatment Group and the adaptations being made to ensure a fit both in terms of the length of the programme and also to ensure its relevance to women in the new unit within the high secure hospital, despite the view that the Arson Treatment Group should be mixed.

Q6. Question six asked the participants for their specific role within the Care Planning Team?

The evidence gathered here directly relates to the policies and practice which either facilitate or block rehabilitation for the women.

Both institutions operate the Care Programme Approach, and have structured similar procedures in relation to admission, assessment and the maintenance of the treatment programme agreed by the Care Planning Team. Each woman admitted to the unit is allocated a ‘care team.’ This is a multi-disciplinary group of professionals involved in her care and who can offer the services and treatments agreed as necessary. In the secure hospital, the assessment period is two weeks before a care treatment plan is agreed. A woman admitted to the medium secure unit is assessed for a period of three months prior to the treatment plan being finalised. It is then reviewed every six months, with those responsible for the funding of the patient, invited annually.

Below are comments which reflect the roles from each of the professional groups concerning their role within the Care Programme Approach structure. A supplementary question concerning the decision making of the Care Programme Approach committee with each participant asked whether they thought that their views were taken into account in the final decision making plan for the patient. These comments are detailed for each participant.

Nurse 1, medium secure unit, a) "Well I am a 'named' nurse with a care team'. Our first priority is to work on a care plan when the patient is admitted. The first is the harm prevention plan. Others may be developed following this depending upon what is required for the patient. The patient is involved in the
care plan and has to sign agreeing to it. A patient can have 3 or 4 different plans to deal with different situations, self harm being the most important. "We write a daily record of the patient, they are discussed each day in the ward handover plus 2-3 times in a 24 hour period".

b) "Yes, our views are taken into account when it comes to the assessment of progress for the women. All of the reports and records are used, particularly the nursing reports because we are with the patients 24 hours a day".

Nurse 2, high secure hospital, a) There is a multidisciplinary team for each patient and the multidisciplinary team care plans are discussed and usually agreed with the nursing care plan, they usually feed into each other. "The first plans are often made before the patient arrives and then we have the chance to work with them and see what their particular skills or strengths are which may not be taken account of in the initial assessment". "For example, one woman came with a skill of 'mindfulness', (this means that she can use visualization when she is having bad, upsetting thoughts and can move herself away from them by doing this)". This is a skill learnt but not all women can do it, and this is now taken into consideration in her care plan.

b). I am listened too because the team know they can trust my judgements. I argue the case when I think their skills or strengths are not being recognised or used. "There are so many negatives recorded that it really is important that care plan assessments fit the needs of the patients, but also recognises their strengths and skills".

Psychiatrist 1, high secure hospital, a) "The care planning meetings are held every six months, local Mental Health Commissioners are involved annually". When we are looking to transfer a woman, we may hold them more frequently to put pressure on resources to effect a transfer. The programme will include Dialectical Behavioral Therapy, possibly Drugs and Alcohol Group, Arson Treatment Group. We look at the goals set for each individual woman and
then plan accordingly. "Medication is regularly reviewed and needs assessed. Physical health is assessed, as well as lifestyle and fitness". As you can see many of the women are overweight, a combination of diet and medication, so it is very important to consider every aspect of the woman’s fitness and well being.

b) “As the responsible medical officer to the women I listen to everyone’s views in the planning meeting and prepare by reading all of the reports beforehand. At the end of the day we attempt to achieve unanimous decisions but it is the majority view that usually prevails”.

Psychiatrist 2, medium secure unit, a) I work with the team and listen to the daily events with the patients from the nurses. “The different people in the care team contribute to the discussion which gives a much wider overview of the patient as a whole. We make decisions collectively on how to deal with different situations”. The main care planning meeting is every six months where a major review of progress, change and needs are discussed and possibly care plans changed.

b)” I tend to want to do things my way but this would probably not work overall”. There may be a situation soon where my decision may overrule the wishes of the group. “I hope they will agree with me but they may not. This has not happened yet in my time here, but I have overall decision making authority as the Responsible Medical Officer”.

Psychiatrist 3, medium secure unit, a) “I am involved in the three monthly multi-disciplinary team meetings where the reports are discussed from each professional involved in the patient’s care”. All those involved in the care of the patient are present, with reports given by the assigned nurse, responsible medical officer, social worker, psychologist and occupational therapist. Progress is discussed with the patient and plans made or changed in relation to their care.
b) "As medical officer in charge of the Unit, I see all of the Care Planning Team's reports and care plans for each patient. I do not interfere with the process or decisions made by the care team".

Social worker 1, medium secure unit, a) "I contribute information from the family and outside agencies who have been involved with the patient. I compile the social history from taking a history from the family, sometimes the school, probation officer, social services, employer, anyone who can shed light on the situation for the patient". "I often feel I have to ask the awkward questions, such as, how safe is this patient to be in a less secure environment".

b) "Yes, I make my views known, sometimes they are taken into account in the planning review and sometimes not, but mostly they are".

Social worker 2, medium secure unit, a) "I am responsible for writing the Care Programme Approach reports, Mental Health Tribunal reports and contribute to the meetings what I can from what I know of the information from relatives or outside organizations such as the local probation department, education services, community psychiatric units who may have been involved with the patient at some point".

b) "I think overall yes, my views are respected, sometimes the rest of the group are 'niggled' by social workers who have wider responsibilities towards child protection and the protection of vulnerable adults. I have to argue my corner occasionally".

Social Worker 3, high secure hospital, a) "I provide the social history to the care planning team meeting. I bring the family into contact with the hospital, which they really appreciate. It helps them also when they visit, not such a daunting experience if bridges have already been built". My role within the team is as varied as it possibly can be and depends a lot on the
circumstances of the individual woman and who is best situated to offer what
the team consider is required.

b) “Yes most definitely. Social work has proved itself to be an important part of
the process. We have been around for a long time and provide a view of the
patient not seen by others in the team. It also depends upon the composition
of the team, sometimes there is a member who may not be on the same
‘wavelength’ but others in the team balance this out and will support my
position”.

Occupational therapist 1, medium secure unit, a) “My role is to assess the
behaviour of the patient in the community and to give information on their
level of functioning in different environments. I also give information on their
progress within the learning and skills groups”. “It often redresses the balance
when looking at progress of a patient to be able to say that they have
progressed in their literacy to City and Guilds level 2, for some patients it
sounds very negative when there is a list of incidents where they have had
difficulties”.

b) “Yes, because I have a view of the patient sometimes not seen by others.
In the occupational groups they feel that they are not under such close
scrutiny and can be more relaxed, consequently they are sometimes more
forthcoming about their thoughts and feelings. It’s a funny thing really because
they do know that everything is reported to the care planning team, whatever
it is they do or say”.

Educator 2, high secure hospital, a) “We write reports on the individual and
their progress. This is discussed as a part of their activities together with their
progress clinically. We are invited to the meeting and I think it is important to
attend”.

141
b) “Our views are heard, they support the process as they are part of the bigger picture, not sure that we would have the last word when it came to whether a person was ready to move on or not”. We need to stress that it is the underpinning knowledge which is the basis and the key to all therapeutic interventions.

Arson Group Facilitator 1, medium secure unit, a) “As a nurse on the ward I contribute to the team both my daily experience of the patient and also my knowledge of them as a member of the Arson Treatment Group. I have two hats for this one. I think it is important for the women that they see me around weekends and evenings as well as just within the group”.

b) “Yes most definitely, particularly when the meeting is about a woman who set fires. The work of the Arson Treatment Group is often key to the discussion concerning the woman's overall progress”.

Director of Programmes, medium secure unit, My role is mainly one of coordination, making sure the programmes hang together and that the different activities are accessible for each of the women assigned to them. We have a Care Programme Approach co-ordinator whose task it is to make sure that all the reports are ready and available in preparation for the meeting. “It is a thrill when progress is reported and you see that the ‘penny has dropped’ for any particular woman and that they are able to benefit from the range of activities on offer to them”.

Psychologist 1, medium secure unit, a) “The Care Programme Approach meeting usually meets after the first three months following admission. It is multi-disciplinary and everyone contributes. At this point we decide on a treatment pathway”. Usually the woman engages in 'pre-therapy' work before they are ready to join the main therapy groups. At the moment we are considering ways to accelerate membership to the Arson Treatment Group. As I say, we have only had one and it is a year in length. “We have begun
another one with a plan to prepare and bring women into the different modules without necessarily having to go through the sequence of the set programme". “Otherwise they would have to wait a year to join the next programme and that's not acceptable”.

b) “We have an important contribution to make to the decision making of the team concerning individual progress. Our reports on the group therapy activities are essential to the overall picture of the patient”.

From the above contributions it would appear that the Care Programme Approach is the vehicle through which treatment plans, monitoring and assessment of patients is driven. This is in accordance with the NHS guidelines, enabling a structured approach, with identified treatment plans and goals to achieve. This forum allows for the assessment of the efficacy of particular treatment approaches plotting and mapping their particular use with individual patients.

Several respondents referred to the annual CPA meeting at which funders and mental health commissioners were invited to discuss the particular needs of the individual patients. Concern was expressed by some participants who did not want this component of their contribution attributed, that the decisions concerning aspects of rehabilitation were influenced by financial concerns, or the lack of appropriate accommodation within their mental health trust, enabling the patient to move to a less secure environment or indeed to a community facility outside of the ‘secure system’.

There was some frustration that clinical decisions regarding the patient's ability to move to a less secure environment were blocked by these barriers outside of their control and to the detriment of the women, who could be set back and forced to wait, in some cases a further twelve to eighteen months, until a decision on a potential move was forthcoming.
Q7. This question asked: What are the most interesting aspects of your work?

This question was asked at this stage because I thought it was important to allow ‘free rein’ after what could have been a difficult question concerning the importance placed upon their contribution to the assessment process. I also wanted to capture the enthusiasm, which might be expressed about their work, particularly with women who set fires. Again I have detailed each participant’s contribution to this question.

Nurse 1, medium secure unit, “Well I love the work. I find it really interesting. I feel that I am helping particular women to get better”. “There are of course some who are wicked and for them there is very little hope of an improvement, they will probably be in institutional care for the rest of their lives because they would not be safe to be let out”. “I know that I can make a difference with some and that keeps me going”. For a while I worked in general psychiatry and worked with people who thought they had problems and experiences which harmed them, “but these women have real problems and need special care which we give here, I am part of this process”.

“I feel that particularly with my named patients, the women who set fires, that I have a good interaction with them, I am helping them take the next step, breaking down barriers”. This is more difficult with women who set fires. “One particular example, was when a woman who had been here a long time and who said she had no feeling. I found her crying, and then she told me that she felt so sorry for the harm she had caused others. This was a major breakthrough for this woman. I along with others of course, helped this patient to see this”. “One woman who when she came in was awful, a persistent fire setter, but she has been out a year now and seems to be doing well. This is progress and it helps me feel good about what I do”. “The patients, I feel, respect me, because I am firm, they feel secure knowing that the support and the control is there to keep them safe”.

144
Nurse 2, high secure hospital, "The 'one to ones' which I think are really important, just to see the women 'move an inch', seeing them develop. One woman, it would not have meant much to anyone else but when she came out of her room wearing a dress. This was really progress. Just small steps that we can see on the ward, these are the most important parts of the job".

Psychiatrist 2, medium secure unit, What I have said before really, seeing that it is possible to help women who have had the most awful experiences, helping them to cope better. I love all psychiatry, you name it, I like it'. "When I worked in general psychiatry it was most frustrating because the people in the community who had problems some similar to those here, but nothing could really be done for them on a 20 minute basis every three months". "The Community Psychiatric Nurses and psychiatrist would go spare attempting to deal with the behaviours in the community that we can manage here and help to change their lives, to really make a difference". "Some of course cannot be helped, sad, mad, yes but not those who are really 'bad'. "I treat people consistently".

Psychiatrist 3, medium secure unit, "I enjoy patient care, seeing patients, ward rounds. I think it is important to be approachable, this way you know what is going on for them on a day to day basis, not necessarily the ones you have direct contact with, but all of them".

Social worker 1, medium secure unit, "From my previous work in prisons and child care, I think that working with women is a logical development. I like the intensity of this environment, it's predictable and uniquely interesting. If I left here it would not be because of the patients, but because of institutionalisation and its impact upon workers".

Social worker 2, medium secure unit, "It's interesting and stimulating. I think progress for women, developing in themselves, however small. It is worthwhile and makes you feel that you have achieved something with them".

145
Social worker 3, high secure hospital, “No two days are the same, Mainly of course the work with patients as mothers. It’s seeing change however small, progress for the women”.

Occupational therapist 1, medium secure unit, “Seeing the women progress, being able to fashion a learning experience uniquely to help them individually. Seeing them get some enjoyment out of life. Improving the quality of their lives”.

Educator 1, high secure hospital, “Seeing some of the progress and positive moves that the secure hospital has been able to achieve for the women, making it a much better service”. “Recognising that change is difficult, challenging entrenched attitudes needs to be handled with care and diplomacy”. “Being on the cusp of major change and having a direct input into making this happen”.

Educator 2, high secure hospital, “The enthusiasm of the learners, delighted at their progress”. “My relationship with the learners, not talking down to them, giving them respect, working with them in an ethos of equality”.

Arson Treatment Group 1, medium secure unit, “I think seeing the women develop and because there is no rigid structure working on the weekly planning of the group to meet their needs. We may have a planned session but this will go to pot if an issue is raised by one of the women who needs attention then and there, or an issue left over from the last session”. “This way they know that it will be dealt with. I see the women developing confidence, self care, making such progress that it does become a realistic goal to plan for leaving institutional living. Some cannot achieve this, but any small gain is something to shout from the rooftops”.

Director of Programmes, medium secure unit, “I enjoy the co-ordination and cross referencing of programmes, it’s a nightmare, a challenge but so
rewarding when you can see the women progress through a coherent and sequential programme of activities geared to their needs. When you see that women can recognize their value, when they are able to be reflective, you can see what empowerment really means and this is very positive”.

Psychologist 1, medium secure unit, “I find it extremely challenging. I think seeing treatment benefits at the end of the day. When you think about it, there has been very little work specifically designed and dedicated to the care of women and less so to women with fire setting histories. I like the planning and creativity of this work”.

In summary

All of the participants mention the importance for them in their work of improvements and gains for the women, however small. To see progress in which they have played a part is an important motivating factor that keeps them engaged with the work.

Q8. This question concerned knowledge about what is the most popular activity with the women in their care.

This question was asked to see if there was an activity which was most popular and to understand why, in order to measure its significance in the treatment plan.

The nurse participant in the high secure hospital where activities outside of the institution was not an option indicated that Bingo was the favourite activity because it gave them a chance to meet women from the other wards, catch up on gossip and just natter. “In the summer between our two wards we will have a BBQ and invite patients on the other ward, likewise they will do the same with us”. “The women also like craft because they feel they are doing something”. They do big things like making rugs or painting toys. These things develop their skills and they have something to show for it at the end.
The nurse from the medium secure unit commented, “Without a doubt the most popular activity is going out. They love this more than anything else”. “I think this makes them feel more normal to get out and go shopping, have a cup of coffee. They also love home visits”. These are often difficult to arrange and some are not allowed this by the Ministry of Justice. “Home visits are resource draining, as not only transport has to be arranged, but also an escort. Some of the patient’s families live the other end of England, so difficult to accomplish altogether”. They also like listening to music and doing IT in the unit when it is available.

The two psychiatrists from the medium secure setting were agreed that occupational therapy was the most popular activity. “They like occupational therapy because they see it as fun, gets them out and about doing things. I think they get a lot out of it”. They are developing skills and learning about themselves in a less threatening way. This can develop their confidence and for some, insight into their behaviour, in what are for them difficult social situations”. “We have a very good occupational therapist who is always finding different activities to fit the needs of the women, to improve their skills and have confidence in themselves”.

Further comments concluded that, they like ‘self care’. Activities with a structure, particularly Clearing your Room, this is discussed as giving them a chance to physically live less chaotically and thereby have an impact on their emotional state. More activities to help them take responsibility for the things that happen to them rather than to say ‘the Home Office won’t let me go’. “To ask the question ‘why not? and for them to see that it is to do with their actions and their behaviour. Helping them find their voice, accepting responsibility”.

The psychiatrist from the high secure hospital felt that the women enjoyed the work in the education centre, but that this was currently curtailed. Activities in the Women’s Centre offered big projects, such as painting large toys and
making rugs, but that this was still fairly traditional. There were ambitious programmes being designed for the Meaningful Day Programme' scheduled for the new unit in the Spring.

The response from a social worker in the medium secure unit thought that smoking and chatting with some access to fresh air was probably the most popular activities. The second social worker felt that the women are offered a range of things to do but sometimes they do not take them up and say that they have nothing to do. “They like painting their nails and each other’s on the ward, I can see the benefits of this, thinking about their appearance, making it a social activity, that is something they may not have done before”. “There needs to be a consistent message about engagement with groups and activities, which I don’t think is always there. They like education and most of all shopping. They now have more money and like to spend this on jewellery and such like”.

The social worker from the high secure hospital thought that the women enjoy art work and craft when they are making things often for family or children. “The women benefit from literacy classes, but these may not always be popular activities. They need encouragement and support to take them up initially, but once they find their confidence then they enjoy activities they know they can succeed in doing”.

The occupational therapist from the medium secure unit observed that “Most of all the women like access to the community and going for a coffee in the shopping centre”. “They also like cooking a meal for a friend, this has to be supervised so not always convenient”. “They are varied in their likes and dislikes, but mainly it is about developing confidence, when they feel they can do something then it is a pleasure to them, otherwise it is a chore that they would rather avoid”.
Educators from the high secure hospital said they were always on the lookout for something different which would interest the women. “They enjoy some of the surprise opportunities that have been made available to them. One was a visit from the local museum looking at how women dressed down the ages. Another successful session was an Indian dancer bringing with her saris and costumes. Anything out of the routine which catches their imagination, they also recognise that we put ourselves out to do these special things and they appreciate it”.

The women enjoy “Arts and crafts, IT and cookery, all the practical skills that are the basis for learning and gaining end results”. Activities where they can physically see what they have done and the progress they have made. “One woman made masks in pencil, they were just black and white and then began to use colour, well that’s progress. The masks were originally for her to hide behind, now they are colourful for the group to play with”.

The arson group facilitator in the medium secure unit, “I would say anything that gives them a sense of ownership over what they do, whether it’s arts and crafts, open ward meeting, somewhere where they can contribute however small and feel that they are being listened to, gives them a status and a sense of importance of themselves”. “It may sound boring to be the patient representative on a clinical governance meeting, but it is somewhere where they have a say, however small and this helps them develop their confidence, and feelings that somewhere along the line they matter and what they say matters”.

“Social Care, they love social care, because it makes them feel good about themselves, it’s fun and really positive for them”. “The one to one education groups are popular as it is a really good boost to women to get certificates of achievement, they laminate them and put them on the wall. When they trash their rooms their portfolios of achievement and certificates on the wall are not
touched. These are very important to the women to gain that sense of achievement when they have seen themselves as being failures for so long.

The Director of Programmes thought that the women liked opportunities where they can be creative, having theme days, these can be St George’s day for example, or breast cancer awareness. The women create special days and get information together, make a social event. “Creativity in the garden, most women can nurture, care and provide for others, and these activities allow these things to show themselves”. This is very positive for them. The women can start to take a hand in their treatment, and have a positive say in their development and progress. “Some like education, English and Maths, computing skills are activities mainly on a one to one, or we have teachers in from the local college, giving courses. Some have done very well”. “They prefer doing courses as one to one. The bigger groups, they do not feel it’s a safe place, not good to feel inferior”. “They are not good on physical activities such as using gym equipment, weights etc. They like line dancing, step, swimming, tennis, and playing with a bat and ball”, but physical activities need to be encouraged more.

Finally the psychologist regarded that smoking was the most valued activity together with self care. He further commented that many get bored very quickly, “they are not really self-motivated, all activities more or less have to be driven externally”.

Again the prevailing observation is any activity, making the woman feel good about themselves, developing their confidence, engaging in social or reciprocal acts, caring for each other. One to one education where they can achieve certificates, recognition for their work. For women in the less secure settings, going out to the local shops, having coffee, buying things for themselves or their children, the kinds of activities in fact that most of us take for granted are particularly important to them.
Q9. Question nine asked the reverse of the previous question in that the participants were asked to identify activities which are the last popular amongst the women.

This question was asked to see if there were activities which stood out as being unpopular and the reasons why this was the case. The participants across the professional disciplines were mainly agreed that ‘therapy’ was the least enjoyed activity. Below are some of the comments supporting this view.

Nurse, “They avoid psychology, I think because they are afraid, it is at a deeper level than the ward talks, and they are afraid of being exposed, or having to talk about things they are not comfortable with”.

Nurse 2, high secure hospital, “They hate the Well Women’s Clinic, anything medical and physical which you can understand. They hate the Dentist, and are not keen on Ashby, the Women’s Day Care Service. They find this boring, doing cross stitch, crosswords, painting, there seems to be no stimulation in these activities”.

Psychiatrist HSH, “As I say, psychology, they do not understand it, why they have to go. They do not like to feel exposed or to feel threatened in any way. They have no understanding of themselves and cannot see the point or the benefit of this work. They do not want twenty sessions of therapy, just sitting there feeling uncomfortable. They think the psychologist can see more about themselves and they feel very exposed”.

Psychiatrist MSU, “They do not like psychology, but this is because it challenges them, back to them taking responsibility really”.

Social worker, “Therapy, because it is generally painful. They dream of fresh start-new start, wipe the slate clean and start again. Of course it’s not like that”. “They have spent so much time particularly in the prison system, blotting out. When they come here they are faced with it all again”. “Dealing with grief,
loss and bereavement is so difficult for them. They have been severely traumatised”.

Social worker, “I think psychology, they are made to look at their problems and past offending, although they say it helps, they mainly don’t like it because it is challenging”.

Social worker, “Definitely therapy. They do not like the exposure, going over past events, feeling bad about themselves even though they know it will help them in the end”.

Occupational therapist, “Therapy, group work, disclosure, addressing issues. Even assertiveness they do not like, they perform better in practical tasks”.

Educator, “The therapies. I think being dragged through history...a necessity...but. Feelings of being exposed and challenged are difficult for most people”.

The second most disliked activities appear to be physical exercise.

Psychiatrist, “I think that it’s back to my ‘bug bear’ to physical activities, and getting a fitness regime going which they all don’t like. They sit around smoking when they should be out exercising. We need to embark on a strict weight loss regime”.

Social Worker, “Physical fitness exercises, they see no purpose to this and find it boring”.

Arts and crafts were also identified by some participants.
Director of Programmes, "When it's day in day out boring, school stuff, arts and crafts with no purpose". "This can be quite child like and not for women".

Group work was also identified as an unpopular activity.

ATG Therapist, "Group work makes them feel a worthless and useless person. This is where the importance of pre-therapy groups come in. This is an opportunity where they can gradually start to think about the things they need to do, and to get into the 'way' of groups. Some have never had the experience, some are hardened to it and feel that it is useless because it makes them feel useless".

Additional comments related to this theme but looking at positive strategies.

A psychiatrist added, "I think that education is a good place to start, to begin the process of esteem and confidence building, so perhaps they can understand more before going deeper into their experiences and their lives".

An educator commented, "well they just drop out if they don't like it. We don't have a high drop out rate. What is really important for them is the smoke breaks, they have 2 every session with three women at a time. It is really important to recognise this and build it into the learning schedule".

It would seem from the responses to this question that therapy comes out clearly as the least popular activity for reasons of exposure, being challenged and not able to feel good about themselves. This is followed by activities where the women can see no purpose, for example, physical fitness, and crafts which use skills below their level of ability. These responses are a consistent theme found within this study.
Q10. What do you think have been the best achievements over the last 10 years in the care for women patients?

This question was asked to plot changes in patient care following the various policy guidelines issued over the last ten years. Again the responses from each of the participants is detailed.

Nurse 1, medium secure unit, “Without a doubt reducing ’re-offending,’ more emphasis on addressing issues around the offence. Seeing more individuals through the system because of this”. “Previously the problems women faced were ignored in the system. We are constantly changing bit by bit, but more and more work with the women, and less of the old style regime, so the ethos is in the process of change I won’t say it is there yet”. “One of the things that I notice, because I go to court often, and bring women here from prison, is the language that is used in court, and where people talk about them as though they are not there. The use of the word ‘disposal’, we dispose of rubbish not people”.

Nurse 2, high secure hospital, “That women get out quicker. When I first came here seven years ago women were in here for twenty years, now they are out much quicker”. “Now with the assessments we do not take women who could be here forever, we take women who we can help to change and benefit from what we offer”. “I worked in XXXXX and we had women there who were much more difficult than the ones here but we couldn’t get them in”. “Also changes in staff attitudes, we are losing the ‘asylum families’ where generations of families have worked here, attitudes are changing”. “We are also due to move to the ‘newbuild’ next Spring. The women chose the colours and furnishings for their ward and now we are told that we may not necessarily have the one for which we have chosen the decorations for!! But even so small changes are better than no change at all”.

Psychiatrist 1, high secure hospital, “I think the biggest change has been the growth of medium secure units throughout the country, which offer a secure
environment. We now have XXXXX offering an 'enhanced Medium Secure Unit.' This will take the patients traditionally taken by us. By Spring 2007 we will have our 50 bedded unit up and running. "I think women's services are on the map particularly with 'Into the Mainstream'.

Psychiatrist 2, medium secure unit, Services for women have been diabolical. The Queens Centre provides a whole range of services now for women, but only for some'. "Our women with borderline personality disorder could not benefit from these community based services, things are improving slightly". "Into the Mainstream' sets an agenda but it will be a long time before these services will be in place for our women”. "We need more low secure units for self harmers and therapeutic communities for women who suffer most with post traumatic stress disorder, which is the root of so many of their troubles”.

Psychiatrist 3, medium secure unit, "Well all women together can't really separate them out. But the focus on gender specific work, and developing care pathways, XXXXXX, being medium secure, XXXXXXX, enhanced low secure and XXXXXX, low secure”. "Recognising women's needs for different kinds of care and focus, the Care Programme Approach. These things have made and will make a great difference to women's care”.

“We need to create services in each geographical area. There needs to be a concentration of expertise, but to have a centre in one geographical area is detrimental to women who come from Kent or Cornwall for example. As the high secure beds are diminishing, we need to see more medium secure accommodation, not happening fast enough at the moment”. “Also women's prisons, whilst I recognise their job is containment, but still services have to be provided within the hospital wings for women with psychiatric problems. Mental health teams operate within the prison service, but demand way outstrips supply".
Social Worker 1, medium secure unit, “I think the most important thing is now the understanding that women’s issues are different to men’s and that it is not a question of one size fits all”.

“I also think of the development of the women’s services and the community development which has taken off. Yorkshire and south of here, Birmingham actually providing services that the women want. Of course there needs to be more, but at least this is a start”.

A programme of ‘meaningful activity’ is needed. They do very little. I think exercise is crucial, their weight gain is enormous, there is no gym here or a programme of physical activity and it is badly needed. “Not much work on empowerment, consciousness raising, collective experience. I think more emphasis in understanding their offending behaviour to understand their moral code to really work with them on this”. “There is little education here. Mainly there is too little for the women to do to fill their days”. “At our current state of human development, human beings need routine, structure and purpose”.

Social worker 2, medium secure unit, “Into the Mainstream, it stands for something”. “Mind you there is a backlash to it. We have just rejected a study wanting to ask women in women only services if they would like to have men around, I think it is a cynical ploy to save money”. “It challenges male perceptions of what women’s services should be. Here issues around gender are looked at fully and the services are developed from a female perspective”. “Risk Assessment strategies are all designed for men which has resulted in women being in environments run by men, for men with no account of the differences and the particular needs women have”.

“It is difficult being a woman in women’s services because you are up against the injustices and the prejudices all of the time. Here some of these battles do
not have to be fought. There is a basic understanding most of the time about women's needs and issues”.

Social worker 3, high secure hospital, “Without a doubt the emphasis on women focussed services, all of the developments of gendered services and facilities”. “Women can feel safer in a service provided for women, some women in the past have gone out to an MSU and have been the only woman patient in with a population of men. Getting women out of high secure services, providing environments suited to their needs”.

Occupational therapist, medium secure unit, “Mild acceleration of movement to supervised community hostels, or lower secure units. There has been consistent handling of the women, firm boundaries, they have been able to test out skills, unlike being in high secure where this is not possible”.

Educator 2, high secure hospital, “I've only been here four years. Despite all the angst, gender specific sessions has worked really well, with far more women wanting to come to the Centre”.

Arson Treatment Group Facilitator, medium secure unit, “Without a doubt, ‘Into the Mainstream’. For so long there has been no recognition of gender issues for women, the fact that they are socialised into being submissive and unimportant in relation to men. They have no self-esteem to begin with and coupled with mental health issues, they have huge barriers to overcome”. “So ‘Into the Mainstream’, at last recognises the particular issues for women. This is a women only service and there needs to be more of them, but it is a start and we are learning and developing all the time. It is so important that the women feel that there is a service for them which recognises them in their own right and not as an afterthought of male care”.

Director of Programmes, medium secure unit, “Recognition of need to focus on fire setting, need for units like ours, greater understanding of the issues
facing women, seeing that they are different to men and need a focussed treatment programme which recognises their needs”. “Another achievement which we operate here, comes from the work of Irene Burkett with her construction of pre-therapy groups, social groups, cooking, communal activities. She began this in Rampton and it worked well”. “Women need to be gently eased into therapy not jump in when they are not in a state to really understand it or make the best use of it”.

Psychologist, medium secure unit, Partnerships in Care, “Arson group for women. Although this has only been going for a year, it is a breakthrough. We went to XXXX XXXXX in Rampton who has the ’niche’ in Arson groups and based the programme on his, which is a mixed group, but with a focus for women”. “We are still working in the dark, there is little research, studies or writing for us to use as a model for treatment”.

In Summary

All of the participants agreed that some major improvements had been made, particularly through the ‘Into the Mainstream’ recommendations. The growth of medium and low secure units throughout the country, although more need to be commissioned particularly in places geographically isolated from centres where resources are more focussed.

The recognition of Arson Treatment Programmes as a way forward for women who set fires is required. The acknowledgement that women’s mental health issues are different to that of men and that the development of gender specific facilities, are long overdue. Several participants referred to the Care Programme Approach and how it has imposed a structure and pathway of rehabilitation. One participant pointed to the paucity of research into women’s mental health issues.
Other problems noted and identified above were the level of craft activities, below the interest and competence of the women. Recognised was the need for more educational work, preferably on a one-to-one basis.

**Q11. The final formal question asks: What in your opinion remains to be done to enhance the opportunities for women with fire setting histories here?**

I have conveyed the comments from each of the participants rather than offering a summary.

Nurse 1, medium secure unit, “I think that progress is achieved by absolute and blatant honesty in the report writing, assessment process, with the women and with the professionals who will take responsibility for their care”. Using the Care Programme Approach and sticking to it. So important in liaising with other units and agencies.

“I feel that what I do makes a difference and helps women to see that for some of them they have a future, and that they can move on from their past. As I say, I think the key is to be blatantly honest and straight with them and the people who will take on their care when they leave here”.

Nurse 2, high secure hospital, “I think we need to engage women in meaningful work, and equip them with skills which will help them outside. In the past the hospital had workshops and a farm but all that has gone. When I came here ‘self valorisation’ was the ‘in’ word, but it didn’t’ seem to mean that the women could achieve it through gaining skills in work”.

“I think also communication, this needs to improve so that we have an overall sense about what happens here in the different departments. We see in the records that so and so has seen a…. but no further information, this could be improved”.

160
“Also now that the women have segregated activities it means that no contact with men is allowed in any of their activities, and whilst I know that abuse could occur but there is no experience now in dealing with the opposite sex so when they do go out they probably haven’t spoken to a man except for ward staff for a number of years”. “I think we have to be less precious about what we do, less professional protectionism”.

Psychiatrist 2, medium secure unit, “At the moment we are at an embryonic phase. Women with problems are treated as a burden, men with these problems are usually in prison. No service really caters for these women. Women need safe controlled environments, offering security, containment so that they feel safe and then can start to work on their problems”.

“I think a range of services need to be in place, from an education programme offering skills building, social skills, coping skills, then therapeutic day hospitals, there are very few of these available, therapeutic communities, low secure environments, to medium and high secure units for the most severely damaged women. We have to accept that some women will never be able to leave institutional care, but at least a range of services relevant to their need would be an important way forward”.

Psychiatrist 3, medium secure unit, “Creating services in each geographical area. There needs to be a concentration of expertise, but the current situation is detrimental to women who come from Kent or Cornwall for example. As the high secure beds are diminishing, we need to see more medium secure accommodation, not happening at the moment”.

Social worker 1, medium secure unit. “Yes one other thing and that is the ‘post code’ dimension to disposal. In different areas two women with identical offences, one ends up on a ‘37’ and the other on a ‘37-41’. “These things really need to be looked at in terms of equity and fairness to the women”.

161
Social worker 2, medium secure unit, “In this work, to understand how women have been oppressed since birth. The need to maintain stability, but at the same time recognising their potential. One woman feels that she cannot live without a man in her life, she has no conception of how she could change her life, or how she could do things differently’. 'Into the Mainstream' is the start but we need to progress and develop more opportunities for women to explore what it means to be a woman”.

Social Worker 3, high secure hospital, “Providing a service at the point of need, earlier identification of problems, getting a range of support and help to them so that they can access what they require and when they require it”.

Occupational therapist, medium secure unit, “We take a group to the Gym each week, but if we had the resources available to us, to have a gym, swimming pool, access to more physical activities this would be good. Many of the women are very overweight. It would be good if we had a beautician to come in and give sessions. Social Events in the evenings, they had Karaoke the other evening and they thoroughly enjoyed it”. “More educational opportunities on a one to one basis. Looking at ways in which we could develop literacy skills for people who have none. Having a teacher come in on a sessional basis, but I know paying them is problematic. All of these activities would increase self-esteem, confidence and sociability”.

Educator 2, high secure hospital, “The age old issue, more resources, ways to create more facilities for women in the building. We are fully staffed with 6 full time and part time lecturers. It is difficult, but if we offered more to the women, we stand to lose staff because they cannot be used to full capacity in working with the women”. “This would then affect what is offered the men. So it is a difficult juggling act, and it's all political”. “I am in addition to the staff group and was meant to work on the wards, but again this is not always possible because ward time is often taken up with occupational therapy and it’s about
encroaching on their territory". "So not an easy situation, but as I say a lot of progress has been made in quality of resources for women if not quantity".

Arson Treatment Group Facilitator 1, medium secure unit, "It seems we are 200 years behind and have some catching up to do. We need more gender specific facilities, and to continue to develop services for women. The possibilities are endless, and we are only in the early stages of doing something, and hopefully getting it right. There is no research about women in particular and we need to look at what works for them. We must work to prevent institutionalisation of women, making their problems worse. We need more pre-therapy, and more education for women here". "We have only just started and it feels exciting and good but we just need to be able to do more and faster".

Director of Programmes, medium secure unit, "We need hard evidence of what works, evaluation and validation of fire setting programmes. Get rid of the vagueness around fire setting, clear risk assessment, arson treatment programmes to be evaluated and put on the same basis as the sex offender programme". Getting the Ministry of Justice to seriously look at what happens to women with fire setting histories.

Psychologist, medium secure unit, "A facility dedicated to women fire setters, where the whole focus of work of a team of people is purely on that. We could then have a dedicated service researching, writing material, designing therapy approaches, cross-pollination of ideas across a range of settings. Unfortunately all of us have other clinical duties, we cannot devote 100% time and attention to the problem".

In summary

A broad range of responses, some identifying policies, others looking at practice, identifying gaps in provision, but all with ideas which would provide a
better service to women who set fires and to women in secure settings in
general. These points are discussed in the final chapter.

At the end of the interviews a final 'roundup' question was asked of each of
the participants, to highlight or reiterate comments relating specifically to their
own contribution. Some chose not to reflect further but below are the
additional points made by some of them.

Psychiatrist 2, medium secure unit, the question was asked about the
importance placed upon the assessment of the work the women achieve here
in terms of helping them move on to the next stage of rehabilitation:

"The necessary things are motivation, to work on their problems, a secure
environment offering containment and control. You can really see women
change, it may take years for them to develop to a stage where they can
move on but here they have the chance to do that. This system allows
breathing space to work and the women have specialist support to help them.
Most of these women have had such awful traumas and have been so badly
damaged by childhood experiences, post traumatic stress disorder has left
them not knowing who or what they are, here we can work on this, and for
some, we can prepare them for a different sort of life and hopefully to get
better".

Psychiatrist 3, medium secure unit, "The question concerns whether enough
is done to ensure that women move on as befits their continuing needs". "This
is a problem, the resources are not there, so women stay for long periods in
inappropriate settings". Returning to the community requires them to take on
the responsibility for themselves in order to do that. Some women are most
unrealistic about what living in the community means. Some will never be able
to achieve that, they will always need some kind of support and could never
be 100% independent. "The best we can hope for is that we give women the
quality of life at the level best suited to them. For some this means they will never leave institutional care. I see this as our responsibility to them”.

Social worker 1, medium secure unit, “Yes, to reiterate my previous point and that is the ‘post code’ dimension to disposal. In different areas two women with identical offences, one ends up on a ‘37’ and the other on a ‘37-41’. These things really need to be looked at in terms of equity and fairness to the women”.

Social Worker 2, medium secure unit, “Yes, I think that we need to capture women in transition from children to adult services, they should not be detained in mental health services. A kind of community is needed where they can be safe, develop confidence, learn skills, before being put out on their own to fend when they have no real means of doing this, this is how they end up in these places”.

“I also think Pornography plays a part in oppressing women, they are duped into thinking they are making choices but in fact they are being abused and oppressed. They could be helped to explore what is sexual expression and what is right for them, and know the difference between sexual expression and sexual exploitation”.

Educator 1, high secure hospital, “I thought that the arrangements would be a big improvement on existing facilities, but concerned about the overall environment in terms of the high fences, installed following the recommendations of the Tilt Report and aspects of security regulations which had an effect on the overall quality of the lives of the women in Rampton”.

“Again though, the progressive and positive work carried out with the women here, often the best physical and emotional environment the women have ever experienced, offering consistency, availability and a structure to their otherwise fairly chaotic and traumatic experiences”.

165
Educator 2, high secure hospital, "Well this goes back to the previous question and the balance between education and clinical work. What we do offer for the women is a Shield each year. I have forgotten the exact wording but it’s not for academic achievement but for the best all rounder in the Centre. Women really need to see that they can achieve and that we recognise this potential”.

Psychologist, medium secure unit, “The women who set fires need dedicated support outside to manage independent living. Of the six women in the Arson group at the moment, possibly only two will be able to return to some form of living outside of an institution. Partnerships in Care used to be ‘Pastoral Care’ meaning that the patients could live here for life. With Partnerships In Care and a focus on therapy, treatment and moving on, some of the women have been really upset and fearing that they would be moved on to somewhere they would not be happy. So some will stay within the facilities we operate for life. About a third could possibly move on”.

Finally, the collection of data ended with the interview with the Director of Women’s Services. She focussed upon the organisational framework of therapeutic, educational and leisure resources geared to the rehabilitation programme for the women in the new high secure unit, called the Elms Unit. The Director talked of the excitement of the women and of the staff as the time of move to the Unit approached.

“The Meaningful Day Programme was the structure aimed to give coherence and meaning to the daily activities of the women. This programme is designed to ensure that each of the women have activities with defined aims allowing them to work to achievable goals”.

The programme has been devised in response to the recommendations of ‘Into the Mainstream’ (2003). These recommendations also suggest a structured programme that offers education as well as therapy, training to
develop skills, and activities, which are designed to encourage women in a focussed purposeful way to address their problems.

The Director described the programme which was constructed by a project steering group, working in partnership with the women, through patient focus groups, which utilised an analysis of patient diary reflections. The project steering group undertook a review of the current therapy and education department provision, patient uptake and an examination of local and national Meaningful Day Policy and Guidance, (Meaningful Day Provision Proposal, 2006. p1).

The Director of Women’s Services currently estimates that between 60 and 70% of the population of women patients in the Elms Unit will have a fire setting history. The treatment options to be incorporated into the Meaningful Day Programme will be required to reflect the needs of this group. The concentration of women with fire-setting histories within the unit, reflect the move from high secure to the medium secure units of women without fire-setting histories. It also testifies to the fact that fewer women within the high secure settings were without the advantage of access to an ATG as none of the three high secure hospitals have provided an ATG within the last two years.

The Director asserts that the Meaningful Day Programme “will create a balance between activities and relaxation which is to be configured within 5 domains. These are to take place daily, between 8am and 9pm”.

- Day to Day Living – personal tasks related to self-care and care of others
- Personal Time – time for herself, reflection, doing something, doing nothing
- Active Engagement – crafts, education, workshops, achieving by doing
- Social, Recreation & Well-being – enjoyment, relaxation, keeping healthy

- Psychological Intervention – Working on mental health and offending needs to enable the patient to move on as soon as she is able

(Meaningful Day Provision Proposal, July 2006, P2).

I was prevented from reproducing the programme giving the times for each of the activities from the five different domains. This showed that the women could spend up to 5 hours of each day in unstructured activities, reliant upon their own motivation to do something or to do nothing. When examining the interviews of the women participants, it becomes all too clear that motivation to manage any self directed activity is problematic.

The policy document states that the programme is built around the individual needs of the women who will access the five domains in a purposeful and planned way which has meaning for them, enabling them to work towards their treatment goals, identified in conjunction with their Care Programme Approach Team. The range of therapies required by the women have been built into the programme, and now includes a revised ATG which recognises the particular and different issues of fire-setting for women as opposed to the male treatment group. The range of activities that include education and leisure are clearly identified as essential to the well-being of the women.

The director went on to tell me that the provision of the meaningful day activities is “a shared responsibility between clinicians working in the NHSHSW and the hospital centralised Therapy and Education Department (TED)”. “Personnel from both these services contribute to the provision of activities from all 5 domains although it is predominately the ward nursing staff who provide the activities in domains 1 and 2”.
The proposal identifies the staffing requirements to provide the Meaningful Day Programme effectively, taking into consideration the contribution required from the NHSHSW, from TED and from other hospital services such as Healthy Lifestyles and the Health Centre. As with all hospitals in the NHS, services and resources are configured in cost centres, which are responsible for a budget and are required to 'buy' services from one another. As previously identified, the education centre is only financed to provide the equivalent of one day of activities to the Elms Unit. The ATG, which operates under the TED umbrella, provides a service which will have to be financed in order to provide a treatment plan which meets the basic provision recommended in 'Into the Mainstream' (2003). Therefore, there are logistical issues and problems to be resolved before a meaningful day programme, can indeed be meaningful.

The proposal examined the consequences of not providing a structured 'meaningful' day to the 50 patients to be accommodated in the Elms Unit. The proposal states that the provision of a Meaningful Day Programme 'is not optional ... but a basic requirement in a high quality national service' (p9). The emphasis on the meaningful day will create shifts in the ethos and culture of the daily provision for women. The physical move to the new unit creates an opportunity for both the women and staff to work with the programme and share in its aims and goals. The director recognised that change will require "for some staff a significant refocusing of some of their approaches and practice to make the best of this new provision, for this group of the most difficult and vulnerable women in treatment".

The discussion moved onto theories in project management, which point to some of the difficulties individuals encounter, faced with change in the workplace, which are relevant to this study. The loss of familiar working practices, alliances and relationships, coupled with the emotional and intellectual energy required to adapt to new situations. The fatigue of working in an organisation undergoing rapid change, in a relatively short space of time was recognised by Beer (cited in Hughes et al. 2002). The problems
associated with change were commented upon with the professional cohort interviewed and in part contributed to one of the blocks to rehabilitation found in this study.

However, the Director emphasised that "the Programme has been constructed in partnership with all of the professional groups involved and the women patients, who will be the recipients of the service". Therefore there is a commitment from all stakeholders in its success in ensuring that a varied provision of activities, therapeutic, educational and recreational are available for the women providing structured and achievable goals which are the building blocks to successful rehabilitation. It remains to be seen whether the service is able to fulfil its commitments to the women within the unit, given their current level of funding, staffing and resources.

In conclusion

The information elicited from these interviews, give insights into the lives of the women living within these settings, a sensitive understanding of the experiences that have led to their containment and vision concerning their requirements and future prospects of rehabilitation.

The interviewees from the education department clearly linked their contribution to the women's learning with their eventual rehabilitation as an end goal. They were frustrated that the women lost opportunities when the single sex policy was introduced within the hospital, although they saw the benefits of this in terms of women's overall need. They worked hard to ensure the reduced curriculum contained as many opportunities for learning in a different format, as in the previous curriculum.

The observations from the professional group concerning what is needed for the rehabilitation of women who set fires is matched by the comments of the women participants recorded in the first section of this chapter. Any activity
which exposes the women to feelings of powerlessness or inadequacy is avoided and little progression noted. It seems as though there was mostly common agreement from the women concerning their attitudes to their life in their particular setting which is concurred by the professional groups. These in particular are the attitudes to therapy and to traditional craft activities. It was also clear that the contributions made by the occupational therapists and educationalists were on the whole seen as helpful and important in developing self esteem and confidence.

The reliance by the women on their key workers and ATG therapists indicates that the one to one work undertaken in both individual and therapy and education are the most beneficial but that any groupwork whether it is therapeutic or educational tends to reinforce feelings of inadequacy. Both groups of participants are aware that there are insufficient activities for the women on a daily basis to keep them occupied in meaningful activities which help them feel that they are engaged in a rehabilitative process towards independent living. This is the goal of the Care Programme Approach introduced in the late 1990’s and the aim of the women recipients as well as the professionals working within this system.

The interviews with both cohorts gave useful and wide ranging information which can be used to answer the study questions. Much of the information also concurs with other studies (Stewart 1993) commissions and reports (Reed 1993; WISH 1999-2001; Tilt 2000; Corston 2007) which are discussed in the literature review.
Chapter 5

The Arson Treatment Group: Learning in Action

In this chapter, the history and background to the unique sixteen-month, weekly treatment and education programme known as the Arson Treatment Group (ATG) is examined and determines how its content is now being geared specifically to women participants. The content contains strategies and skills combining both learning and therapy in ways that mirror the arguments located in Chapter 6, concerning the overlapping territories between therapy and education and also the professional tensions which can exist.

Many of the arguments and analysis put forward by Jarvis (2006) concerning action learning can be applied to the learning which takes place in the ATG. For example, the learning programme requires the participant to picture themselves in different situations, and to consider the different responses they could make, sometimes acting them out in the group to gain feedback about their choice of action.

The Arson Treatment Programme is key to the treatment and rehabilitation for women who set fires, and central to both study questions. The learning opportunities taken by the women in this study, offered as part of the ATG, have been a decisive factor in enabling several of the women to 'step down' by being transferred to less secure accommodation within the secure mental health system.

It has become increasingly necessary for all women and men who have set fires to access an ATG, as this is seen as an important criterion by the Ministry of Justice for measuring progression and reducing the risk factors associated with patients' eventual release from the secure mental health system. It was argued by psychiatrists, prior to the availability of the
programme, that specific areas such as anger management, or anxiety reduction were offered in the course of a more eclectic treatment programme and some are still of the opinion that this is all that is required to treat individuals who set fires. However, reliance is now placed upon 'addressing the offending behaviour' as a core measurement of assessing risk factors for the safety of the individual and also for the community. Membership to the ATG is seen as an important stage in a rehabilitation plan, and some of the blocks to patient access are examined below.

Some of the professionals interviewed consider this requirement by the Ministry of Justice as only seeing part of the picture; they argue for a holistic treatment which includes part of the fire-setting programme but perhaps not in its entirety. Many of the issues, particularly for the women, they assert, have already been addressed in other therapy groups or in one-to-one work with a psychologist or psychiatrist. However, the ATG programme considers all aspects of treatment in relation to fire-setting and the focus on the offence gains positive ground for the patient in the eyes of the Ministry of Justice. As it is the Secretary of State, Ministry of Justice, who determines the progression of women fire setters through the levels of security, their view of rehabilitation is the one that counts.

Until recently, only a few women have had the opportunity of accessing this programme, particularly in the secure hospital regime. Over a period of approximately 10 years, the ATG Programme was offered in each of the three high secure hospitals, but mainly geared to the experience and treatment of arson for men. Women were assessed as able to join the programme, but few stayed the course (Interview: social worker, Broadmoor, June 2005). A further barrier for women is that they may be assessed as suitable, but due to the waiting time for the new group to begin, they may have relapsed in terms of their mental and emotional state, to a point where they cannot make good use of the ATG (interview: psychiatrist, Rampton Hospital, April 2006).
The current ATG takes sixteen months to complete and therefore requires the Care Programme Approach Team to factor in this programme within a time scale where progress can be measured prior to 'stepping down' to a less secure environment. Similarly the ATG programme offered in the less secure units will need to be completed prior to the woman leaving the secure mental health system for accommodation in community housing projects, or referral to community mental health facilities.

The ATG modules therefore, may need to be accessed individually as work with the woman concerned is progressed. For example, a woman may be admitted with a fire-setting history, but therapists may see this as only a symptom of an underlying pathology, with other areas needing to be addressed before dealing with the fire-setting behaviour itself. One professional commented that fire-setting is never seen within the secure hospital setting and so does not arise as an immediate matter to be dealt with. Within the Medium Secure Setting only very few fire-setting incidents have occurred. Very stringent rules apply both inside the units and when the women are escorted on visits outside. No access to matches or other such material is allowed. (Cigarette lighting in the secure hospital and the community units is accessed through a tamper-proof machine on the wall.)

In 2005, the Arson Treatment Consultant from Rampton Hospital was asked to lead a team within the medium secure unit of Partnerships in Care. This unit and the other low secure satellite units in the area offer a treatment programme exclusively for women. The team therefore was able to focus on the needs of women and adapted the original programme to suit them. This venture met with some success in that of the original six participants, four completed the 16-month programme, and the one participant who was part of the sample cohort for this study commented in her interview that the ATG Programme changed her life. It allowed her to be discharged to a low secure unit. She now sees hope of eventually living a life outside the mental health system as a realistic possibility. She also commented that she had attended
CBT and DBT groups in the past and engaged in therapy, but without the focus on fire-setting, she felt that they were not particularly useful.

During the data collection period of this study in the secure hospital, an institution containing both sexes, the policy of 'Into The Mainstream' was being implemented. This meant that men and women were to be treated separately with no integrated activities. To recap, 'Into The Mainstream' offered new guidelines for the treatment of women in mental health care. It had long been recognised that women were often subjected to bullying and harassment by men patients, thereby negatively exacerbating their frequently vulnerable emotional and psychological states. The policy was implemented during 2006, making all social, recreational and therapeutic activities, gender specific.

In practice, this policy also has a downside, as the resources that financed the joint activities were divided pro-rata. This meant that the patient ratio of 40 women to approximately 400 male patients led to an unequal division of recreational and educational activities, resulting in more women spending longer periods of time on the ward without designated activities. With the transfer to a new fifty-bedded unit, and with a new activities programme in place, these problems have been recognised and are to some extent, being addressed.

In terms of the women who set fires, modifications to the ATG programme had to be implemented within the high secure hospital to ensure that they were relevant to the women. This treatment requirement for women who set fires was stated in 'Into the Mainstream' guidance document (2003).

Consideration of this programme took several months before a revised treatment group focusing on the needs of women was successfully negotiated. The educational facilities offered to the women were also reconfigured. Most learning opportunities are now offered within the
boundaries of the new unit (discussed in detail in Chapter 4). All staff engaged in therapeutic, recreational or educational activities have had to make changes to what can be offered, not just in terms of 'Into the Mainstream', but in the provision of the 'Meaningful Day Programme' for the women in the new unit.

The ATG Programme 'was developed from Jackson et al. (1987)' (internal document), Arson Treatment Group. The model used within the criminal justice system considers 'social integration and displaced aggression theory, within the conceptual framework of functional analysis', (reference as above p2). 'This approach is integrated with strategies drawn from a social learning perspective that develops skills of assertiveness and other coping mechanisms specific to the needs of the individual' (reference as above p3). I return to an interpretation of the statements contained in this document as the detail of the programme is revealed below.

To date, the ATG has been offered since June 2007 to women in the new unit who are assessed as being at a point in their treatment and rehabilitation where they are able to make use of it. The ATG did not appear in the original therapeutic provision for the new unit. This development indicates that the ATG programme has been significantly revised to ensure its relevance to women fire-setters and now also recognises the ethos and values embedded within the 'Into the Mainstream' (2003) recommendations.

I suspect that the basis for the model used mirrors the ATG that was devised by the ATG Consultant together with the staff at the medium secure unit. I have not been able to confirm this, despite several attempts.

This medium secure unit has led the way in terms of treatment for women who set fires. They have devised and implemented a successful programme, recently resulting in three women from the first group being transferred to less secure environments. The unit is currently midway through the second
treatment programme. The outcome cannot be assessed until the autumn of 2007. To date, this report has not been available to me.

However, the first programme offered the best opportunity devised at that time for women who set fires to address their problems. The conclusion of this study recommends that despite not having seen an evaluation of the recent programme, it should still be offered to other mental health facilities and the prison service. This recommendation is based upon the previous knowledge of the programme. An evaluation project should be built in to assess its efficacy over a longer time period.

Although it is seen as being part of the therapeutic treatments, a close examination of the ATG programme emphasises aspects of learning critical to the successful completion of the programme. As such, an examination reveals important avenues of self-learning through engagement with materials designed to develop skills to deal with thoughts, feelings and behaviours. The strategy is to recognise early on the triggers which lead to thoughts of fire setting and to replace them with others which block this pathway. This approach is part of a psycho-social integrated therapy and learning programme now commonly seen in cognitive behavioural treatment programmes (Royal College of Psychiatrists, CBT fact sheet, 2006). Teaching women to use this strategy is an important skill and recognised as essential to their learning and eventual rehabilitation.

The revised programme is divided into four modules, the term of which is indicative of a learning environment. Each module lasts for approximately 12 weeks, depending upon what material needs to be covered by individuals in the group. The modules cover a range of related topics grouped together allowing for a substantial degree of concentration upon each aspect of the programme. I think this model is important because the structure of the programme bridges the gap between therapy, which the woman feels she is
powerless to affect, and learning, where she can play an active part and feel more in control of what is happening to her.

All potential participants willing to access the programme undertake an assessment, incorporating the following aspects:

- Background
- Predisposition
- Offence history
- Readiness to change

Following the ATG, all participants undergo post-psychometric testing to assess the success or otherwise of their participation in the programme.

The treatment programme also has a feature not widely practiced in models of group therapy, which again liken it more to an educational activity than a traditional type of group therapy. Participants are assigned to a therapist who is a member of the Arson Group working team and who will see the participant outside the group for additional support or guidance. Most theories underpinning group-work do not recommend work being undertaken outside the group. The rationale for this is that it detracts from the work of the group and there is concern that important material remains hidden; alliances contrary to the well-being of the group can therefore be formed which are then detrimental to the group as a whole (Whittaker, 2000); (Douglas, 2000). These concerns mainly fit the conduct of therapeutic groups outside institutional settings.

However, in this case we are dealing with individuals locked in a secure mental health hospital or a medium secure unit who have a history of fire-setting and therefore are a potential risk to themselves and others. The
treatment programme takes place once a week, and within an institutional setting. Living in a secure environment gives little opportunity to escape thoughts and feelings that may have been aroused within the session. It is therefore essential that there are opportunities for support, to help the woman make sense of emotions and thoughts that may be occurring as a result of their work within the ATG Programme. The option for the women, to have the opportunity to reflect and discuss aspects of the learning hopefully taking place, enables the learner to integrate the cognitive and feeling processes which underpin change in thoughts, emotions and actions.

The ATG programme is organised as follows:

**Module One: The Dangerousness of Fire (12 weeks)**

- Accepting responsibility for fire-setting
- The dangerousness and volatile nature of fire
- The consequences of fire
- Developmental aspects of arson: fire play, hoax calls, vicarious experiences, fire-setting episodes

Accepting responsibility for fire-setting is an important step (interview: ATG Co-ordinator, August 2006). Only four of the ten women interviewed for this study volunteered the fact that fire-setting was the reason why they were in a secure setting. Given that the research study concerned their rehabilitation it can be argued that this information was therefore redundant. However, both participants and myself avoided the term 'arson' throughout most of the interviews. The women did not like the use of the term. One of the more articulate women in the study said this was because she was labelled an 'arsonist' and defined by this one particular action, when she felt that she was
much more, and that her ‘good points’ were not recognised. Concerning the
dangerousness of fires, one woman assessed as suitable for the Arson group
within the secure hospital did say that she was frightened and had not
realised the seriousness of the situation she created.

Most of the professional workers who participated in the study felt that the
consequences most noted by the women were that setting fires immediately
removed them from a situation which had become intolerable for them. Some
of the women participants said that no one listened to them, or helped them,
and that they were desperate and could not cope any more; “when I heard the
fire engine, I knew help was coming” (interview: woman participant MSU).

The last topic of the module, concerning the developmental aspects of arson,
which appears to be crucial in terms of the antecedent behaviours, possibly
the arousal and excitement which may contribute to their fire-setting. Stewart
(1993) looks at possible motives, which are detailed in a previous chapter. To
briefly recap, Stewart’s research indicated that desperation was a primary
trigger factor for her study cohort.

Learning to accept responsibility for fire-setting behaviour is probably the most
important first hurdle. The rest of the module is information-giving and
provides opportunities to really examine motives and their consequences as
they affect the individual woman’s circumstances. This returns us to the work
of Jarvis, who argues that for every individual learner there is a trigger that
motivates learning and allows the individual to develop and expose herself to
other potential ways of dealing with difficult situations. This learning can also
be applied to the scope of action learning techniques (Jarvis 2006), referred to
above.

Whilst the context of learning does not allow the women scope to try out their
skills outside the institutional setting, they are nevertheless absorbing skills,
identifying dangerous trigger situations in which their learning can still be
practised within their living environment. Women tend to have practised other skills that signify their levels of stress, particularly in the form of self-harming. Unfortunately the women learn that self harming also brings some rewards, however negative, when they engage in these actions.

Therefore, it is expected that within this module the women will learn the trigger situations, unique to each individual, where they express their distress in self-harming and substitute for this less harmful ways to signal their angst. It was commonly agreed by the professional participants that fire-setting fits the self-harming spectrum and that this is the most common form of exhibiting their distress to others within the institutional settings studied (Coid 1991). Therefore, there should be careful monitoring of each woman undertaking the ATG, using as a measurement of progression, how far there is a lessening of the frequency of an individual’s self-harming behaviour.

**Module Two: Effective Communication and Listening (24 weeks)**

- Assertiveness
- Problem Solving
- Anger management
- Coping with insoluble situations

The focus of this 24-week module is on skills designed to address the women’s proclivity to fire-setting. As discussed above, it is possible that they may already have participated in all or some of the above groups or individual treatments, but not with the emphasis on fire-setting behaviours. Therefore the women may well have a foundation of skills, but possibly due to denial of their complicity in fire-setting may have blocked learning which addresses this behaviour. The overall picture and rationale for the ATG is becoming clearer.
Rather similar to the philosophy which underpins Alcoholics Anonymous, the recovery begins with acknowledging that the individual has a problem, before she can utilise the support to help her address it, and deal with underlying issues which may have precipitated her actions.

The fact that this module is twice as long as the others, accentuates the importance of the learning and internalisation of the thought patterns, leading to responses which must take place before any real progress can be made. Repetition and even to some extent rote learning, where the individual is conditioned almost in the 'behavioural' sense to replace certain thoughts with others, is a skill which demands much practice. The one woman in this study who had successfully completed the ATG repeated almost in mantra fashion sentences that I suspect must have replaced earlier thought processes.

There is clearly a downside to this means of thought transposition as it can sound as though the individual is merely 'talking the talk.' An assessment may reflect this technique negatively as there is no way of measuring the 'depth' of this superficial-sounding learning until the individual is in a position to 'walk the walk.'

This leads me to consider again Jarvis’s (2006) discussion of chinese techniques of learning. These resonated with my experience when teaching in Russia. On first contact with the system of rote learning it seems that this is not a learning technique, but simply the transporting of information from the teacher to the learner, what Freire calls the 'banking system', a technique mostly out of favour with teachers in the western world (Freire 1972).

Confucian teaching, examined by Jarvis (2006 begins with rote learning, which is then integrated into the thought patterns of the individual, but real learning takes place in its application, and critique of what has been learnt. The last question to be asked using the Confucian approach is, 'how can this be made better?', or 'what else needs to be considered?'.
Clearly the designers of the ATG programme were not concerned with the teachings of Confucius but it is easy to see how this technique may work with patients whose thought-patterns and emotions were so distorted in the first place, leading to their actions. The monitoring of the programme throughout asks the question, ‘how could we improve on this?’. When patients see this question, they may treat it with disdain because they see it as lip service and that nothing changes. In this programme within the medium secure unit, they do see changes, influenced by their suggestions, thereby sowing the seeds of active participation through learning. This also alters the power dynamics between teacher/group worker and patient, which is something that may not have been genuinely experienced in other aspects of their lives.

Module Three: Self-esteem and Self-Awareness (12 weeks)

- Self-esteem levels past and present, with particular reference to self-esteem and any association with fire-setting, exploring methods of enhancing self-esteem in the future.

- Developing self-awareness, challenging distorted perceptions of self, and a better understanding of personal strengths and weaknesses associated with their offence behaviour.

- Stress-management and goal-setting.

Within this module, we can see how the integration of learning about self and the development of interpersonal skills are nurtured in the management of more acceptable coping mechanisms. Again, this learning can only be evidenced within their living environment and their interactions with the same people for twenty four hours, seven days a week. An important point to consider is the hothouse environment of living with twelve other women. (This is the number in each ward, both in the new unit and within the medium secure unit).
All of the women exhibit severe behavioural, emotional and personality problems and they are all at different stages of their treatment. In their living space continual nursing shift change-overs with other personnel coming and going, together with noise and disruptions. Ward life can be used as a useful testing ground for trying out different responses learned in the ATG. This can be seen as a testing ground for change, in all but their fire-setting proclivities.

This module allows the women to make assessments about their self-esteem, self-awareness and plot their progress through the course of the programme. This is an important technique used in other teaching and learning scenarios. Often a student will face a block in their thinking or feelings where she feels despondent, or that she cannot see that she is achieving her goals. Sitting with her, or getting the whole group to map out where they started, to where they are now, often breaks this negative cycle and they return to their studies with more confidence in their ability to achieve success (interview with adult learning consultant, May 2007).

One of the participants interviewed was at this stage and at the time feeling very negative about her progress, despite encouragement from her named nurse and ATG therapist. Another participant had discontinued her work with the group, but would give no explanation of why. When asked what could have made it better, she did not have an answer. This I think demonstrates the vulnerability of the women undergoing treatment and how at times their thoughts and emotions temporarily put them beyond the reach of those who wish to help them.

Module Four: Relapse Prevention (12 weeks)

- Offence Cycle: Examining circumstances of fire-setting episodes, with regard to offence related patterns and trends, including emotional and cognitive states.
Recognising any behaviour that may be considered functionally equivalent or to parallel that of fire-setting, with particular regard to secure environments.

Target coping strategies and avoidance of high-risk situations.

Victim empathy.

Recommendations for further therapy.

By this point it is expected that the woman can exercise 'emotional distance' in considering her past fire-setting behaviours, and recognise triggers and patterns of behaviours and environmental situations in which a relapse could occur. She should also be able to put feelings and emotions into words that are authentic to her.

There is some evidence that connects fire-setting to other self-harming behaviour as a replacement or substitute for the former. This view is held amongst the forensic psychiatrists who participated in the study. A study about to be published (Miller, 2007) claims to have established a link by reviewing case material and statistically cross-referencing the two behaviours, in a group of women in secure hospitals. To establish further connections through research would be a useful study, as it would also give far more ‘weight’ to addressing self-harming alongside fire-setting in this programme. However, it has to be taken into consideration that there are virtually no opportunities for fire-setting in the secure environment, but opportunities do exist to self-harm and patients may take this option when they feel under extreme pressure.

Developing coping strategies, is the underlying theme of the whole of the programme. Avoiding high-risk situations is probably easier in a less secure
environment than in the hothouse environment described above. In this social environment, it is possible to remove oneself from situations that are emotionally threatening. The downside is that immediate support that may be required will possibly not be available. One of the women participants, talking of the need to remove themselves from difficult situations, said that in prison she could go to her cell and may be punished for not going to work, or whatever was expected of her, but in hospital it was impossible to escape.

In the institution there are many aspects of community living that may cause aggravation, with the temptation to revert to previous negative coping strategies, but on the positive side, twenty four hour support is available.

Within this last module, victim empathy is focused upon. This also includes elements that have been core to the treatment process throughout, of challenging distorted perceptions of self, encouraging empathy. To manage an audit of strengths and weaknesses associated with their fire-setting is still probably difficult for them. This seems to be the litmus test, where their response to the problems set in challenging their thinking about their fire-setting behaviour and in demonstrating their revised thinking and feeling in terms of empathy for others, indicates a crucial milestone. Interviews with both cohorts revealed examples where this learning, linked to feelings of empathy for the victims of fire-setting was apparent.

A commonly held misconception about people assessed as having a personality disorder such as the women in secure provision, is that they are not capable of empathy, and that their own agenda is paramount. www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems (accessed 8th May 2007). The ATG provides an environment where the confluence of therapy and learning are intermixed. To a certain extent all individuals in order to make changes must put themselves at the centre of their universe. What is required is a capacity to intersect their universe with
realistic considerations of others, what it is like to be in their shoes and to see the dilemma from another's perspective.

An example of where empathy for others was demonstrated was when some of the women talked about their family's reaction to their past behaviours and how they reacted to their admission to a secure mental health facility, particularly when talking about their children. There were other instances, which demonstrated the integration of thought, feelings and behaviour of the women in relation to how they were dealing with their situation without thinking of themselves as 'victims' but able to acknowledge the harmful behaviours of others towards them. One of the women's biggest problems is seeing the strengths and positives that they do have and their ability to recognise weaknesses in others.

Possibly the biggest need is to reach an equilibrium where it is possible to balance the need for emotional self-survival and recognising the emotional integrity of others. The cognitive aspects of learning and thinking change, when the learner experiences an integration of thoughts and feelings and when they recognise that this has been achieved (Magezis 1996). This is the core of this module. It also signifies the development of the 'whole' person, the coming together of a healing and learning process. Both Jarvis, and Confucius, hopefully, would agree with this analysis.

For a woman in an institution, to be involved in a programme that has spanned up to sixteen months of her life, there would be many opportunities to test out what she has learnt and to try different strategies of managing situations. She would also be able to draw upon the additional support available to sustain her motivation, if a strategy used did not have the desired effect, this being part of the learning curve.

Learning is part of being human and developing ways of coping with different situations is what we all do most of the time. Coopersmith (1967) defines the
process of self-evaluation as the ‘looking glass self’. It is what we see that makes us engage in change. The ATG programme is designed to have maximum effect on not just the learning of different strategies, but of internalising them so that they are part of an integral range of strategies to be used for different situations. The tools of self-evaluation are also put in place so that the individual can hopefully assess the success or otherwise of an intervention, and to be flexible in the skills or approaches chosen to deal with particular situations.

The strength of the programme is that it integrates all social learning which challenges past behaviours in ways that do not demean or diminish an already damaged psyche, but helps to build a healthier, emotionally competent individual with behavioural skills that enable them to continue to progress. As the programme combines emotional and cognitive learning, it is a useful model that could be applied in other mental health settings, adjusted to meet the specific issues needing to be addressed.

We see the different components within the modules address therapeutic issues in terms of group work, with additional interim support. It also shows participants ways of learning that can be found in most community education programmes. Individuals with limited skills are usually under-confident in spite of a demeanour that may suggest the opposite. They need to be encouraged with respect and warmth, but also with an expectation that they will achieve. This approach sows the seeds of confidence which has to be ‘spoon fed’ initially.

In a somewhat analogous situation, working in a community action project in the North West of England, I quickly recognised that the participants in the project, although they were not literate at the time of joining, had other strengths and compensatory skills. They came because they knew that lack of literacy was preventing them from achieving their goals of community development. They also recognised that action of the people was a strength.
they had in challenging the decisions made by their local council. Therefore their learning needs were very specific, they explained their problem in terms of having a voice to challenge a particular road building scheme that would have divided their estate in half with all its attendant problems. They were not about to start with ‘Janet and John’, early reading books, but how to produce a community newsletter, write letters to the council and then be able to read the responses. Their motivation led them to develop literacy skills that could also be used in other aspects of their lives.

In the same way, the women who set fires need to be heard. Their actions led them to the secure environments of prison or secure mental health settings. When they are assessed as ‘ready’ for the ATG, hopefully, by being assigned to participate in this treatment, it means that they are someway down the path of searching for the skills, and knowledge they require to deal with their problems in a less dangerous way. I am aware that several of the women in the study will never achieve this goal or manage to live independently in the community, but if the learning they achieve helps to make their lives more liveable then this is still an important outcome.

The commitment of the multi-disciplinary staff group who work with this group of women who set fires, and who amended the original programme to meet their needs has resulted in improving the life chances of three of their ex-residents who participated on the first group and no doubt others who will come after them. This model is to be used in the high secure unit in Rampton Hospital in June 2007, and hopefully this will continue to be offered as an important treatment intervention for women who set fires both in the prison system as well as secure mental health resources.

To gain detailed knowledge of the ATG has allowed me insights into the learning offered and the learning acquired by the women in the sample, which provides evidence enabling me to answer the questions posed by the study. Firstly, the ATG is the only treatment specific to the needs of women who set
fires. There is evidence, that women who successfully manage the treatment are moved to less secure units.

Secondly, the ATG now being used in the secure hospital for women is gaining recognition for the essential treatment and learning it offers. One block identified is what appears to be the slow acceptance of the ATG as central to the treatment regime for women who set fires. The following chapter examines the treatment and activities programme, identifying the current positives and negatives in this provision for women who set fires.

However, it appears that the Ministry of Justice, latterly the Home Office, considers that a criterion for 'stepping down' through the secure mental health system is that the 'offence' is addressed as a major focus of treatment, although there appears to be no guidance for this in the policy documents located for this study. The experience of some of the women in the sample is that Arson Treatment was in addition to primary treatments of drug therapy, group therapy and for some, psychotherapy. For some, arson treatment was not available to them for a number of years after their admission.

‘Into the Mainstream’ guidance briefing (2003) for healthcare staff, state that arson, now recognised as the biggest single reason for the containment of women, urges staff to address the problem in arson treatment groups and in addition, that sufficient opportunities for learning, particularly literacy is made available within the treatment and rehabilitation strategies in all levels of secure containment.
Chapter 6

Women learning for change: The interconnectedness of therapy and learning

Introduction

This chapter examines the problems of literacy experienced by a substantial number of women who set fires. I argue the case for literacy skills to be recognised as an essential component in their treatment and rehabilitation programme. The case will be made for the encouragement of literacy to be acknowledged as equally important to activities considered as ‘therapies’ and vital to the process of rehabilitation which is the central argument in this study. Furthermore, women’s resistances to education and therapy will be examined and the possible causes and solutions will be considered against a backdrop of theories of learning which identifies some of the ways in which the blocks to their rehabilitation can be minimised.

Women and their experience of formal education

In Chapter 2 it was noted that women who set fires had often experienced disruption in their education. The most common causes of this disruption are family breakdown, family violence, abuse, homelessness, geographical moves, or living in the care of the local authority. These conditions were often present early on in their lives, so that by the age of 6-7 years many had already experienced serious disruption and associated emotional trauma. Stewart (1993) calculated that in her sample of women fire setters, 80% did not have usable literacy skills and much of her cohort had left education prior to the statutory age.

From the age of five, children in primary education are expected to grasp the basic rules of literacy and numeracy and to attain the standards set for the appropriate age until they attain ‘adult’ proficiency. Piaget in the 1950’s
developed a theory of cognitive development still recognised and utilised in the education of children today. He considered that children between the ages of five to ten have developed intellectually to the stage of 'concrete operations,' (Piaget cited in Gleitman 1983). This stage is characterised by inquisitiveness, and an ability to master the intellectual tasks associated with gaining rules and understanding symbols. These rules connect well with the mental constructs of learning to read and write.

Eriksson, a neo-Freudian, whose seminal work was published in the early 1960's, was concerned with emotional development of individuals and constructed a theory of life stages with emotional life tasks attached to each one. He saw the individual as having to grapple between two alternatives with failure on one side and success on the other. For a child between the ages of four and nine the conflict was between industry and inferiority. If children mastered the age-specific tasks, then they were successful and could progress with confidence to the next stage of development. If they did not master them, then they were in danger of seeing themselves as an inferior being who had failed to progress and whose development would be marred as a result (Erikson, 1963). Whilst both of these theories are not without serious flaws, particularly in relation to gender differences, nonetheless they are integral to the educational principles and theories that have influenced how children have been taught in schools over the last thirty years.

Most of the women in the sample were of the generation where these psychological theories of human development that influenced primary educational practice would be relevant. Primary education can be seen largely as a number of intellectual hurdles to be overcome and that certain accomplishments should be achieved at particular age. In particular, the basic skills of literacy should begin to be achieved around the age of five years and adult attainment in terms of reading and vocabulary, by the age of fourteen, Burt, Reading Proficiency Test (1961).
Erikson's theories concerning the emotional development of children consider that the experience of failure has severe consequences for the developing individual. The consequences for the women in the sample when they talked of their difficulties in concentrating on what was happening in the classroom were easy to see. They talked of feeling overwhelmed with what was happening to them at home.

Women from an earlier study I conducted, talked of behaviours that they adopted to disguise their lack of literacy. These included getting noticed in the classroom by causing disturbances, bullying, provoking arguments with other children and being verbally aggressive to their teachers. Some women also said that they attempted to draw attention to themselves in order to find someone who could take control of what was happening to them. (Conversations with women supported by the WISH Community Support Scheme, 2003). One participant in this current study told of strategies she used to disguise her lack of literacy and how she enlisted the help of those around her to read information for her without exposing her inability to do so.

In this study, some of the women told of humiliating experiences at the hands of teachers in the formative years of their education, which for them created blocks to learning as an adult. Others felt that they had not ‘got on’ with their school teacher. For some of the women who participated in this present study, where group learning was currently on offer, this had been declined again, for fear of exposure and failure.

One woman in the sample talked of being labelled a ‘trouble maker’ and believed that her teachers thought she lacked a basic interest in education and in conforming to the rules of the classroom. It would appear that there was little questioning of why, as a child she behaved as she did, nor was there, apparently, a sustained attempt to discover the reasons for her behaviour in the first place.
Looking at her problem from a sociological perspective, it is possible to speculate that questions of class and family background could have influenced the teacher's judgement. It is questionable, that if the participants had come from middle class backgrounds more of an effort would have been made to engage them and to alert their parents to the problems in the classroom. Bourdieu examines how 'cultural reproduction' shows how the education system together with other aspects of family life and leisure opportunities, 'help perpetuate social and economic inequalities across the generations (Bourdieu 1986, cited in Giddens 2006 p710).

One of the women in the study commented that she could not understand the teachers in her primary school and that it was as if they 'spoke a foreign language'. Bernstein’s (1975) study of class and language provides an explanation for this experience. He talks of working class culture as using a 'restrictive code' in that experiences are 'understood' but not described and that commands rather than discussion influence the life of the child. Teachers are likely to communicate using what Bernstein called an 'elaborative code' which involves explanation and discussion which a child from a middle class background would understand and therefore benefit more easily from teachers who used their language style.

In all probability the problems experienced by many of the women were compounded by the fact that the women conformed to a working class stereotype; mainly poor, with an apparent lack of parental interest, and seemingly no aspirations for achieving educational goals. Illich (1973 ) refers to the 'hidden curriculum' which compounds the class and cultural difference in children to the detriment of working class children.

Despite the best efforts of these women, it would seem that their distress was not noted and their behaviour mainly resulted in temporary and, for some, permanent exclusion from school. Stewart (1993) showed that only 14% of her sample completed statutory education. In this present study, out of a
sample group of 10, only three, left school at sixteen years of age, the other six left school between the ages of thirteen and fifteen with one of the woman in my sample said that she had not attended a single day of education since the age of twelve, walking away with no literacy or numeracy skills.

Learning as adults

Jarvis (2006) argues that the motivation to learn is either stimulated or repressed by emotional experiences, by physical as well as psychological. He provides evidence to demonstrate that the difference between the child and adult learner lies in their stage of cognitive maturation and the effect of its respective learning environments, in opposition to the view that approaches to learning are different, as suggested by Knowles (1980).

Considering issues of motivation and environment the women in the study were at different stages of motivation in addressing what they saw as their educational failures. Some said they were afraid to learn in a group because their 'failures' would be apparent for the whole group to see. Learning in a 'one-to-one' situation can take place in some units, but there are limited resources. Members of staff with the required skills and expertise may not be available in a one-to-one environment, and budgetary restrictions may prohibit the purchase of services and expertise from outside of the unit.

Literacy schemes often emphasise the value of establishing a relationship with the learner as a pre-requisite to learning. Thompson (2001). This is often not easy for women living in high secure mental health settings, as respect from the teacher for the learner, and trust between the learner and the teacher, may be difficult or impossible to establish, yet essential to the learning process. An adult literacy teacher consulted as part of this study, emphasised the necessity to engage in a detailed assessment of need for each learner, to break down the overall aims the learner wishes to achieve into short term goals, and to encourage without being patronising. This view is supported by Usher and Edwards (1994 cited in Giddens 2006). They take a
postmodernist perspective which accepts ‘cultural pluralism’ as the starting point for individuals to pursue their own educational aims as and when it is required or of interest to them.

Blocks to learning

Considering blocks to learning it may be helpful to examine the two types of learning: formal and informal, we all experience and consider how this is perceived by women in secure mental health settings. The women live in an environment over which they have little control. They need to adjust to regular changes of ward staff and the comings and goings of patients, the interruptions of schedules and the cancelation of planned activities.

These aspects of daily living impose a routine, and an expectation of what may or may not happen to them. Informal learning is required to manage this environment. These learning opportunities also include when the woman is interacting with others, either inmates or staff outside of therapeutic sessions, watching TV or looking at magazines. This definition of learning is espoused by Rogers (2004) and whilst he mainly writes about these definitions in terms of education in developing countries, it applies equally well to the women in this study. Informal learning is 'lifelong learning.' This is something that humans do all of their waking lives. We learn to adapt to our environment emotionally, cognitively and physically. Some choices we make may not be in our long-term interest, but all chosen actions are purposeful and have meaning for us at the time (Rogers, 2004).

Formal learning for women in this environment includes the range of therapies used, treatment groups, individual counselling, leisure, skills or educational groups. The issues faced by these women before they can begin to address any aspect of their treatment, low motivation, lack of trust, limited self esteem, little confidence, fear of exposure and anger are just a few of the deficits and problems to be addressed before any type of learning through formal opportunities can be accessed.
It is clear that for the women to progress towards rehabilitation, both learning approaches are required. Formal learning opportunities give the women the opportunity to re-think and re-appraise their problems, informal opportunities allow them to experiment with different responses and to reflect on their success or failure.

Jarvis (2006) agrees that as humans we learn from our environment and that we shape our reactions to deal with our current situation. Whether familiar to us or not, we are constantly testing our performance and monitoring the consequences of our actions, deciding whether or not this strategy or that gives us what we want. Many social learning theorists demonstrate to us that we take on roles and persona that fit our environment. The experiments of Zimbardo in the 1970-1980's, which he revisits in his latest work (Zimbardo, 2006), demonstrate all too graphically how the influence of others can affect our thinking and actions. This can of course either be a positive influence or a negative one. The women involved in this study gave several accounts of their experience in learning to change.

Learning strategies

Jarvis (1987) cites the Kolb learning cycle, which demonstrates the connection made between learning and experience and how this results in the changes discussed above. It is the work of Kolb that has influenced much of the strategies of community adult action learning programmes from the 1960's and still continue to this day. It is also the theoretical basis of active learning, which takes place in groups designed to influence changes in thinking and the subsequent actions of an individual.
Diagram 1. Reproduced from (Jarvis 2006)

However, Jarvis takes Kolb's learning cycle as the template, but builds upon it, exploring in more detail the connections and loops which underpin human learning.

Diagram 2. Reproduced from (Jarvis 2006)

Figure 1.1 Kolb’s learning cycle.

Figure 1.2 The process of learning (Jarvis 1987:26).
Jarvis (2006) learning cycle captures in diagrammatic form the essence of the learning process. The diagram shows the steps taken by the learner when dealing with a situation. The experience can either reinforce the learner’s previous perceptions and he or she remains ‘relatively unchanged,’ or he or she can reflect on events and change his or her thinking and or actions. The learner stores the memory and may choose to practise or experiment, trying a different response to the situation. This experience is ‘memorised’ and then ‘evaluated’.

At this point the learner may choose to add the response to his or her repertoire or discard it, if the desired outcome was not achieved. The learner is involved in a circle of experience, experimentation, memorisation, reasoning, reflection and evaluation leading to an accumulation of experience and a choice of responses.

The women in the study can be seen to have begun with concrete experience, which was mainly negative and rather than reflective observation, use ‘gut reactions’. One respondent informing me of how she thinks, told me ‘She thumped me, so I thumped her back harder, she won’t do that again in a hurry’ (Interview: study participant Feb 2006). Some participants found it very difficult to reflect on their own thoughts or actions, or to consider explanations for the behaviour of others that could lead them re-consider their own behaviour.

As noted earlier, women in secure mental health units have usually come via the prison system or other mental health facilities. Most have been exposed to group living outside their immediate families. These experiences from an early age have shaped the person they show to the world, their private self, shielded by their self-protective strategies. Goffman examines this phenomenon: how we present ourselves as the person others think we are, or would wish us to be (Goffman 1960).
Negative adaptations through institutional living

Goffman in his earlier work explains some behaviours of human adaptation to institutional living as 'institutionalisation' that recognises physical survival is often at the expense of emotional and intellectual autonomy. Women participants very often voiced fears about living independently. A part of this fear is the knowledge that they will need to think and act for themselves, to draw upon skills they do not think they possess. This is clearly recognised in the ATG where detailed discussion about the acquisition of living skills, to communicate effectively, reduce their stress and learning to cope in what are for them, difficult situations. These skills are also encouraged in the 'going out' groups. The occupation therapist, assessing carefully the interactions of the women in public or social environments outside of the unit.

Fear of exposure, of managing in circumstances that are untested, result in resistance to change. Anger also motivates a 'Shirley Valentine' response (Russell 1989). Women in the study who felt they have been humiliated, rejected or misunderstood in learning and teaching environments were observed to have adopted a 'don't care, shan't care' attitude to formal learning groups.

Where the women feel they have failed, they had little appetite to compound that failure by further exposing themselves to that particular environment. Failure does not bolster or restore confidence or self respect. These two emotions were inextricably linked with the women participants. However they are expressed in different ways. A woman may consider herself as a person respected in the group by virtue of her criminal reputation, or by her verbal or physical confrontations. This may give her some measure of self-esteem, however damaging this may be to her prospects of rehabilitation in the future. Her confidence in her abilities limiting her capacity to test out her potential strengths or skills in other ways. Her self-respect or self esteem is located in her perceived position in the group, 'the pecking order' does not translate into
confidence to tackle other situations. The Becker ‘outsider’ studies in the 1950’s attest to this phenomenon (Becker 1963).

Another way of examining the phenomenon of self-presentation is by looking at the work of Festinger, cited in Gleitman (1983). Festinger coins the term ‘cognitive dissonance’, which basically means that there is cognitive or emotional ‘discomfort’ between actions, beliefs and or emotions. Festinger’s research shows us that under the pressure of cognitive dissonance, individuals are more likely to change their attitude or belief to match their behaviour, than the other way around. His explanation for this was that others can, and do, judge the behaviour of the individual without access to other interpretative information. Therefore, the individual justifies his or her action by changing his or her thoughts to achieve internal harmony.

In some of the conversations with the women participants this process was clearly evident. One woman, for example, referring to an ‘incident’ which resulted in violence to another patient, said that she hadn’t meant it, but knew she would not be believed, so she justified it by saying how the woman ‘deserved it.’

The seminal works of Goffman, Becker and Festinger offer an analysis of how individuals develop external personas. Social learning theorists show how different environments affect the way we behave, and how pressures placed upon us make us behave in ways that can be understood once we recognise the reasons behind the actions for each of the actors in the scenario.

Zimbardo and Elms’ work clearly demonstrated the power and influence of the group in determining the behaviour of the individual (Zimbardo 1966, 2006; Elms 1971). All of these social interactions, whether they produce negative or positive emotions, thoughts or behaviours, are aspects of both formal and informal learning.
Transformational learning

In attempting to explain the behaviours and attitudes discussed with both the professional and women participants in this study, I turn to Mezirow (cited in Jarvis 2006), and assess what he calls ‘transformational learning.’ This learning takes place when the situation observed above is reversed. This is where previous knowledge or beliefs are challenged making them no longer tenable or acceptable, this means that a change of perception has to take place in order to achieve harmony between thoughts, feelings and actions. Mezirow (1997 cited in Jarvis, 2006) sets out some of the triggers that may accelerate transformational learning, but also acknowledges that this is part of ‘lifelong learning,’ which recognises that as humans we are in a continual state of development and change. Goleman identifies similar situations introducing ‘emotional intelligence’ as a major factor influencing our learning and subsequent responses (Goleman cited in Jarvis 2006).

Transformational learning for women in secure mental health facilities may be more difficult to achieve in terms of a practical assessment of behaviour changes, as routine and communal living may mitigate against the reconstruction of their experiences which would facilitate transformational learning. However, it is possible, as acquiring learning, and having their beliefs challenged within the therapeutic or group learning environment, may provide the trigger to re-evaluate their experiences and help them to see situations differently, or in ways which will make it possible for different strategies for action to be considered. Transformational learning is required of women who set fires, they will need to demonstrate that they have learned that fire setting is unacceptable and that other coping strategies can be assessed as being in place. Almost all of the women participants interviewed agreed that this learning had taken place, but of course it has not and cannot be put to the test within the secure mental health system.
**Learning through therapy**

‘Talking treatments’, such as individual psychotherapy, are conducted by qualified therapists and these attempt to help the patient deal with their past traumas and experiences. Psychotherapy uses interpretative techniques based upon the work of Freud, Jung, Adler or Klein. The various approaches require of the patient a fairly sophisticated level of the ability to think conceptually. The women in the sample seemed to be mainly ‘concrete thinkers’; they may also lack the concentration to make use or sense of such approaches.

Rogers (1968) developed his ‘client centered therapy’ which emphasised listening to the individual based on three core values. The first was ‘congruence’ meaning that the therapist responded to the client or patient displaying their genuine self, without the need for ‘distance’ between the therapist and patient. The second value what was what Rogers called ‘unconditional positive regard’. Rogers interprets this to mean an ‘acceptance’ of the patient as they present themselves and whatever they present, without making a judgement either negative or positive on what is heard. The third value is that of ‘empathy’ in which the therapist is able to understand and feel what is being conveyed from the perspective of the patient. In Rogers’ view the relationship he espouses accelerates growth and well-being in the patient.

Central to Rogers’ theory is his belief that the individual is the ‘expert’ on themselves. Given the opportunity to experience a counselling relationship, such as the one outlined above, then the patient learns about themselves and is able to identify and work on their own solutions to their problems.

Rogers’ (1969) theories span the therapeutic and educational aspects of working with individuals. Rogers, like Illich (1973) was critical of conventional education, stating that it did not encourage people to think, but instead, rewarded compliance.
In this study some professionals identified elements of Rogers’ (1968) core values as essential tools of communication with the women in both therapeutic and learning situations. One of the women interviewees said that for the first time she felt 'listened to' when discussing her progress and imminent transfer to a less secure environment. Another women who had successfully completed the ATG programme said that she had been able to think differently about her life, that things now slotted into place and that she was able to deal better with situations that previously had caused her stress. The integration of Rogerian principles in therapy and learning led to the transformational learning argued by Mezirow, (1973 cited in Jarvis 2006) and the development of emotional intelligence (Goleman 1996 cited in Giddens 2006).

The women in the study have also been treated by the use of other social psychological approaches which have gained prominence during the last 15 years. These include Cognitive Behavioural Therapy (CBT) and more significantly for patients assessed as having a borderline personality disorder, Dialectical Behavioural Therapy (DBT). These therapies are based upon Gestalt, which means dealing with the ‘here and now’ rather than dwelling on the past.

The treatment is a combination of learning to think differently and consequently behaving differently. This is considered to have a more immediate impact by shaping, building and experimenting with novel responses and actions not hitherto within the individual’s repertoire (Sheldon, 1995). Dialectical Behavioural Therapy was the original work of Marsha Linehan (1991) who worked exclusively with patients assessed as ‘borderline personality disordered,’ a common diagnosis or label applied to women who set fires generally, and one that was applied to each of the women in the study group.
Dialectical Cognitive Therapy is an approach which teaches patients who have difficulties in controlling their emotions, who are impulsive and who are unable to deal with any appreciable level of stress. The approach is designed to help the individual change the way in which they interpret situations, helping them to identify their personal ‘triggers’ which cause them distress and to reframe their internal ‘self talk’ (Lineham, Oldham & Silk, 1996).

Other psycho-social approaches which use the dialectical behavioural model as a basis are anger management groups, anxiety and stress reduction treatments, and drug and alcohol groups. All of which are available treatment options within the environments engaged in this study and used in either individual sessions or working in small groups. These approaches require active involvement by the woman who is encouraged to keep a diary, to record summaries of feelings, thoughts and actions, giving them a sense of taking some control over their lives. This is, of course, not an easy or attractive proposition for women who may fear that their lack of literacy could be exposed in the group.

The establishment of trust is recognised as a major pre-requisite to making progress using psychological treatments such as cognitive behavioural therapy, (CBT) or Dialectical Behavioural Therapy,( DBT) or the more traditional psycho-dynamic therapies. Without trust the women require all of their energies to maintain the defences which apply to all aspects of their lives, whether this is to manage their daily living environments, engage in therapy or undertake any of the activities (including education and leisure opportunities) that are open to them.

Physical barriers to learning

Motivation to learn may be low because of the effects of medication, which often inhibits physical energy and focus of thought. Some of the women in the study group found it quite difficult to focus their thoughts and transmit them coherently. One woman actually dozed during the interview, apologising,
saying that she was sleepy due to medication she was given an hour prior to our interview, which was at 10am.

An individual’s physical condition makes a significant contribution to her motivation and ability to learn. Most of the women were very overweight, often due to medication and also possibly, the institutional diet consumed over years spent in prison or other psychiatric institutions. The women also expressed a dislike of physical activity, although they said that they liked being out in the fresh air. These physical conditions and environment could have been a contributory factor to their lack of motivation not just to develop literacy skills, but also to undertake other leisure or craft activities. Some women did not recognise the need to develop literacy or see any benefit to achieving this for themselves, which may be indicative of a generally low level of self esteem.

**Literacy and self expression**

Whilst literacy is an essential skill in a ‘literate’ society it is also crucial in developing a vocabulary that can be used to express thoughts and feelings. Much of therapy relies upon the use of words to describe feelings, and to reflect on past experience, to develop a sense of who we are, to be able to describe our attributes and failings accurately through an ability to experiment with words. The ability to read enables us to access ideas and thoughts, written by others, which may have meaning for us. Competency in reading opens new worlds of ideas, it validates and acknowledges feelings and thoughts and helps us to recognise and empathise with the feelings and thoughts of others.

The interviews with the women participants often revealed a very limited vocabulary with which to describe aspects of their lives, their daily activities, their hopes for the future. Clearly noted was their use of blanket terms, such as ‘useless’, ‘rubbish’, ‘boring’, ‘great’. Similar to the description by Bernstein’s (1975) restrictive code. There was an inability to see or convey elements of a
task or an aspect of their life that would have benefited from a more complex analysis, such as the ability to describe what was good, as well as what was bad, or to describe a level of feeling. Another striking characteristic, which applied to most of the participants, even those with better conversational skills or a wider vocabulary, was their inability to describe themselves.

The question, ‘how would you describe yourself to me?’ was met with either an embarrassed silence, or an admission that they were unable to do this. When probed further, it seemed that their perception of themselves when voiced was that of others, a diagnosis; “well I’m impulsive”, “get depressed” and other similar comments. I think that at this stage it is important to look for explanations of this inability to know oneself, and for its significance to the individual. I examine for an answer, the influence and impact of ‘emotional learning’ as defined by Goleman (1996) referred to earlier.

**Emotional intelligence**

Over the last decade, learning theorists have examined more closely the relationship between emotion and learning, although the association between the two has long been recognised. Goleman, cited in Giddens (2006) examines the different emotions and their relationship to learning. We know for example, that to achieve a goal we may have some anxiety associated with matching our performance to its achievement, but that this may act as the motivation to spur us on. If our anxiety or other emotions overwhelm us then we are rendered incapable of performing to the best of our ability, and we therefore fail. Where negative emotions of fear, self-hate and anger are overwhelming, as appears to be the case for the majority of women who have set fires, it is clear this can impede their cognitive development. Feelings of self-hate, make it very difficult to have anything but a negative view of oneself, if a view, at all.

Indeed, in order to make more substantial claims about emotions and learning, I would need to devote an in-depth study focussed on this issue
alone. Other professionals who participated in the study agreed that this is a problem, and that group activities were tried, including discussions, aimed at improving the women's self-concept and self-esteem.

This issue is noted in the findings of Belenky (1970) who investigated the lives of women in the United States and how they managed their lives in violent relationships. They were only able to see themselves as others saw them, and would not provide a picture of themselves by themselves (Belenky, Clinchy, Goldberger, and Tarule, 1986). Belenky described women who participated in her programme as 'subjective knowers'. By this she meant that they were starting to listen to themselves and their opinions about things, rather than taking their sense of identity and knowledge of the world from others. Belenky describes the transition for women, some of whom were in mental health facilities and had been in penal institutions. In learning to have a voice, not to take on the perceptions of others about them, and to develop their own sense of identity for themselves was crucial to their self-esteem.

Part of the learning also enabled the women in this study to take responsibility for their actions, thoughts and feelings instead of relying on explanations that others were to blame, justifying their inaction. Whilst indeed, many of the women were victims of every kind of abuse, in all spheres of their lives, the only way to improve their situation was by learning to change their reactions to their experiences. DBT, analytical work and the social learning groups all encouraged the women in the study to take responsibility for their learning and to understand their situation and what the future could hold for them (Interview with educator, August 2006).

**Literacy for living**

In a 'literate' community it appears that literacy is taken for granted. There is little recognition of the fact that members of the indigenous population may not be literate, despite the information from the Department of Education and Skills (DfES), who estimate that seven million adults living in England have
literacy skills below that expected of an eleven year old. The latest figure estimates that as many as 7% of the population over the age of 16 are unable to read and write Department of Education and Skills (2006)

Without the means to read and write, as well as the personal and individual drawback related to literacy skills, the individual is at a severe disadvantage in accessing knowledge, information and skills essential to gaining employment and engaging in social activities. The management of everyday tasks, such as understanding a utility bill or comprehending instructions are beyond their grasp. These deficits are a problem to be faced in rehabilitation and preparation of the individual to take a further step of surviving in the community. Illiteracy restricts the person's ability to function as an autonomous individual, to be part of their community and a part of society as a whole.

The importance of literacy is recognised by Women In Secure Hospitals, (WISH). They have begun a project of support in the community called the 'Moving On Scheme'. WISH is working with the Open College Network to establish literacy and skills' programmes individually tailored to suit the needs of the woman about to return to living in the community or those who are in supported hostel accommodation. The women involved in this study are graduates of the secure hospital system and are accessing the education they want, in order to enhance their skills. The work is carried out on a 'one-to-one' basis, as this is the preferred relationship for the women accessing the scheme for all of the reasons identified above.

The women in the study group who volunteered information about their illiteracy seemed well aware of the lack of these skills and their importance, even though they appeared disinterested in achieving them. Some of the women in the study relied on a family member or partner to attend to tasks which required written information or instruction.
Learning for change

Many of the principles which influence the practice of teaching literacy skills to adults comes from the work of (Freire 1972). Friere was a political activist and educator. He wrote in the 1970's of his work in South America where he engaged with peasant farmers living in poverty. He recognised and valued their life experience whilst also seeing that without literacy they could not raise themselves from poverty or exploitation, to actively engage in the affairs of the community, or to have a voice which could bring about change for themselves and their families. Freire saw literacy as the key to full citizenship and therefore a political necessity for his participants (Friere, 1972).

Freire's (1972) work has been the cornerstone of many community-based education projects which emerged during the 1970's and 1980's. For community action groups embracing 'citizenship' and feminist groups using consciousness raising, Freire's grass roots' approach had popular appeal and formed the basis of their work.

In many ways, Freire's (1972) account of his work, and the guiding principles he used, applies equally well to the women of this study. Where women have had the opportunity to learn literacy they have been encouraged to work alongside the tutor, to try to redress some of the fears of inequality, of being 'talked down to' and patronised. The principles emphasised by Friere (and also those of Rogers (1968) noted earlier,) for the learner of meeting their needs in ways that are relevant to them have proved essential in working with the women participants in this study (Interview: educationalist August 2006). Some of the women in the study saw the need for literacy, but were reluctant to engage in the task when they had the opportunity to do so. In our discussions, I considered their resistance was mainly fear of exposure and embarrassment.

One woman who did successfully achieve literacy and maths skills at Level 2 was extremely proud of her achievements, and felt that it had been a huge
boost to her self-esteem. One of the therapists with the ATG commented that where women had achieved educational or skills certificates, if they 'trashed' their room, they left their certificates untouched (interview; ATG therapist, April 2006).

Loss of opportunity to study also comes from the mental health units themselves, where there is no facility to employ an adult literacy teacher or where there is scant recognition that it is relevant to more than a minimal number of women. One of the smaller low secure units had tried unsuccessfully to gain the services of an adult literacy teacher willing to come to the Unit. One of the women from the unit was keen to go to the local FE college and was waiting for permission to register. I was not able to ascertain how realistic was this request.

Modern learning theory suggests that little learning will take place unless the teacher engages with the learner and recognises the worth of their experience and utilises it in creating a more equal partnership. The knowledge to be transferred has to be useful and relevant. The learner has to want the knowledge, skills or information that is on offer (Coare and Johnson, 2005).

One of the participants told of how she felt she was "treated as a kid" and felt stupid, but now she has individual lessons on a weekly basis and feels that she is "getting on better". However when I interviewed her again six weeks later, she said that she had stopped the lessons as she was "bored". Trying to seek further explanation, I asked her to explain 'bored' and after silence, suggested possible explanations, such as, feeling uncomfortable, out of her depth, to which she responded 'yes'. So much for my experience as an interviewer!

From the interviews it is clear that keeping women learners motivated in a secure environment is difficult. Mood and interest can change very quickly, creating a mixed response over the whole range of therapeutic, recreational
or educational projects designed to support and enable the patient. One psychiatrist interviewed commented that women's moods were complex and volatile and that this had a major impact on treatment options and educational opportunities. An example was that a particular patient was assessed as being ready for the Arson Treatment Group programme, but when the time came to join she had again become very emotionally unstable and missed the opportunity for another eighteen months when a new group would become available.

The ethos of the ‘Into the Mainstream’ guidelines has been taken on in the units involved in the study, encouraging partnership in learning and therapy. This, together with the Meaningful Day Programme, despite its current deficiencies, together with the range of structured activities on offer in the less secure environments, all involve the women actively taking more control of their activities. This is designed to increase their motivation as they begin to see the benefits of active involvement, as seen in some of the women in the study rather than passive resistance.

Stewart (1993) showed that low self-esteem, depression and lack of confidence contributed to the participants’ reluctance to engage in any activities that could prove useful, as they could not see the benefits, or could not envisage any hope beyond their current daily existence. However, 80% of her sample were on remand awaiting a hearing, or awaiting sentencing following conviction for arson, therefore, their indecision may also have been because they felt in limbo. They were anxious to know what would happen to them in the immediate future. Similar patterns of behaviour are seen with the women living in secure mental health settings. The women in the study commonly seemed to be waiting on one decision or another, however small or life changing, leading to a reluctance to undertake an activity, as it could effect what was for them the 'bigger picture'.
Most individuals, with the exception of some who are severely brain-damaged, are able to interact or respond to their living environment. As humans we are capable of developing strategies, by learning about our environment, which help us cope with it. Our method of coping may be at the expense of certain emotions or actions, but nevertheless choices are made either consciously or at some deeper apparently, less conscious level. Criminal acts and anti-social behaviour such as fire setting may be conscious acts, or they may be motivated by feelings and thoughts not within the immediate control of the individual.

From a young age the women in the study have been seen to devise strategies for their survival living in groups where they were vulnerable and unprotected. Often their choice was not in their long-term interests but it served to remove them from situations that to them were intolerable at the time. One participant said that no one would listen to her, but she knew that if she set a fire, ‘everyone would come running’.

Social learning theorists explain how this behaviour can be moulded by ourselves and others to engineer specific actions to achieve certain goals, for example, the acclaim of others, an improvement to our self-esteem or to reduce dissonance between our thoughts, emotions and behaviours and as in the case of the young woman described above, to secure a ‘place of safety’ (Milgram, 1974 cited in Gleitman, ; Zimbardo, 1971).

Learning within therapy

Much of this work also comes within the orbit of therapy and counselling, although there appears to be a distinction between what happens within a ‘therapeutic’ environment and what happens in the rest of the activities. This includes the ATG detailed within the Care Plan for individual women. Whilst a number of professional interviewees in the study identified the importance in therapy of women possessing literacy, it appeared that any blocks to women’s progress was not attributed to its absence.
Returning to Rogers (1968) work, he bridged the gap between learning and counselling. His central theme was that humans are moulded and shaped by experiences with which they interact and learn by. He asserted that the ‘healthy’ person ‘lived his experiences’ and could adapt and change as new experiences were integrated into their concept of self. If these were denied then the emotional and cognitive tensions could warp the individual’s identity.

It is the process of learning that is the mechanism by which it is possible to make sense of the different aspects of therapy, rehabilitation, learning and leisure activities which make up the day-to-day living of the individual woman, leading, hopefully, to her rehabilitation.

In summary

Rogers (2004) argues that the distinction between informal learning and informal education is relevant to women living in institutions. He argues that there are clear distinctions between formal and informal education and that informal education can have elements of choice for the learners within it. This would apply to the ATGs. Rogers (2004) also warns us of the distinction between what is provided educationally and what is self taught by the learner. He reminds us, as does Jarvis (2006) that self-learning is a process continuing throughout life and draws upon the knowledge we gain from all aspects of daily living.

In terms of learning, we can attribute the concept of ‘self learning’ to Rogerian type counselling, as detailed above this is guided discussion, leading to the development of insights, from thoughts, memories and feelings (Rogers 1968). The education taking place in the ATG offers more structured learning; and the application of Dialectical Behavioural Therapy, Lineham et al. (1995) is also a structured learning tool. The experience of the craft groups and other leisure activities may offer informal education, equally essential and relevant to the learner. Daily living within the group setting is more likely to be informal learning as described above. Newly acquired strategies and skills may be
tested out in this environment and subsequently the learning from these situations will be assessed by the learner and incorporated into her individual repertoire or discarded if found not to be useful, bringing the learner full circle, as depicted in diagram 2, Jarvis (2006).

The discussion could be summarised by acknowledging that Carl Rogers (1968) advocated the therapist, counsellor or teacher listening to the individual, while Alan Rogers (2004) advocates the learner listening to herself.

**Conclusion**

Learning involves all aspects of living, all of the senses and the whole range of human emotions. Most of the women in the study have not yet recognised the range of their skills and strengths and some do not believe that learning, based upon how they perceive it, is possible.

I have examined women's experience of learning and applied a range of theories, which would help to explain some of the difficulties they have encountered. I have made claims for their potential to learn and change, which hopefully, could assist their progress towards rehabilitation, in answer to the first question of the study. The interviews with both the women and the professional cohort support the assertion that there is potential for change.

This, together with this examination of learning theories, contributes evidence, answering the questions about rehabilitation, upon which this study is based. The learning theories discussed in this chapter provide the basis upon which to review current practice and to formulate a model for treatment, fusing the hitherto perceived different activities of therapy and education.
The evidence of some of the women in this study showed that the basic skills of learning, help to foster confidence and self-esteem, which are essential qualities in terms of their rehabilitation. For some women, it is possible to see this process at work. Where they have acquired skills of literacy, they appear to develop confidence, enabling them to discuss their progress, and their treatment goals on a more equal footing with the staff responsible for their treatment. This process was demonstrated by two of the participants, and acknowledged by the staff responsible for their care.
Chapter 7

Conclusion and findings

Introduction

This chapter draws together the evidence which has been presented throughout this study to answer the research questions posed. Other research and discussion of theories have been used to support the evidence found in this study. The information gathered is examined in the light of the organisational policy 'Into the Mainstream' and the structure of the Care Programme Approach. This in itself is set within the legal framework of the Mental Health Act 2007. The organisational and legal framework create both the physical and the human environment in which the women live and the professionals work.

As previously discussed the Care Programme Approach is the vehicle through which treatment and rehabilitation programmes are assigned and the monitoring and assessment of patient progress is driven. This is in accordance with the NHS guidelines, enabling a structured approach, with identified treatment plans and goals to be achieved. This forum allows for the assessment of the therapies, learning and leisure opportunities, plotting and mapping their particular usefulness with individual patients.

It is important to see the learning opportunities embedded in the organisational framework of the Care Programme Approach and the Meaningful Day Programme within the high secure setting and a similar structure which prevails in the less secure environments. It has the advantage of being transparent where gaps and blocks can be more easily identified. Both cohorts who participated in this study referred to the organisational structure and the changes in high and medium secure care which affect the daily lives of the women contained therein. These structures provide the
umbrella under which all activities are organised whether they be categorised as therapy, learning or leisure.

Therefore the Care Programme Approach is important in that it details and records the learning opportunities available, identifies gaps in provision and assesses their usefulness to the individual patient. All disciplines involved with the patient submit reports concerning their progress and all, including the patients are invited to contribute to the six monthly report as well as to the annual report on progress to their mental health trust funders.

Following the need to understand the framework in which the activities for the women are organised, studies were trawled to finding supporting evidence regarding the evaluation of learning opportunities within rehabilitation programmes offered to the women who set fires. Whilst some identified the need to evaluate therapies, learning and leisure opportunities, (Stewart 1993), (Corston Review, 2007), (Bartlett and Hassell, 2001), (Lart et al., 1999), no recent evaluations could be found. One unpublished chapter examining the attitudes of men and women arsonists to an ATG group, (Gill 2006) was found to be useful.

To have meaning for the stakeholders of this study, answers to both questions need to be set within the organisational structure identified above. The first question asked:

To what extent do learning opportunities for women fire-setters in secure mental health services contribute towards their successful rehabilitation in the community?

The learning opportunities given prominence in this study were the Arson Treatment Groups, educational classes and activities designed to enhance self esteem and confidence, such as 'Cleaning Your Room' sessions.
The content of the programmes were searched for opportunities to gain literacy and to support the development of self awareness, confidence and a growth in self esteem. There were opportunities found in many of the activities and therapies offered. Both groups of participants cited examples of learning, of developing their self awareness and confidence which in part assisted the women in achieving goals associated with their individual treatment and rehabilitation pathway.

Whilst there are many different triggers that motivate a woman to learn or change, what may be useful to one will not be helpful to another. As discussed in Chapter 6, motivation to learn, particularly literacy and numeracy skills presents to some extent a chicken and egg conundrum. The question of whether the women's increased self esteem and confidence motivated some of the participants to learn skills that would be useful to them, or whether the learning of skills developed their self esteem and confidence. Examples of both pathways were found in this study.

The interviews with the professional volunteers talked about the assessment process indicated that a hierarchy of therapy as the primary focus of assessment, with learning and leisure activities seen as secondary in the process existed. The impression created was that it was in 'therapy' where the work was done and the educational and leisure activities were of lesser importance to some of the staff, but not to the women participants.

It also seemed to be the case that therapies were evaluated in terms of their success in relation to a psychiatric assessment of the women's mental health, rather than recognising therapy as a provider of opportunities for learning, particularly the ATG, the Alcohol and Drug Awareness group and the Clearing Your Room group. All of these activities require exercises in keeping diaries or logs of their daily activities, for the women to express their thoughts and feelings and to describe their actions in writing or drawing. What may be required is greater recognition of the aspects of the therapeutic groups to
measure progress made in literacy skills which may enhance the women’s self esteem and confidence as much if not more so than the primary therapeutic purpose of the activity. Indeed, one psychiatrist argued this point in a paper to hospital managers when educational services were under threat.

The opposite argument relates to some of the educational and leisure activities. Opportunities to interact in social environments outside of the units available to women in the medium and lower secure units are powerful lessons leading to the development of confidence and self esteem. One woman described herself as ‘being normal’ outside of the unit.

In terms of the first question of the study, membership to the Arson Treatment Group is an important measure used under the Mental Health Act 2007 to assess the ‘fitness’ of a women to be ‘stepped down’ to a less secure environment. The learning opportunities within the ATG designed for women who set fires span all four objectives of acquiring self knowledge; developing confidence; enhancing self esteem; and gaining literacy, the first three of which were seen as essential in the rehabilitation of the women and the latter seen as useful by some of the women and most of the professional cohort interviewed.

This study showed that women who had accessed the Arson Treatment Group were ‘stepped down’ to lower secure environments soon after completion or in one case during the programme. One of the participants in the study commented that belonging to the ATG ‘turned my life around’. She went on to engage in other therapies and was continuing with literacy and numeracy skills useful to her future rehabilitation.

Balanced against this, two women who had previously accessed the mixed gender ATG accommodated in the low secure unit, gave little evidence of an increase in their confidence levels or of their motivation to develop learning skills. There are possibly two reasons for this, the first is that the mixed group
attended in 2000 did not cater for their needs and the second being the detrimental effect of institutionalisation. Both women appeared too institutionalised to develop autonomy of action or independent thinking, culminating in a situation where further rehabilitation to non-secure settings is extremely unlikely. This observation was confirmed by professional interviewees in their unit. Therefore the practice of taking membership to the ATG as evidence of progression for the women is questionable and with the criteria adopted within the Care Programme Approach hopefully now not the only criteria for ‘stepping down’, but assessed as one positive step within a detailed profile of others.

Therefore to answer the question as to the extent that learning opportunities help women who set fires to be rehabilitated back to the community relies upon the examination of all of the activities that the women can access without making the traditional distinction between therapy and learning. This argument brings us back full circle to the issues identified above. That equally important to an analysis of the opportunities themselves, it may be a question of timing, what is offered and when, within the rehabilitation programme.

Evidence gathered in the study pointed to the fact that women in the earlier stages of rehabilitation and who were mainly younger appeared to understand the achievement of goals through the stages of the rehabilitation process. The professional interviewees in the study attested to this fact. This would appear to be the result of the Care Programme Approach with its clearer focus on progression through the secure system. Comments regarding the progress of the women, ‘when the penny dropped’ and noting behaviours and activities demonstrating changes in attitude, mood and behaviours.

There were examples from the women participants where the evidence indicated both possibilities. As noted above, the participant who felt that the ATG motivated her to change, whilst another women thought that it was
learning literacy and maths which helped her feel better about herself and that this for her was the trigger to progress in other ways.

Therefore the answer to this first question as evidenced in this study is that opportunities to learn do accelerate the progression through the secure system, but that the key to successful rehabilitation lay not only in the treatments and learning opportunities themselves but that their efficacy is influenced by the length of time contained in institutional living. Goffman (1961) refers to the dumbing down of emotions and how the routine, mundane rituals of daily living rob inmates of their sense of self and of any thought of independent action. The evidence for this is that the women in the low secure unit had an expectation that what they did on a daily basis was provided by the staff. They complained that there were few activities laid on for them, and what appeared to be little awareness of what they could initiate for themselves, with little motivation to instigate independent activities.

Further evidence of the negative effect of institutionalisation was, in my assessment, the women's inability to think or to relate anything positive about themselves in response to a supplementary question, 'how would you describe yourself to me'. The pain for some of the women in responding was palpable, and described in Chapter 4.

The final evidence linked to the effects of institutionalisation for some of the women, particularly those who had been contained the longest was their lack of ability to see a future for themselves. The women participants in higher secure environments realistically were looking to the next stage along their rehabilitation pathway.

The Director of Programmes talked of the initial need of some of the women to be in a secure environment where they did not have to think for themselves or cope with life as it was for them. This was identified as one of the reasons behind their fire setting. Whilst the regimented life in the remand centres and
prisons where the women were sentenced may have offered them security and protection, this would soon have begun the process of institutionalisation that (Goffman 1971) identified and continued albeit modified, through to their transfer to the secure mental health system. This affects a number of women trapped in the system at the low secure end who have nowhere to go according to one of the social workers interviewed.

The evidence points to the importance of a programme of activities available to the women to access at a level appropriate to their needs. That the waiting time is reduced for women to be able to join, in particular the ATG when they are at a point that they can benefit from this programme. That less time is spent in inactivity. It is also important that women see that achieving goals will result in their progression through the secure system.

Several respondents referred to the annual Care Programme Approach meeting at which funders and mental health commissioners were invited to discuss the particular needs of the individual patients. They indicated that the decisions concerning aspects of rehabilitation were sometimes influenced by financial concerns, or the lack of appropriate accommodation within the relevant mental health trust, enabling the patient to move to a less secure environment or indeed to a community facility outside of the ‘secure system’.

There was frustration voiced by both the women and the professional interviewees that clinical decisions regarding the patient’s ability to move to a less secure environment were blocked by these barriers outside of their control and to the detriment of the women. Women could be set back and forced to wait, in some cases a further twelve to eighteen months, until a decision concerning their membership to a particular group or activity or for a potential move was forthcoming. This problem was also noted in the work of Bartlett and Hassell (2001).
The second question of the study asked what are the other factors which (a) enhance rehabilitation and (b) what are the blocks to progress.

The first factor enhancing the rehabilitation of the women is the staff who support them in every aspect of their lives within the wards and units. The responses to the question asking the professional interviewees, what they most like about their work, was fairly unanimous in their excitement about the progress, however small the women may demonstrate.

This level of commitment and involvement is clearly recognised by the women’s responses when asked who were the most helpful to them. The day to day communication of encouragement and support is critical to the basic wellbeing of the women. In times spent waiting to interview staff or women participants I had the opportunity to observe some of these interactions. In an interview with a psychiatrist, she was hailed from the window when women saw her sitting at her desk, clearly demonstrating a level of friendly informality between them.

I was also aware of incidents which were less positive and where verbal interactions escalated beyond the control of the woman involved. The ‘hot house’ environment in which the women and staff lived meant that situations of tension which arose were dealt with as and when they occurred with the available staff. In the ‘cooling off’ time, the issues could then be talked through and some resolution achieved. However these created unsettling times for the women, as evidenced in one of the interviews.

The staff as well as the women also suffered levels of frustration when arrangements for activities were cancelled, or recommendations made by the care team were not actioned or agreed in the Care Programme Approach meetings. This was commented on in several interviews with both cohorts.
Several staff talked of issues of communication where reports on daily activities missed transferring vital information to care staff on the ward, leading to further miscommunication with the individual patient. Very often the comment from staff was that it was not the patients that caused them stress but the operational procedures, when they went wrong.

The study discovered a support network of professional workers across the secure care units in the region. There were regular meetings both formal and informal which led to a vibrant cross fertilisation of ideas from the hospital to the units and vice versa. Expertise was shared across the region as noted in the development of the women only ATG within the medium secure unit.

Employment opportunities also allowed for workers to experience aspects of the work from different perspectives. This shift in employment and also visits for staff from the different facilities meant that they kept in touch with the women as they progressed from one area of care to another. This was equally important for the women. One commented that she regularly saw her previous 'key worker' when she visited.

The pattern is finally being eroded where generations within families are dependent upon work in the institution, although this is still apparent in Rampton. To be employed by the institution can ensure a job for life, where all needs are catered for including housing and social needs. It is not unusual for 'hospital families' to intermarry, and maintain the cycle of employment.

This can be seen negatively and certainly Goffman (1960) was critical of such practices, as change was slow to achieve in the old style institutions. However, it would be difficult not to be aware of the measures being taken to rid Rampton of the image of the total institution. I observed the notice board in the staff education centre, and was struck by the level of professional development available to staff and of the ability of the institution to meet targets of staff training, as a performance indicator of good practice. The
programme included issues such as awareness of racism in mental health and the new focus on 'gendered' practice that can be taken up by all levels of nursing, education and therapy staff, although I was not in a position to discover how many staff in the Women's Directorate were availing themselves of these opportunities.

Evidenced in the study, the staff from all disciplines have previous work experience in other areas of their particular field. Several respondents pointed to the fact that within the secure setting they had a greater opportunity to actually influence the life chances of individual women, or that they were involved in creating models of practice or treatment they would not have had the opportunity to do elsewhere.

**Time scale of decision making**

Another factor supporting the rehabilitation process, and in part discussed above is the Care Programme Approach as it allows for a sharper focus on the progression of treatment and rehabilitation assessed formally every six months. This is a positive advancement in that decisions need to be taken within certain timescales and there is now less likelihood that patients will be 'lost' or drift from one year to the next. Even so, within this working ethos it still happens that a woman can wait several weeks or months for decisions on fairly mundane requests. It was commented that a woman participant was told that she had to wait for a decision because her RMO was on holiday for three weeks. One professional interviewee noted that the women do not get weekends or holidays and that this aspect must be born in mind when decisions are needed, however routine.

**Creative learning opportunities**

Noted in the Medium Secure unit was the creative initiative taken by the Occupational Therapist to provide projects for the women, usually 'theme days' such as breast cancer awareness, St Patrick's day, no smoking days,
where the women put information together and made presentations to their friends and staff. This was fun for the women to do and was appreciated by the women and staff of this unit. This positive experience of learning was reported several times by the women involved.

Finally, in noting aspects which enhance the women's progress, as observed above there are many day to day activities and interactions which are positive learning experiences for the women but which cannot form any part of an assessment plan because it is part of daily living experienced by the individual. It was noted that what sometimes appeared to be the most insignificant triggers led to major steps in their progress. Comments of encouragement or advice which may have been said many times before, but suddenly 'hit home', made sense, or was in some way relevant at that particular time. 'The penny dropped' as noted by one of the professional interviewees.

**Blocks to progress**

'Into the Mainstream' Section 11, recommended a programme of activities including literacy and other skill development opportunities relevant to the needs of the women. Both the women and the professional interviewees identified the low level of activities offered in the Units, a lack of physical exercise and that the women were in the main, under-occupied.

The Meaningful Day Programme was constructed in response to 'Into the Mainstream' recommendations and in preparation for occupying the new unit. However, the programme appeared to schedule activities already in existence rather than locating other innovative activities to be offered.

Although the hospital and the lower secure units operated inter-professional structures offering a 'seamless programme' where therapy, learning opportunities and leisure activities were integrated in terms of assessment,
(the Hospital department 'TED' Therapy & Education Department). The net result still manifested itself in a hierarchy of value with progression in therapy assessed as more important evidence over and above other aspects of the woman's development as noted above. The educationalists commented that they would not expect their contribution to be valued or decisions based on their assessment over that of the therapist in the CPA meetings.

Other evidence attesting to the 'heirarchy effect' is that the hospital organised a 'stakeholder' conference for managers from the NHS, Mental Health Trusts, Prison Service and Magistrates advertising the opening of the new high secure unit. The programme offered presentations throughout the morning which emphasised the physical comfort of the new unit and aspects of therapeutic interventions with no opportunity for education or activity staff to present their work.

One poster display showed different contributions that the women had made through their creative writing class and art sessions. This demonstrated that even though structures may be in place as recommended by 'Into the Mainstream' the internalisation of this ethos is still to be accomplished by some of the managers of the service. However, it appeared that within the lower secure units, this heirarchy is less in evidence. One psychiatrist commenting that although he was the RMO, he would abide by the decisions made by the multi-disciplinary care team.

Resistance to Individual and Group Therapy

Whilst it is not the intention of this study to portray therapy sessions as a block to rehabilitation there are however problems associated with it. Both the women and the professional interviewees identified therapy as one of the activities most disliked. The reasons given for this were that it was feared and resented by the women as it did nothing to make them feel good about themselves, but took them back to negative feelings and bad memories of their experiences as well as their fire setting activities. A further reason is that
the women felt that they were 'exposed'. One of the women commented that it felt 'eerie ... xxxxxxx could see right into me’.

Returning to the discussion in Chapter 6, blocks to learning, or any other kind of cognitive or emotional development, occur when individuals are made to feel uncomfortable or worthless. This was also the reason given by some of the women concerning literacy learning in groups, discussed below.

It was not possible to accurately confirm in this study the impression that most therapy, certainly in the lower secure units was conducted by men. This in itself may have presented a block to the development of a secure and trusting relationship, a basic requisite in therapy. Although it has been argued that interaction with men who present a non-abusive role model may assist the women to build more healthy relationships with the opposite sex. However, it is difficult to be convinced of this argument in relation to therapeutic interventions.

Several women participants referred to initial help, in preparing them for therapy, supporting them to understand what was happening to them. This occurred in what were called 'pre-therapy groups' which helped the women to understand what to expect and how therapy could help them. One of the professional interviewees also commented on the need for the pre-therapy groups which were no longer available. It was not possible to discover the reason for this. Clearly the re-instatement of these preparatory groups could help the women and possibly support them to overcome their resistance to individual therapy sessions.

**Inactivity, repetitive boring crafts**

Evidence suggests that within The Meaningful Day Programme which was initiated at the inception of the Elms Unit, that although there may be benefits in identifying activities throughout the waking day for the women, it is
estimated that there are approximately five hours in each day in which the patient need do nothing. As noted above, it seemed to be the case that the Meaningful Day Programme reproduced what was already available with no additional activities.

A consistent theme emerged from both the women and professional interviewees across all of the units, that whilst opportunities to acquire literacy and social skills were built into other leisure, craft and learning activities, both staff and the women participants were aware that there were insufficient activities to fill the day. Any expectation that the women can and will occupy themselves in meaningful activity is fairly unrealistic for many of them. It has been argued above that these are problems caused by institutionalisation, where self motivation is difficult to encourage or stimulate and where the expectation of the women is that activities will be provided alongside other aspects of institutional living such as the provision of food and laundry.

Associated with the gaps in provision was the recognition that activities particularly those classed as ‘craft’ were of a low standard. The Director of Programmes commented that it is ‘the same boring old stuff day in and day out’, with the exception of the ‘theme days’ and shopping trips out of the unit.

Whilst the women who did take advantage of literacy teaching and commented positively about it. Teachers providing literacy work with the women were not always available and were required to be ‘bought in’ as budgets allowed. In effect this left long gaps between opportunities to provide literacy sessions. I suspect there was reluctance to allocate resources to employ a teacher on a one-to-one basis. However, most of the women who commented upon literacy learning said that they were unhappy to learn in groups as they felt that their inadequacies were exposed to the other women. Some women suggested that if they could have individual sessions or possibly attend classes outside in the local college then they would at least attempt to acquire basic literacy skills.
The Reports of Reed, Vol. 3 (1993) and Tilt (2002), Into to the Mainstream (2002) and the Corston Review (2007) all emphasised the necessity to engage women patients in secure mental health settings in more educational and leisure opportunities with the aim to develop literacy where needed and the social skills required of most.

The review of the literature identified studies of women who set fires and gave explanations for their actions, Stewart (1993) in particular identified literacy skills as a problem that required focussed attention. Lart et al. (1999) and the Bartlett and Hassell (2001) study each comment that there has been insufficient examination of what provision is made in the rehabilitation programmes of women in secure mental health settings and even less on what particular therapies or learning opportunities benefit the women.

Several professional staff commented that education was an essential element of the treatment programme and that it enabled the woman to make better use of therapeutic resources. One professional interviewee said that in her opinion that learning skills and engaged in social activities was more productive for the women than the countless hours spent in therapy.

Physical health and weight problems

The physical problems of the women in secure settings was a consistent theme reported by the professional cohort, with some reference from the women themselves. All but one of the women interviewed were overweight and observing other women on the wards and in the units, clearly problems of obesity is a major issue. Despite attempts to provide some physical activities these are not valued by the women who resist most attempts to engage in them. The problem of weight gain also leads to other conditions of poor health which affect the quality of life for the women in these restricted environments.
Cost centres in the hospital provision

A further block was noted within the secure hospital setting, this relates to the devolvement of budgets to the different hospital departments, based upon the numbers of patients catered for within a particular activity. The women sector is placed at a financial disadvantage, as their capacity is fifty women with the men's sector numbering four hundred. The education centre have to some extent addressed this in managing the reduction to one day per week, devoted to the women by developing the ‘learning by stealth’ strategies. There is still a major loss of resources in that none of the women can access computer studies. The reduced budget for the women’s sector also results in the loss of other activities such as entertainment, and the work of the community theatre which would be beneficial for the women.

Policies concerning transfer of women patients

A woman who had been transferred two months previously from a medium secure unit in the south was very unsettled and unhappy. She was still being assessed and as yet had not been presented with her treatment plan which meant that no educational or activity groups were available to her at the time of interview. She explained that she had been moved against her wishes but because of the decision of her mental health trust funding her placement. She was originally from the area to which she had been transferred. It was put to her that she would be closer to her family, although she had been out of contact with her family for the last ten years.

According to Bartlett and Hassell (2001) it is an all too common experience for women to be moved back to the area of the funding authority, regardless of whether the move is one desired by the woman or not. Some women would prefer to be rehabilitated into the community close to their last placement because of their familiarity with the support networks available to them and friends they may have made. This is seen as preferable, rather than to return to an environment which holds bad memories for them regarding their offences or mental health issues and where their family may have been
abusive or hostile to them in the past. Bartlett (2003) comments that this is a practice often seen because of the funding formula for women contained in secure units outside the Trust responsible for their treatment. There have been a number of Trusts that have operated 'exchange' of patients, but these are still few and far between (Interview: Director of WISH 2005).

An unintended consequence of the requirement by the Home Office to move women down the scale within the secure mental health system has resulted in the loss of choice and flexibility to move from high secure settings to other appropriate placements. No longer is it an available option to refer women to substance misuse residential treatment settings such as those offered by Turning Point, but which are not designated 'secure' provision. Nor is it possible for a woman to move from high secure to the community, side stepping less secure provision, even if this is seen as appropriate (Interview, SW 3 High Secure Hospital). It is the experience of some women moved to mixed sex medium secure units that they are very much in the minority, making them again vulnerable to emotional, physical and sexual abuse Bartlett (2003).

Other policies and practices identified

Clearly there is considerable pressure for changes to practice brought about by ensuring gendered practice, with issues of ethnicity and racism to be tackled, the subject of the following directive from the Department of Health, 'Inside Outside' (2003). Targets which determine length of stay for women within the high secure setting and the increase of available places within other lower secure settings, ensuring more provision for women only secure settings, as recommended in 'Into the Mainstream'. The hiatus currently seen in low secure provision where there is insufficient supported accommodation to move women into the community creates blocks higher up the system, (Psychiatrist 1 High Secure Hospital). Bartlett and Hassell (2001). Bartlett (2003) also identifies this situation as a major problem in the process of rehabilitation of the women in secure settings.
This study has examined the rehabilitation of women who set fires through the secure mental health system and has recorded the facts and opinions of both the women contained and the professional workers who are responsible for their treatment and rehabilitation. During the last five years major changes to the legal basis of treatment and influential policies governing practice have been instituted.

This study is one of the first that has employed a qualitative approach seeking the views of those living and working within the secure system. This study responds to the opinion that qualitative studies need to be undertaken in order to gain a detailed evaluation and insight into the procedures and practice within this sector of mental health provision Bartlett and Hassell (2001); Lart et al (1998); Corston (2007).

**Validity of the study**

The accuracy of sections of information examined was confirmed by a number of stakeholders recruited from the professional cohort who scrutinised drafts of the material.

<table>
<thead>
<tr>
<th>Chapter 1. Policy Framework</th>
<th>Director of WISH</th>
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<tr>
<td>Chapter 5. ATG</td>
<td>ATG Facilitator, Medium Secure Unit</td>
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<tr>
<td>Information on the Meaningful Day Programme</td>
<td>Director, Women's Services, Rampton Hospital</td>
</tr>
<tr>
<td>Chapter 7. Women, Therapy and Education</td>
<td>Assistant Manager, Education Centre, Rampton Hospital</td>
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</tbody>
</table>

Table 15. Verification of information used in this study

The recommendations from the above experts resulted in useful amendments, enabling me to present the information with confidence in its accuracy (but with reservations which are discussed below). The difficulties in undertaking the study as an ‘outsider’ to the system have also been discussed in Chapter 4 and is now summarised.
The women who participated in the study were 'volunteered' by their responsible medical officer. However, confirmation of the representativeness of the cohort of women who participated in this study was assessed by comparing their background histories, and other characteristics with studies and information gained from a wide range of literature.

The negotiations to gain entry to undertake the research were long and protracted. Any breach of protocol would have resulted in the termination of my access. I gained the trust of staff and women in the time spent in each of the settings. As I wish to extend this study I was acutely aware of my position as an outsider, invited in on the terms of the institution. Nevertheless I was struck by the openness and apparent honesty of some of the comments and criticisms made of the service overall particularly those of policies and funding regimes which are examined within this study, identified mainly as a block to the rehabilitation of women who set fires.

Other steps to ensure accuracy of the information recorded in this study is that all interview notes were sent to the participants requesting amendments if inaccuracies in the record were found. This enabled correspondence with the participants following their involvement with the study and gave them some sense of ownership of the study and an interest in its outcomes, this aspect is discussed further below.

Despite the difficulties encountered in undertaking this study useful material was gained from the women participants and the professional group. Using a qualitative framework for data collection allowed flexibility to explore various issues and aspects relating to the environment in which women who set fires are contained. It was possible to explore areas of policy and practice which took the study beyond its envisioned remit. The tensions between therapy and learning in the daily activities was explored against a backdrop of theories and knowledge concerning the way in which we learn that extended beyond the original study questions. This allowed a wide ranging examination of the
different issues facing the women in the study. The fast changing conditions for the women in high secure provision after what appears to be years of stagnation required the study to be constantly updated and policies re-examined in relation to practice.

The Study was sufficiently robust to meet the requirements of 5 Ethics Committees that demanded detailed arrangements concerning the protection of the participants, particularly the women patients. Therefore the study was reviewed five times in the space of two years prior to any of the data collection being undertaken.

When it came to putting the proposal into practice it was found that practices within the settings made some of the anticipated research difficult to achieve and some questions either redundant or not appropriate. The sampling of participants detailed in the proposal could have been amended to reflect what was possible in practice.

The interviews with the women asked questions which expected reflection and discussion. For the majority of participants this was not forthcoming as previously discussed in Chapter 3. The ‘telling of the story’ involved a journey of some complexity, developing themes with the women that led to answers to the study questions.

I referred earlier to the ‘feminist principles’ that underpin the study. This was attempted in the way in which I tried to engage with the participants and to give them ownership of the study through correspondence and the practice of ensuring that all participants had the opportunity to review the interviews and comment accordingly.

Humphries (1994) talks of ‘empowering’ participants by giving them a voice. Lart (1999) and Bartlett (2003) comment that much research in forensic settings involves the examination of records, with a reliance upon quantitative
data to address research questions. Bartlett advocates research, asking questions of both the patients and professionals involved. In the current climate of evidence based practice, it is increasingly important to ask the subjects of particular treatments about its usefulness, from their point of view.

The difficulties encountered in undertaking this qualitative study arose partly because I was an 'outsider', asking for access to patients and workers inside a closed system. Despite these difficulties, related in Chapter 4, useful information was gained.

With hindsight the semi-structured interview questions could have been less circumscribed and more clearly focussed on the material that was required. The sample of professional participants could have been more directed to achieve a balance of disciplines between the high secure hospital and the lower secure units. With the experience of this study behind me and having gained some recognition and trust within these settings, I think that a more balanced study sample can be obtained for the next phase.

I think that sufficient data has been yielded to argue the case for a more detailed study of women who set fires and their progression through the secure mental health system. Issues have been identified throughout this study and a further focus on them will contribute to knowledge of their circumstances that will hopefully lead to more focussed treatments and therapies for them in the future.

A high level of consistency was found in information cited in other commissions and reports founded on information gained through inquiries and investigating teams (Reed 1993; Tilt 2000; Corston 2007) which can with some confidence meet claims of the reliability of the study. To some extent finding that similar situations to those identified in the Reed Report published fifteen years previously noting concerns about literacy was disappointing. Notwithstanding progress in other directions, basic and fundamental issues
are not yet resolved and continue to threaten the process of rehabilitation for some of the women in this study.

As noted this study was conducted during a period of rapid change and development, making it necessary to constantly revise and reflect on the implications for the women and the staff involved. Therefore the study evolved as the ground constantly shifted.

Despite the weaknesses of the study which I believe are mainly related to the semi-structured interview process, limitations on permission to record and recruitment difficulties, claims concerning the reliability of the study to answer the questions set, and its validity in terms of the findings have been met. On the basis of evidence recorded, these final recommendations are volunteered.

Recommendations

- Identify, promote and assess learning opportunities through all daily activities;

- Recognise that women’s achievements in learning and leisure activities have equal weighting to their therapeutic progress;

- Make more opportunities available to develop appropriate self expression;

- Develop Arson Treatment Groups, which are seen as central to rehabilitation of the women;

- Provide flexibility of learning opportunities, when and where the women can make best use of them;
- Focus on rehabilitation goals from the point of admission;

- Ensure funding in the geographical place of the woman's choice;

- Provide more support for women with children to help them deal with what are realistic hopes concerning future contact;

- Give encouragement to engage in physical activities and weight reduction programmes.

**A model of treatment for women who set fires**

There were important areas of work identified in the study which it is considered can be brought together and used as a model of treatment. Attempts were made to seek opinions from professionals engaged in ATG work, but these were not forthcoming.

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>The assessment of the patient prior to admission. Currently it appears that literacy is identified as part of the strengths or weakness of the individual, but not prominent in the treatment plan. Therefore vital to the treatment plan is the integration of learning, encouraged and emphasised by all staff involved with the patient. Every effort should be made to encourage and involve the woman in developing literacy using a range of options, from outside teachers to computer programmes.</th>
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<tbody>
<tr>
<td>Stage 2</td>
<td>The importance of pre-therapy groups should be acknowledged and utilised in the beginning phase of treatment. They should begin with learning assertiveness, and skills which focus on developing or improving confidence and self-esteem. This phase could last between three and six months before progressing to more formalised treatments.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>The ATG should become central to the treatment plan for women who set fires and not an 'add on'. It should be focussed on the areas required by women which are acknowledged by them as well as their care team as key to their progress, for example, stress.</td>
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</tbody>
</table>
management, anger management and the use of drugs and alcohol. These elements which are treatment groups in their own right, should be integrated into the Arson Treatment Programme as the primary treatment approach. In addition, the opportunity to develop assertiveness skills promoting confidence and self-esteem are critical areas for personal development. The emphasis of the programme should be on the acquisition of skills and strategies to keep them safe. This is in the final phase of the ATG as it is now offered.

Stage 4

On completion of the programme more intensive, in-depth psychotherapy and other elements that may require further attention, could be undertaken.

This approach to treatment would avoid women being exposed before they are ready for the therapies identified in Stage 4, ensuring that they could make the best use of them and hopefully removing some of the blocks to these treatments that have been expressed in this study. It would also give them a clear plan of progression and rehabilitation in the knowledge that if they successfully achieve the stages then they can be considered for admission to less secure settings, community facilities or rehabilitation into the community. The key to any treatment model is not just the co-operation of the individual, but that they have an investment in it, shaped by their involvement in the decisions about it, right from the beginning.

Table 16. Proposed treatment model for women who set fires

This model could be tried and evaluated over a two-year period which would go some way to address the concerns noted by (Bartlett 2003) that very little evaluation of any treatment strategies has been undertaken for women in secure settings. With the Care Programme Approach over ten years old, the climate and culture of having treatment plans is well established, and although evaluation strategies are still at an early stage, none have been placed in the public domain. A measure of discomfort concerning this neglect was detected in this study.

Finally

There have been major changes in the secure mental health services for women over the last five years. Into the Mainstream (2002) has been the driving force behind them, advocating gender specific provision and treatment approaches within the secure services. Looking anew at individual treatments
for women who have specific needs, as in the case of those who set fires, can only serve to further improve the life chances of women who have found themselves in the secure mental health system.

This study has demonstrated the necessity to focus on arson treatment and to provide opportunities for the women to address this behaviour first and foremost. The study has also shown the importance of providing a range of learning opportunities in order for the women to develop skills which will equip them to live independently or semi-independently in the community.

Lastly the study identified that reviews of treatments and other activities were assessed with regard to the individuals undertaking them, under the Care Programme Approach. The need remains for a system ongoing which constantly evaluates and updates the rehabilitation programmes available to the women. Crucial to their recovery are that opportunities to progress are available and offered within a timescale to ensure that they spend the least amount of time in institutionalising environments, thus providing them with the best chance of re-establishing themselves in the community.

Hopefully the women will have more opportunities to learn about themselves, understand their problems, possibly like themselves a little, having dealt in some measure with some of the experiences that have led to their journey through the secure mental health system.

Maureen Sears
December 2008
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Appendix 1

University of Surrey Ethics Committee
letter of approval
Dear Ms Sears


On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **14 October 2005**

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:

- **Document Type:** Application  
  Dated: 05/10/05  
  Received: 07/10/05

- **Document Type:** Approval Letter from the South Essex LREC  
  Dated: 23/09/05  
  Received: 07/10/05

- **Document Type:** Letter from WISH Confirming Sponsorship of the Project  
  Dated: 24/02/05  
  Received: 07/10/05

- **Document Type:** Research Proposal  
  Dated: 02/05  
  Received: 07/10/05

- **Document Type:** Information Sheet  
  Dated: 09/05  
  Received: 07/10/05

- **Document Type:** Advertisement to WISH Newsletter  
  Received: 07/10/05
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman Ethics Committee
    Professor R Middlehurst, Department of Law
Appendix 2

NHS Ethics Committee
letter of approval
Ms Maureen Sears  
Lecturer  
University of Portsmouth  
Institute of Medicine, Health and Social Care  
St Georges, 141 High Street  
Old Portsmouth  
PO1 2HY

Dear Ms Sears

Full title of study: Women Who Have Set Fires, Learning for Change. A critical examination of education and training opportunities used in rehabilitation programmes within the mental health secure system for women who have fire setting histories.

REC reference number: 05/Q0302/101

Thank you for your letter of 19 September 2005, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 17 August 2005. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:
<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
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<tr>
<td>Application</td>
<td></td>
<td>19 July 2005</td>
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<tr>
<td>Investigator CV</td>
<td></td>
<td>01 May 2005</td>
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<tr>
<td>Protocol</td>
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<td>Covering Letter</td>
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<td>Letter from Sponsor</td>
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<td>24 February 2005</td>
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<td>Interview Schedules/Topic Guides</td>
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<td>Summary of responses to the previous submission to the Northern and Yorkshire Multi-centre Research</td>
<td>01 July 2005</td>
<td></td>
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<tr>
<td>Applicants checklist</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
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<td>Thank you letter Women participants (WISH)</td>
<td></td>
<td>01 February 2005</td>
</tr>
<tr>
<td>Letter to Volunteers not accepted</td>
<td></td>
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<tr>
<td>Reminder Sheet concerning participants rights</td>
<td></td>
<td>01 July 2005</td>
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<td>Supervisors CV</td>
<td></td>
<td></td>
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<td>Other</td>
<td></td>
<td>19 July 2005</td>
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<tr>
<td>Schedule and time frame for inclusion of women participants</td>
<td></td>
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</table>

**Research governance approval**

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.
With the Committee’s best wishes for the success of this project

Yours sincerely

Dr Karl Metcalfe
Chair

Email: suzanne.emerton@essexsha.nhs.uk

Enclosures: Standard approval conditions

Copy to: WISH, Women in Secure Hospitals
18 Borough High Street
London
SE1 5QG
Appendix 3

Partnerships in Care Ethics Committee
letter of approval
Dear Ms Sears

Re: Research Study, Women Who Have Set Fires, Learning for Change

Thank you very much for your letter of 13th January 2006 enclosing a further set of papers.

We have now considered the proposal again and would be happy for you to go ahead at Annesley House.

I would be grateful if you could liaise through Dr Elizabeth Gethins who is Medical Director at Annesley House.

We look forward to seeing your completed research.

Yours sincerely

[Signature]

Dr John Taylor
Medical Director

cc Dr Liz Gethins
Appendix 4

NVivo 7 processed material relating to question 4
Category A

Name: A

Description:

<Documents\interviews\01_participant_01> - § 2 references coded [15.09% Coverage]

Reference 1 - 8.73% Coverage

4: Participant 1, used a range of therapy groups, alcohol and drug group, CAT therapy and DBT. Her opinion was that they were good, she learnt coping skills, and also found she could help others. A.

5:

Reference 2 - 6.35% Coverage

20: Participant 1, says that it is the nursing staff who are the most helpful to her. 'They are there all the time, I can go to them when I want'.

17:

<Documents\interviews\01_participant_03> - § 2 references coded [14.78% Coverage]

Reference 1 - 6.12% Coverage

3: Likes group work, but sees herself as usually quiet, but learns a lot from them. She described to me a full week programme.

4:

Reference 2 - 8.66% Coverage

17: Participant 3, I think more help at the very beginning would have been useful, to help me understand what was happening to me, and to make me feel more secure. No one listened.

18:

<Documents\interviews\01_participant_06> - § 1 reference coded [25.80% Coverage]

Reference 1 - 25.80% Coverage

10: Participant 6, Attended the first ATG offered at the MSU. She thought it was most helpful therapy she had experienced, although she was extremely sceptical at first. It was because of her success that she was allowed to move to a less secure environment. The interview with this participant showed her to be a thoughtful, articulate and confident person. She was able to describe how she had been, her thoughts, feelings and behaviour and compare these to how she is now.
Participant 7. She also attended the first ATG at the MSU, whilst she had some reservations about it, she said that it was very helpful and she too was moved to a less secure environment. She identified various modules as being more helpful than some, and described how being made to face up to the damage and destruction to other people’s lives had been very hard, but eventually liberating, as she was able to deal constructively with her guilt and anger.

Participant 9. Attended an ATG at the HSH when they were able to run a mixed gender group. She thought it was very helpful and speculated that it was her attendance at the group that enabled her to move to her current environment.

Category B

Name: B
Description:

Likes 1-1 does not attend any other group.
Appendix 5

Chi Square Tables
calculated from the National Case Register
High Secure Hospital Service
### Case Processing Summary

<table>
<thead>
<tr>
<th>Cases</th>
<th>Valid</th>
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<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
</tr>
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<td>0</td>
<td>.0%</td>
<td>520</td>
<td>100.0%</td>
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### Arson * Admission Hospital Crosstabulation

#### Count

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<th>Rampton</th>
<th>Total</th>
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<td>69</td>
<td>80</td>
<td>149</td>
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<tr>
<td>Arson No</td>
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### Chi-Square Tests

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<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
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</thead>
<tbody>
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<td>Continuity Correction a</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
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<td>.019</td>
<td></td>
<td>.020</td>
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<tr>
<td>Linear-by-Linear</td>
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<td></td>
<td></td>
<td></td>
<td>.012</td>
</tr>
<tr>
<td>Association</td>
<td></td>
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<td></td>
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a. Computed only for a 2x2 table  

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 67.91.
### Crosstabs

**Case Processing Summary**

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<th>Total</th>
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<td>104 100.0%</td>
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**ethnicity for admissions from 1992 (new codes) * Arson Crosstabulation**

**Count**

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</thead>
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<td>2</td>
</tr>
<tr>
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<td>3</td>
</tr>
<tr>
<td>Indian</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>any other ethnic group</td>
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<td>0</td>
<td>1</td>
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<tr>
<td><strong>Total</strong></td>
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<td>73</td>
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**Chi-Square Tests**

<table>
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</thead>
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<td>Pearson Chi-Square</td>
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a. 9 cells (75.0%) have expected count less than 5. The minimum expected count is 30.
## Crosstabs

### Case Processing Summary

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<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
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### Nationality * Arson Crosstabulation

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</tr>
<tr>
<td>West Indian</td>
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<td>14</td>
</tr>
<tr>
<td>Indian</td>
<td>0</td>
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<td>2</td>
</tr>
<tr>
<td>Other</td>
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<td>7</td>
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<td>Total</td>
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Crosstabs

Case Processing Summary

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Personality disorder * Arson Crosstabulation

Count

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<td>Personality disorder Present</td>
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Chi-Square Tests

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<tr>
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<td>.002</td>
<td>.001</td>
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a. Computed only for a 2x2 table
b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 51.14.
### Crosstabs

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<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
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**Alcoholic * Arson Crosstabulation**

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<tr>
<td>Absent</td>
<td>127</td>
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**Chi-Square Tests**

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*a. Computed only for a 2x2 table*

*b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.37.*
## Crosstabs

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### qualifications * Arson Crosstabulation

#### Count

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<td>GCE O Level; CSE Gd</td>
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## Crosstabs

### Case Processing Summary

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<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
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### age patient left school * Arson Crosstabulation

#### Count

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<tr>
<td>&lt; 12 yrs</td>
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<td>3</td>
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<tr>
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<td>11</td>
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<td>14 &lt; 15 yrs</td>
<td>21</td>
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<td>55</td>
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<td>15 &lt; 16 yrs</td>
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<td>134</td>
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<td>18</td>
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## Crosstabs

### Case Processing Summary

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<td>Percent</td>
<td>N</td>
<td>Percent</td>
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### employment status of patient * Arson Crosstabulation

#### Count

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<td>64</td>
</tr>
<tr>
<td>employed (sheltered)</td>
<td>No</td>
<td>49</td>
<td>64</td>
</tr>
<tr>
<td>unemployed</td>
<td>Yes</td>
<td>58</td>
<td>185</td>
</tr>
<tr>
<td>non-employed</td>
<td>No</td>
<td>127</td>
<td>185</td>
</tr>
<tr>
<td>housewife</td>
<td>Yes</td>
<td>10</td>
<td>38</td>
</tr>
<tr>
<td>student</td>
<td>No</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td>at school</td>
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<td>9</td>
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| Total | 122 | 258 | 390 |
## Crosstabs

### Case Processing Summary

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<th>N</th>
<th>Percent</th>
<th>N</th>
<th>Percent</th>
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### social class of patient * Arson Crosstabulation

#### Count

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<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>professional</td>
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<td>intermediate</td>
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<td>skilled</td>
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<td>unskilled</td>
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<td>armed services</td>
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<td>Total</td>
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### Chi-Square Tests

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<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
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</thead>
<tbody>
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<td>Pearson Chi-Square</td>
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*a. 3 cells (25.0%) have expected count less than 5. The minimum expected count is 1.23.*
### Crosstabs

#### Case Processing Summary

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<td>Percent</td>
<td>Missing</td>
<td>Percent</td>
<td>Total</td>
<td>Percent</td>
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<td>100.0%</td>
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<td>453</td>
<td>100.0%</td>
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#### Drug Addict * Arson Crosstabulation

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<th>Arson</th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
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<td></td>
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<td></td>
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<tr>
<td>Absent</td>
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<td>403</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total</td>
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<td>311</td>
<td>453</td>
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#### Chi-Square Tests

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<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
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<td>.828</td>
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<td>.484</td>
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<td>.928</td>
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a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.67.
## Crosstabs

### Arson = Yes

**Case Processing Summary**

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a. Arson = Yes

**Alcoholic * drink problem Crosstabulation**

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<tr>
<th>drink problem</th>
<th>never drinks</th>
<th>no drink problem</th>
<th>yes</th>
<th>Total</th>
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<tbody>
<tr>
<td>Alcoholic</td>
<td>Present</td>
<td>1</td>
<td>6</td>
<td>4</td>
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<tr>
<td>Absent</td>
<td>36</td>
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<tr>
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a. Arson = Yes

### Arson = No

**Case Processing Summary**

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<th>Percent</th>
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<th>Percent</th>
<th>Total</th>
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a. Arson = No

**Alcoholic * drink problem Crosstabulation**

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a. Arson = No
Crosstabs

Case Processing Summary

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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
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<td>.0%</td>
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Childrens,community home,Approved School * Arson Crosstabulation

Count

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<tr>
<td>No</td>
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Chi-Square Tests

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<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
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<td>.003</td>
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a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 36.85.
## Crosstabs

### Case Processing Summary

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<tbody>
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<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
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<tr>
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### type of school * Arson Crosstabulation

#### Count

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<td>Judicial</td>
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<tr>
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<td>14</td>
</tr>
<tr>
<td>Never attend sch</td>
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<td>2</td>
</tr>
<tr>
<td>Total</td>
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<td>277</td>
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</tbody>
</table>
Appendix 6

Information sheet for participants
Women Who Have Set Fires, Learning for Change  
NHS Ethics Committee Reference No. 05/Q0302/101

An exploratory research study examining education and training offered as part of the rehabilitation of women who have set fires.

Thank you for responding to the notice, or to the advertisement in the WISH Newsletter.

Invitation
You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Get in touch with me through the above address if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Purpose of Study
The research is an examination of education and training opportunities available to women fire setters in the MH Secure System and how these opportunities may help women as part of their plan of rehabilitation and eventual re-integration in the community.

The research aim is to examine the ways in which the 'Arson groups' work and also other education and training opportunities. The study aims to gain information about the way study groups operate, their frequency, structure and the measurement and assessment used for individuals who have attended them. It is also intended to ask the views of workers involved in the delivery of these education and training opportunities as part of a rehabilitation programme.

The study will be run over a period of 4 months of collection of the information from women involved and the people who provide the programmes. Following an examination of the information collected a report to WISH will be delivered in the Autumn of 2006.

For women who have experience of being a patient I appreciate your response to the notice or advertisement and wish to reassure you that your contribution is entirely voluntary. You can decide whether you wish to take part or not. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part will not affect in any way your relationship with WISH or any other agency which supports you.
Who will be invited to contribute to the study?
Colleagues working within the rehabilitation units in two secure hospitals, by interview and questionnaire and colleagues from 15 MSUs by questionnaire.

Women who in the past have had the experience of setting fires, and who may be associated with the WISH Project. Women who have begun the process of rehabilitation, or who have come through the system and who are now living in the community. Women who live in supported accommodation will also be invited to discuss their training and educational opportunities with the researcher.

Agreement to participate
As additional protection for you I need to ensure that the person who has overall responsibility for your care agree to your participation in the study. This is to ensure that they consider that taking part in this research study will not have any adverse affect upon you. There is a place on the consent form to provide this essential information, or if you are currently a patient in Rampton or Broadmoor then this support has already been obtained.

What will you have to do if you live in an RSU or in the community?
Your response to the advertisement or information sheet has led me to send you this information sheet explaining the research project. First of all you will find an attached 'Consent Form' which needs to be completed and returned to me at the WISH address in the stamped addressed envelope. All contact and correspondence will be through the WISH Office at 18 Borough Court Road, London Bridge, SE 1 9QG.

I will also need you to complete the details of who you would want to be with you at our meeting to act as your support. This can be the WISH support worker or your key worker, whoever you feel comfortable being with you.

We will arrange to meet and you will be asked questions about the training and educational aspects of your rehabilitation programme. This discussion should not take longer than one hour of your time and can take place either at the WISH office, or where you live.

However in preparation for the interview, we will arrange a preliminary meeting before you take part, just so that questions you may wish to ask or if there are details you need explained we can deal with those and then arrange a time and place for the main interview for the study. We can meet either at the WISH office or your place of residence together with your choice of support worker for both the first meeting and the research interview.

If you are currently a patient in Rampton or Broadmoor
You will already have gained consent to participate in this study. If you have been chosen to take part in this study, I will arrange to meet with you in the hospital at a time convenient to you and those supporting you to talk about the
project before arranging the interview itself. You can still withdraw at any time. The following information applies to your participation in the study except the need to contact through the WISH project. You will be able to communicate about the project to your care staff who will ensure that the named on site contact person is informed.

**What will happen to the information I may give you?**

Notes will be taken of our discussion. At the end of our meeting the notes will be read back to you so that if you think there are inaccuracies in the notes, they can be rectified then and there. You will also be sent a copy of the notes again so that you can satisfy yourself that you agree with the record of our meeting. You will be provided with a stamped addressed envelope for this purpose.

Your contribution to the study will be examined in detail and the results of the overall study will form the basis of a report that hopefully will help both workers and patients who are currently involved in this aspect of rehabilitation work to improve it or at least understand it better.

I undertake that as far as possible anything you tell me is in strictest confidence. The only information that will be required to be passed on to people in authority, is if you tell me anything that could possibly cause harm to yourself or others, or if a criminal act has or is about to take place.

**Will I be named in this study?**

No. It is not intended that any one who helps in this study will be identified. It may be the case that you would want to be thanked in the acknowledgement section, in which case you can write this on the consent form.

Any information you give me concerning other people or places will be removed so that they cannot be identified. At the interview your name and other identifying details will be removed from the notes.

**What happens if I do not want to continue my involvement in this study?**

You can withdraw from the study at any time, before, during or after the interview and you do not have to answer any question you do not want to. As previously stated, withdrawal from the project will not affect your inclusion in any of the WISH community support projects, or other community services. You will still be offered the £5.00 voucher in appreciation of your interest and time given to the study.

**What happens after the interview?**

As stated above, you will be sent notes of the interview within 7 days and you can make further alterations at this stage if you do not think that they are an accurate reflection of your contribution.

All notes taken during interviews will be destroyed following completion of the study, conforming to the legislation under the Data Protection Act 1998.
If things go wrong
If you should feel that you have not been treated with care and consideration during the time of your contribution to this study then you have the right to complain to the Director of WISH, at the address on page 1 of this information sheet.

You will be contacted by your support worker in the week following your interview. The purpose of this is so that you will be offered support in the unlikely event that you feel that you have been affected in any way by your contribution to this study.

What will happen to the results of the study?
The results will be published as articles in professional journals and possibly contribute to a conference paper in an educational or social care forum. No individuals will be identified in this work.

You will be informed when the study is completed and if you would like a copy, it will be sent to you. All institutions allowing workers to participate will be sent a copy of the completed work, once it has been assessed.

Who is organising and funding the research?
The study is in part fulfilment of a Doctorate in Education, supervised by colleagues in the Department of Education at the University of Surrey. There is no funding for this work.

Who has reviewed this study
The study has been reviewed and approved by the Ethics Committees of the University of Surrey, University of Portsmouth and has been subject to scrutiny by the NHS South Essex Local Research Ethics (MRECs) Committee and the Ethics Committee for Partnerships in Care.

And finally
I hope that you will agree to contribute to this study which is intended to explore some of the issues involved in the rehabilitation process of women who have set fires. I am sure that your contribution will prove extremely useful and will help all of those involved the opportunity to reflect and think through the process. This opportunity may possibly contribute to fresh or reformed ideas which may influence the lives of the women currently involved, and affect their rehabilitation to the wider community.

The researcher is formerly the Director of Social Work Studies, University of Portsmouth and maintains a long standing interest in rehabilitation for women who set fires.

Maureen Sears
Researcher
Jan 2006