original papers

Declaration of interest

None.

Appendix

Consultant respondents ($n = 288$) per subspecialty (of which seven had 'split posts' involving two subspecialties)

General adult and community psychiatry	102
Psychiatry of old age	63
Liaison psychiatry	15
Forensic mental health	22
Rehabilitation	12
Child and adolescent psychiatry	34
Learning disability	15
Addictions	9
Other	9
Unanswered/spoiled	14

References

1 Royal College of Psychiatrists. *Forgetful but Not Forgotten: Assessment and Aspects of Treatment of People with Dementia by a Specialist Old Age Psychiatry Service (Council Report CR119).* Royal College of Psychiatrists, 2005.

2 Scottish Intercollegiate Guidelines Network. *Management of Patients with Dementia (SIGN86).* SIGN, 2006.

3 NHS Quality Improvement Scotland. *Integrated Care Pathways for Mental: Bipolar Disorder, Borderline Personality Disorder, Dementia, Depression, Schizophrenia.* NHS Quality Improvement Scotland, 2007.

4 Royal College of Psychiatrists. *Psychiatric Services for Children and Adolescents with Learning Disabilities (Council Report CR123).* Royal College of Psychiatrists, 2004.

5 Royal College of Psychiatrists. *Meeting the Mental Health Needs of Adults with a Mild Learning Disability (Council Report CR115).* Royal College of Psychiatrists, 2003.

6 Royal College of Psychiatrists. *Psychiatric Services for Adolescents and Adults with Asperger Syndrome and Other Autistic-Spectrum Disorders (Council Report CR136).* Royal College of Psychiatrists, 2006.

7 Scottish Intercollegiate Guidelines Network. *Assessment, Diagnosis and Clinical Interventions for Children and Young People with Autism Spectrum Disorders. A National Clinical Guideline (SIGN98).* SIGN, 2007.

8 National Collaborating Centre for Mental Health. *Attention Deficit Hyperactivity Disorder. Diagnosis and Management of ADHD in Children, Young People and Adults. National Clinical Practice Guideline Number 72.* British Psychological Society & Royal College of Psychiatrists, 2008.

9 Mental Welfare Commission for Scotland. *Not my Problem, Report of the Inquiry into Deficiencies in the Care and Treatment of Mr G.* Mental Welfare Commission for Scotland, 2007.

10 Royal College of Psychiatrists. *Links not Boundaries: Service Transitions for People Growing Older with Enduring or Relapsing Mental Illness (Council Report CR153).* Royal College of Psychiatrists, 2009.

11 Dementia Services Development Services. *A Fuller Life. Report of the Expert Group on Alcohol Related Brain Damage.* Scottish Executive, 2004.

***Johan D. Jurgens** Consultant Psychiatrist, NHS Forth Valley, Bonnybridge Hospital, Bonnybridge, Stirlingshire FK4 1BD, email: jdjurgens@fvpc.scot.nhs.uk, **Maggie MacKinnon** CHP Clinical Effectiveness Facilitator, NHS Forth Valley Clinical Effectiveness Support Service, Stirling

Psychiatric Bulletin (2009), **33**, 457–460. doi: 10.1192/pb.bp.107.016808

LISA CONLAN, HELEN READ AND ELIZABETH PICTON

Taking the temperature: attitudes of patients on an all-female psychiatric ward to staff gender

AIMS AND METHOD

To survey the attitudes of in-patients on an all-female ward to staff gender. All patients were invited to complete an anonymous questionnaire which was then repeated on a four-weekly basis for 4 months. Staff members were surveyed once within this period.

RESULTS

Only 15% of patients ($n = 52$) wanted all staff members to be female, whereas 87% reported feeling comfortable with male staff; 51% would prefer a predominantly female, mixed-gender staff. All staff ($n = 11$) were in favour of mixed-gender staffing.

CLINICAL IMPLICATIONS

Current best practice for staffing single-gender acute in-patient units is unclear. This survey is in line with findings from other studies in that a large majority of female in-patients prefer to be in a unit with mixed staff.

In April 2006, Alex House Ground Floor Ward at the Bethlem Royal Hospital was converted from a mixed-gender to an all-female in-patient unit but retained its mixed-gender staff. There has been ongoing debate surrounding the issue of staff gender. Should an acute female in-patient psychiatric unit be staffed by women alone?

In 2002, the Department of Health released a report entitled *Women's Mental Health: Into the Mainstream.*[1,2] It focused on the main issues facing psychiatric care for women and suggested that a single-gender unit (staff gender not specified) should be an option for women, stressing their right to choice.

There is very little published data on this subject. In a study by Hingley & Goodwin, 48% of women preferred mixed-gender in-patient accommodation.[3] A further study by Batcup found that only 19% of the sampled in-patients wanted a single-gender environment,[4]

original papers

whereas Mezey *et al* found that the majority of female in-patients preferred a mixed-gender unit.[5]

An audit at the Bethlem Royal Hospital (January 2006) looked at attitudes of service users and their carers to the proposed changes from mixed- to single-gender wards and towards staff gender.[6] More than half of the female responders (58.9%, $n = 67$) showed some preference for female staff: primary nurses (61.4%), psychiatrist (39.8%), ward doctor (38.6%), occupational therapist (52.9%), social worker (55.7%) and psychologists (51.1%). However, the study was aimed at service users in general, rather than women who had been in-patients on a psychiatric ward. We were only able to find one other study that addressed service users' views on staff gender, by Barlow & Wolfson.[7] They surveyed a sample of 50 female in-patients from acute and rehabilitation wards and found that although just 14% preferred female-only staff, 42% preferred a female key worker and a similar number (40%) had no preference.

As regards staff views, there is little published research, but Daffern *et al* found that although staff gender ratio calculated on a shift-by-shift basis had no effect on the number of violent events, staff confidence in managing aggression seemed to be influenced by the presence of male staff.[8] This accords well with a study by Hatch-Maillette who found that male staff viewed threat situations as significantly less threatening than female staff.[9] In a further study in 2003, the same author highlights similar issues making the link between employee well-being, job satisfaction, morale and organisational productivity.[10]

Our survey aimed to look at the views of current in-patients on an all-female ward to staff gender. The ward is a 20-bed unit for women with acute mental health problems aged 18–65 years. Current staffing balance is 3:1 (female:male). There is a fast turnover of patients, with average in-patient stay being 28 days.

Method

A simple questionnaire (Brief Satisfaction Survey, Box 1) was designed, comprising seven questions on attitudes to staff gender, the current staff ratio and perceptions of safety, but not intended to assess general satisfaction on the ward (this is audited separately). The questionnaire was distributed by a junior doctor to all 20 in-patients once a month over a 4-month period (August–November 2006); patients were asked to complete it anonymously and honestly. No other staff members were involved and the questionnaire was collected later the same day. Even if a patient had completed the questionnaire the month before, they were asked to fill it in again to give an accurate cross-sectional representation of the ward.

Collected data excluded patients on leave but included those who refused and/or were too unwell at the time of study. As the survey was ongoing, many patients who had been too unwell to participate one month were able to participate the following month.

Box 1. Brief Satisfaction Survey[a]

1. Do you feel safe on the ward?
2. Do you prefer the ward to have only female patients?
3. Do you feel comfortable having male staff on the ward?
4. Would you prefer the staff to be all female too?
5. Do you prefer a majority of female staff but some male staff too?
6. Do you think the current staffing balance is right?
7. Is there anything you would like to see changed on the ward which would improve your care?

a. Answers to questions 1–6 were: yes, no, not sure; the last question is an open one.

Staff attitudes to staff gender were surveyed anonymously in October 2006 using the same questionnaire and the same method.

Results

Patient survey

The survey was carried out four times in 4 months, with 52 surveys completed in total (Table 1). The average response rate was 74.5%. Of the responders, 83% reported feeling safe on the ward, 50% said they would prefer a single-gender rather than mixed-gender in-patient environment, 87% reported feeling comfortable with male staff and 15% would like the staff to be all-female. Regarding staff ratio, 58% thought the current ratio correct and 51% reported preferring more female than male staff.

The only additional comments made by patients were about staff ratio – four expressed a preference for an equal male:female staff gender ratio.

Staff survey

The staff survey revealed that 100% felt safe on the ward, 55% preferred female-only in-patient wards, 100% felt comfortable with male staff, no staff members (0%) supported an all-female staff and 82% were in favour of a predominantly female staff. Regarding staff ratio, 45% thought the current 3:1 ratio was optimal.

Three staff members made comments; two regarding safety on the ward: 'Having male staff around makes me feel safer if a patient becomes violent or aggressive' and 'I would be concerned about our ability to safely restrain patients if staff was all-female'; the other comment was about the ward itself, saying it was 'a safe and friendly environment'.

Discussion

This survey is the first within our trust since the initial service review to explore the attitudes of patients and staff to staff gender. The aim was to obtain a representative cross-section of patients' attitudes by repeating

https://doi.org/10.1192/pb.bp.107.016808 Published online by Cambridge University Press

Table 1. Patient and staff responses to staff gender survey[a]

	% (*n*)		
	Yes	No	Don't know
1 Do you feel safe on the ward?			
Patients	83 (43)	11 (6)	6 (3)
Staff	100 (11)	0	0
2 Do you prefer the ward to have only female patients?			
Patients	50 (26)	38 (19)	12 (7)
Staff	55 (6)	27 (3)	9 (1)
3 Do you feel comfortable having male staff on the ward?			
Patients	87 (45)	4 (2)	9 (5)
Staff	100 (11)	0	0
4 Would you prefer the staff to be all female too?			
Patients	15 (8)	72 (37)	13 (7)
Staff	0	100 (11)	0
5 Do you prefer a majority of female staff but some male staff too?			
Patients	51 (26)	26 (14)	23 (12)
Staff	82 (9)	18 (2)	0
6 Do you think the current staffing balance is right?			
Patients	58 (30)	27 (14)	15 (8)
Staff	45 (5)	45 (5)	9 (1)

a. Patients $n = 52$, staff $n = 11$.

this survey over a 4-month period. The study had a good response rate of 74.5% given its setting in the acute in-patient ward. Although 50% of patients surveyed preferred to be in a single-gender (female) ward, 87% reported feeling comfortable with male staff and only 4% felt uncomfortable with men. Further, 15% of responders would like to see the unit have an all-female staff, but 50% preferred more female than male staff and 58% felt the current 3:1 staff gender ratio was acceptable; 72% of the patients in our study would like a mixed-gender staff, which was reflected in the patients' comments.

The staff were unanimously (100%) in favour of mixed staffing on an all-female ward, although remained in favour of having more female staff. It is interesting that the views of staff and patients are in line, although the staff sample was particularly small (Fig. 1).

These results are in line with those of Mezey *et al*,[5] in that most patients preferred a staff gender mix in the acute in-patient setting, felt comfortable with male staff and were not in favour of the idea of a female-only staffed unit. Staff who responded were strongly in favour of retaining male staff, who play a vital role on the ward. Several staff members commented on safety, particularly at times when patients need to be restrained. Our survey does not draw any conclusions with regard to safety and its relation to staff gender, although this is an area that needs to be explored further.

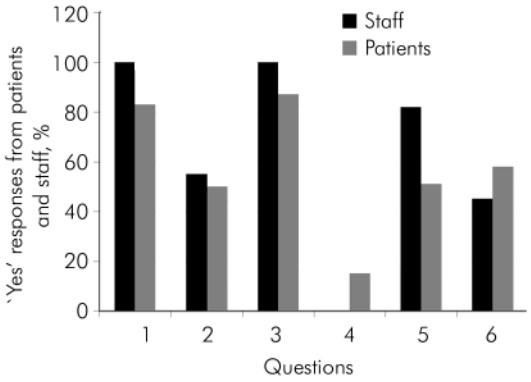

Fig. 1. Comparison of the percentage of patients and staff who responded 'yes' to questions in the Brief Satisfaction Questionnaire (Box 1).

Limitations

The limitations of this study were the small sample size (which reflects the study's pilot design), not having additional data for patients (age, ethnic background, religion) and perhaps also the fact that a known team member was distributing the questionnaires, which could introduce bias but which was necessary in this simple study. The simplicity of this study is one of its key strengths, which is why we chose to use the same questionnaire for patients and staff.

Although women with mental health issues are more likely to have experienced abuse, our study supports Mezey *et al* in showing that in most cases this does not cause them to feel uncomfortable with men.[5] It could be argued that excluding men from the ward might reinforce negative stereotypes. Both patients and staff report that they feel safe, but it was beyond the remit of this study to explore whether they actually are safer and to what extent feeling and being safe contribute to clinical outcome.

Conclusions

Current best practice for staffing single-gender acute in-patient units is unclear and in this regard our study

https://doi.org/10.1192/pb.bp.107.016808 Published online by Cambridge University Press

original papers

raises as many questions as it provides answers, highlighting the need for further research to address this important question. This should involve a larger sample, ideally across multiple centres, and explore the differing effects of such patient variables as age, diagnosis and previous in-patient experience.

The available evidence reveals that a large majority of female in-patient service users prefer to be in a unit with mixed-gender staff. The real key issue brought up in the Bethlem Royal Hospital audit[6] and particularly in the Department of Health report[2] was that women did not feel their opinions were being listened to.

Declaration of interest

None.

References

1 Department of Health. *Women's Mental Health: Into the Mainstream. Strategic Development for Mental Health Care in Women*. Department of Health, 2002.

2 Department of Health. *Analysis of Responses to the Consultation Document*. Department of Health, 2003.

3 Hingley S, Goodwin A. Living with the opposite sex: the views of long stay psychiatric patients. *Br J Clin Psychol* 1994; **33**: 183–92.

4 Batcup D. The problem of researching mixed sex wards. *J Adv Nursing* 1997; **25**: 1018–24.

5 Mezey G, Hassell Y, Bartlett A. Safety of women in mixed-sex and single-sex medium secure units: staff and patient perceptions. *Br J Psychiatry* 2005; **187**: 579–82.

6 Sullivan L. *Listening to Service Users and Carers*. Acute Inpatient Work Stream Group, 2006.

7 Barlow F, Wolfson P. Safety and security: a survey of female psychiatric in-patients. *Psychiatr Bull* 1997; **21**: 270–2.

8 Daffern M, Mayer M, Martin T. Staff gender ratio and aggression in a forensic psychiatric hospital. *Int J Ment Health Nurs* 2006; **15**: 93–6.

9 Hatch-Maillette M. Perceptions of workplace violence in psychiatric settings: does gender play a role? *Diss Abstracts Int* 2002; **63** (Section B: the Sciences and Engineering).

10 Hatch-Maillette M, Scalora MJ. Gender, sexual harassment, workplace violence and risk assessment: convergence around psychiatric staff's perception of safety. *Aggress Violent Behav* 2003; **7**: 271–91.

***Lisa Conlan** Senior House Officer, General Adult Psychiatry, Luther King Ward, Lambeth Hospital, 108 Landor Road, London SW9 9NT, email: lisa.conlan@slam.nhs.uk, **Helen Read** Consultant Psychiatrist, General Adult Psychiatry, Bethlem Royal Hospital, South London and Maudsley NHS Foundation Trust, **Elizabeth Picton** Senior House Officer, General Adult Psychiatry, South London and Maudsley NHS Foundation Trust

https://doi.org/10.1192/pb.bp.107.016808 Published online by Cambridge University Press