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## **Gender, Masculinity, Contemporary History and the Psychiatric Secure Estate: Back to the Future?**

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### **ABSTRACT**

In contemporary history, the use of gendered treatments for women with mental health issues in the psychiatric secure estate is an issue of major concern in Great Britain. This paper examines women and gender in the psychiatric secure estate from a structural analysis drawing influence from Connell's (1987) theoretical and conceptual work on hegemonic masculinity. Bio-psychological approaches have almost dominated academic discussion in relation to women's incarceration and there is an reflexive need to develop other sociological frameworks on hegemonic masculinity because dominant bio-psychological models have failed to identify underlying configurations which combine to oppress women whilst simultaneously reproducing consequences of masculinity and power within institutional structures.

**Keywords:** bio-psychology, power, gender, secure units, masculinity

### **1. INTRODUCTION**

The relationship between women and mental illness/disorder is complex and multifaceted. It has a long history. This relationship is constructed through multiple forces, and it's nature and character comes to be known through three primary themes; discursive

controls shaping the relationship, legal responses to female offending and the administrative management of women said to be suffering with diagnosed mental illness and disorders.

The culmination of discursive, legal and administrative behaviours render the female subject to sanctions and societal opinions which continue to mis-recognise women who seriously or violently offend beyond bio-medical paradigms.

According to Connell (1987) masculinity plays a pivotal role in the management of society and dominant modes of medicalisation. The notion of 'masculinity' is both an essentially contested concept and praxis of everyday human existence and social relations yet its understanding is complex. It can be defined as simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture. Indeed, the modern term of 'masculinity' assumes that a person's or group's behaviour is a result of the type of person/group they are. It presupposes a belief in individual difference and personal agency. It builds upon the concept of individuality developed in early-modern Europe with colonialism and capitalism (Connell, 1987; Bertram and Powell 2005).

With the rise of 'Enlightenment' saw the consolidation of embedded images of 'masculinity'. It was at this point that notions of reason, science, progress, and masculinity were merged into a unified concept of 'manhood' (Connell 1987). Reason and objectivity also provided the moral legitimacy for the rise of capitalism and the modern organisation of society. For philosophers such as Kant, reason tempered by science could overcome and "manage" feelings and intuition (Pilgrim 2014). At the time of Enlightenment, utilitarian doctrines were gaining momentum enshrined by 'success is happiness': As industrial capitalism and the world of machines grew and flourished, this rationality included competition, planning, and goal attainment and the intensification of gendered power relations (Smart 1989).

## **2. SECURE HOSPITALISATION**

The historical and contemporary administrative management of women with mental illness/disorder who have offended, or at risk of offending is broad. The courts may sentence to prison those with less-serious mental health conditions, or fail to observe triggers, or the potential for a decline in the mental health of the convicted woman at the point of sentencing. Indeed, and not a situation particular necessarily solely to women, the prison system operates with a worrying number of inmates enduring serious and complex mental health problems (Taylor and Williams 2014). Alternatively, the courts may not pass a sentence of imprisonment and utilise a Court Order (Section 37 of the Mental Health Act as amended 2007) to dispose of the convicted person, stipulating treatment in hospital. In a number of cases, and where the court is concerned of future risks posed by the convicted person, this Court Order is accompanied by a Restriction Order (Section 41 of the Mental Health Act as amended 2007) which prohibits discharge unless agreed by the Ministry of Justice or a tribunal. Dependant upon assessment by medical professionals assisting the court, the convicted person will be transferred for assessment and/or treatment to a psychiatric unit which range in their level of security dependant upon the perceived risks of the convicted. High security hospitals, of which there are three NHS operated in England (Ashworth, Broadmoor and Rampton), or medium or low secure units operated by the NHS or private

sector partners. Rampton hospital is the only high security hospital in England that received female patients, however there are a wide range of single and mixed-sex medium and low secure services.

There have been increasing concerns about provision of treatment and services for women in secure psychiatric settings (Parry-Crooke and Stafford 2009; Sarkar and di Lustro 2011). Coupled with this, there have been concerns that services for 'mental illness' are inappropriate and genuinely not meeting need. It is more than twenty years now since the landmark *Department of Health and Home Office Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (Reed 1992) and the *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder* (Reed 1994) that highlighted the management of psychopathic and antisocial personality disorders as a topic for major consideration. The final report of the working group noted the paucity of methodologically rigorous research into the effectiveness of treatment of people in psychiatric secure units with such a diagnosis.

However, treatment for women with and without such diagnosis in secure units has been far from empowering as the Blom-Cooper report (1992) reviewed at that same historical moment in time. This inquiry found that the culture at Ashworth high security hospital was anti-therapeutic in the light of daily life for patients, with specific reference made to four cases where patient harm resulted – one of which being sexual allegations against a staff nurse by a female patient. The culture of the hospital was found to be 'macho', 'militaristic' and 'male dominated' (also see Dale 1995). The report posited that institutional neglect and abuse was prevalent especially as regard to women who were 'almost constantly emotionally abused and at times physically abused...they feel chronically frightened and overwhelmingly powerless'. The report concluded that 'the current regime for women is infantilizing, demeaning and anti-therapeutic'. Mr Fleming for the MHAC (Mental Health Act Commission) could have been speaking for us when he stated '...the Commission's position, I hope it is clear, that radical changes...are necessary if women in Psychiatric secure units are to receive the type of care which will improve their situation'.

### **3. RISK AND SECURITY**

Whilst developing for a number of years, the 2000 *Report of the Review of Security at the High Security Hospitals* (Tilt report) went considerable distance in forging the identity and purpose of high security psychiatric settings further. Criticised for its profound concentration on maintaining and upgrading physical and procedural security (rather than relational security whereby staff minimise risks through meaningful interaction and engagement with service users) (Exworthy and Gunn 2003), these sentiments galvanised the imagery of high security settings as repositories of high risk and dangerous individuals. The re-occurring motifs of psychiatric services for dangerous 'mentally disordered' people is nothing new. The bifurcation of patient populations through the commissioning of 'separate institutions' for 'dangerous' and 'non dangerous' patients emerged in the 1950's and 1960's, largely in response to the development of the 'open door' philosophy in local NHS psychiatric hospitals. Concerns by the courts of a reduction of physical security in local hospitals was resultant in many mentally disordered people being sentenced to imprisonment because of a lack of suitable placements.

The problem of up-scaling in security has been a fundamental problem for secure psychiatric settings. The emergence of a system of low, medium and high security environments brought with it the intention to step-up or step-down based on risks posed. Based on principles that the environment's level of security must be commensurate with the risks posed, the ideal picture would be one of patient movement across security thresholds, progression and appropriate placement. Similarly, the Tilt report (2000) noted failures in stepping-down patients from high secure settings to medium secure environments. In a report by the Centre for Mental Health (2011), risk aversion by clinicians was also cited as a reason for delays in patients egressing settings of security above what is perhaps required. The protectionist stance taken by the courts and services themselves undermine patient autonomy and empowerment. In this respect, and driven by circulating illiberal political and social priorities of public protection, the NHS and independent sector specialising in secure psychiatric detention are self-fulfilling in detaining the 'dangerous' behind their perimeter fences.

The architecture of secure psychiatric units signify that they are built for maximum security for highly 'dangerous' individuals. The secrecy of the high security hospital and its inhabitants, together with psychiatry's somewhat clandestine history also endows its identity as a bastion between 'good and evil', risk and freedom, safety and insecurity. Hence within the walls, such regimes restrict a person's freedom and quality of life. It is a 'liberty' issue which should involve the patient having basic democratic rights. Yet, the very narrow and positivistic conceptualisation of the 'dangerous' patient pervades any discussion of empowerment because of dominant discourses and nomenclature underpinned by 'security', 'risk', 'control' and 'confinement' (Burrow 1991a, 1991b; Burrow 1993; Burrow 1998). According to the admission policy (2015), there are 3 factors which play a crucial role in admission: firstly, 'The presence or absence of recognisable mental disorder'; secondly, 'liability to detention' and thirdly, the level of 'dangerousness'. The policy makes it clear that constant surveillance can only be justified when the highest levels of security are required and less security would not provide a safeguard to the public because of these 3 factors of entry and admission.

#### **4. INTERSECTIONS OF POWER IN PSYCHIATRIC SECURE UNITS**

The structure and organisation around historic and current treatments in secure psychiatric settings is orientated around all or some of the following: Drugs, Psychiatric treatment, Electroconvulsive therapy (ECT), Psychotherapeutic treatment, Milieu therapy, counselling and social therapy (Bertram and Powell 2005). However, a study by Stevenson (1989) has illustrated that such treatments disempower women specifically because of the overuse for example of drugs.

In relation to ECT-where a patient is severely depressed and suicidal and the patient has given permission is seen as a last resort treatment for patients. Moreover, Canadian academic and campaigner Bonnie Burstow, raises concerns over the impact of increased use of ECT among female patients, and its administration typically performed by male doctors (Burstow, 2006).

Milieu therapy, the theory that individuals get better by virtue of being in that (regulated and artificially constructed) 'therapeutic' environment or milieu, was popularised in the latter

half of the twentieth century. Stevenson (1989: 16) quotes a female patient in Rampton high security hospital: 'When I used to work in the sewing room on the machines, they used to say that was treatment-going to that room every day and sewing'. Arguably, this treatment epitomises feminisation as proof of normalisation and institutionalisation in the production of self-governing individuals (also see this in respect of young people in locked psychiatric settings, (Oeye, Bjelland, Skorpen and Anderssen 2009)).

In relation to talking therapies, problems persist in the autonomy and empowerment of female patients. Therapeutic relationships between practitioner and patient have been widely deliberated, and indeed the problem exists of how can a woman patient trust the person they are talking to/being treated by when part of their job is to report on her and maintain her detention.

One of the main critiques of the existing provision of services is how incompatible male and gendered services are in combination. Using the term of integration for treatments for both men and women in the context of mixed wards in hospitals is misleading as it suggests a harmonious whole. Centrally, how can women be integrated or normalised into a male environment? There are few alternatives for women to psychiatric secure units with overcrowding a key feature of the historical emergence of Regional Secure Units (RSU's) (Bland, Mezey and Dolan 1999; Sarkar and Di Lustro 2011). Women become trapped within a system orientated around lack of alternatives coupled with a reluctance by psychiatrists to discharge women into the community (Pilgrim 2014).

Steps have been taken in policy and practice to develop gender-sensitive secure services for women (see Department of Health 1999, 2000). Women-only medium secure services have been a salient feature of service commissioning in this area, with Parry-Crooke and Stafford (2009) reporting a considerable growth of dedicated women-only medium secure units since the turn of the millennium. However, despite what may present as substantial advancement of gender-specific treatment and care-planning for women, concerns persist. In a similar vein to the situation of women's imprisonment, secure units that specialise in the treatment of women only are often considerable geographical distance from the familial and social ties of the patient.

Bartlett, Somers, Fiander and Harty (2014) report that the influence of competing legal, public policy, clinical and commissioning discourses complicate the picture of women entering into specific services. The authors contend that the increasing presence of for-profit organisations delivering services in this specialism balance locality and service based upon business planning rather than anything else.

## **5. MEDICALISED RESPONSES TO FEMALE OFFENDING**

What the sociological literature points to is that gender stereotyping plays a crucial role in the labelling of female offending and social processing of criminalisation. A study by Allen (1987) reveals that women appearing before the court are twice as likely as men to be dealt with by psychiatric means. Women are more likely to be referred for psychiatric reports, more likely to be found insane or of diminished responsibility and importantly more likely if convicted to be given psychiatric treatment at a psychiatric secure unit in place of a penal sentence. Allen's (1987) work builds upon the work of Rowett and Vaughan (1981) who found that mental institutions are devices used by dominant groups to control and regulate the

behaviour of unacceptable marginals. Such is the social construction of medical classification, Rowett and Vaughan (1981: 33) quote Partridge (1953) who chronicled the history of Broadmoor: 'Insanity is often brought on by child rearing...Individual pride in her personal appearance seems to be the requisite to a recovery of a woman's sanity'. Hence, pride in a feminine appearance fulfils the gender stereotype.

Examinations of the confined female have not been restricted to psychiatric setting, as indeed the work of Carlen (1983) illustrates the subjective meanings of female confinement with particular reference to the wider meanings of the experiences of prison. Carlen's (1983) study makes use of interviews with Sherrifs (Judges), police officers and social workers and utilises observation in prisons and courts incorporating a kaleidoscopic (diverse methods) approach. What is revealed by the talk of all those interviewed is the network of interests which underlie the logic and imagery of the judicial and penal systems when they attempt to represent the 'inadequate' woman.

Adshead and Morris (1995) claim that women are contained in psychiatric secure units because of huge discrepancies in the provision of mental health care. These treatments (psychotropic drugs/social-psycho therapies) are unsuitable and damaging because they are designed by males for male offenders. One of the central points gathered is that women do not require the level of security offered there.

Many of the women are suicidal and self-harmers with 80% of the female psychiatric secure unit fitting this description and are in chronic need of therapy/empowerment not containment/security. These authors claim that the psychiatric secure units like prisons brings stigmatisation and a perception of a 'shameful place'. Consequently, psychiatric secure units infantilise and punish women. They argue that levels of 'dangerousness'/perceptions of risk are not proportionate to reality. Similarly, work by Pilgrim (2014) has illustrated that security and containment take precedence over therapy. According to her, women can become institutionalised and can expect to be in psychiatric secure units for years which adds to stigmatisation and makes rehabilitation more difficult.

A study by Eaton and Humphries (1996) utilised a qualitative approach in which fifteen women were interviewed from each of the psychiatric secure units. What these authors claimed was that quantitative research would constrain women to answer set questions which does not reveal subjective experiences. Meanings and life histories were articulated via interview methodologies. This was a useful way of researching women as it gave respondents chances to elaborate upon experiences as opposed to measuring answers via structured/quantified questionnaires. One of the main points gathered by Eaton and Humphries (1996) is that women must feel understood if they are to feel empowered. Empathy may help women deal with their emotions/feelings rather than self-harm.

This paints a picture as women in psychiatric secure units as ignored, lack any control over their own situations/lives and have few role models. In combination, Hemingway locate psychiatric secure units as anti-therapeutic and as adding to the marginality/desperation to which women feel.

Psychiatric secure units act as a structure of symbolic violence which is part of the system of domination of female patients, while at the same time a measure of its imperfection. If the hierarchy were actually legitimate, symbolic violence would not be necessary to maintain it.

## 6. DISCUSSION

Themes of individual pathology influenced by a wider familial environment has been the dominant framework which explained female dangerousness and this is highlighted by the use of milieu therapy (Pilgrim, 2014). However, it would seem that the policy of secure specialised provision for 'dangerous' patients is based upon unfounded yet taken for granted assumptions. As Harrison (2011) point out 'dangerousness' is not such a clear and well conceptualised term. Hence, 'dangerousness' is not a constant, fixed personal characteristic. Rather, mentally disordered people may pose a 'risk' at certain times and in response to certain situations but not in others; for example, highly vulnerable women can be 'disruptive' than very 'dangerous' in terms of behaviour (Powell and Wahidin 2001). Such labels become constructed and applied via complex processes of negotiation, classification and rapport between patients and professionals.

Hence, there is a need to transcend images of 'dangerousness' and locate the institutional mechanisms by which women in such regimes are manipulated to facilitate perceptions of legitimated social control, masculinity and power. However, admission to a secure institution is a self-fulfilling prophecy; patients come to be regarded as 'dangerous', otherwise why would they be there. It is important to recognise that all women in psychiatric secure units are not fearless, manipulative and violent. Fear can be a constant factor in the daily lives of the majority of women in psychiatric secure units and a continuation in some cases from the abuse, deprivations and victimisation pre-admission (see Bland, Mezey and Dolan 1999; Stafford 1999). According to Stanko and Hobdell (1993: 27) this may often leave individuals 'isolated and unable to ask for support'.

Worrall (1990) claims that conformity to a feminine role is negotiable; it is not an absolute requirement. It can be negotiated within the family, within communities and in the larger society, but women have to have something to negotiate with. As Worrall (1990: 34) argues 'Class, race and age all affect the extent to which women can resist the ideological discourse of femininity'. The route by which women come to be either in court or in a psychiatric secure units is that someone (sometimes the woman herself) has identified their behaviour as deviant and there is a requirement that they be judged as either normal/innocent or mentally abnormal/guilty (Worrall 1990).

In order to draw such attention, women may have breached the terms of their negotiated feminine role or they may actually have been conforming to a negotiated feminine role not recognised by those in authority. In this way the structural questions around the psychiatric secure unit regime, its philosophy and practice are translated into individual psychological problems situated on a coping - non-coping continuum. It seems, therefore, whether as individuals or as groups, women are continually put under the microscope with every movement, gesture and response magnified and recorded by predominant 'scientific/clinical' observation.

Tied to this, according to the influential work of Connell (1987: 187) utilising a concept such as 'hegemony' and 'masculinity' is particularly useful in recognising the relationship between domination and disempowerment. Furthermore, Connell (1987) identifies four main themes that have been used to characterise 'masculinity': firstly, *essentialist definitions* pick a feature that defines masculinity (risk-taking, aggression, responsibility, irresponsibility, and more) and describe people's lives according to it.; secondly, *positivist definitions* define masculinity as that which individuals actually are in terms of psychology, biology and

physiology; thirdly, *normative definitions* offer a standard for what people ought to be like (aspirational standards). The problem with this is that we cannot define masculinity according to a standard that only a minute, if any, number of women actually meet; fourthly, *semiotic approaches* define masculinity through a system of symbolic difference between masculinity and femininity. Masculinity is defined as that which is not feminine. This definition uses masculinity as the master signifier, the place of symbolic authority, femininity is defined by lack.

Different conceptualisations of realities and ways of behaving are not simply obliterated by power networks. Thus, while physical and psychological violence might be a cornerstone of female confinement which support dominant cultural patterns and ideologies, they are utilised within a balance of forces in which there is an everyday contestation of power and where there is always the possibility for individual, social and historical change (Connell 1987: 184).

Domination is emphasised at the expense of contradiction, challenge and change both at the level individual identities (women) and social formations (regimes of power). This position is particularly relevant for the study of women in psychiatric secure units for despite the domineering that underpins and reinforces the culture of masculinity inside, this culture has often been undercut by individualist and collective strategies of dissent and sometimes by alternative official discourses (Blom-Cooper, 1992) which have provided a glimpse of the possibility for constructing social arrangements which are not built on violence and domination in such regimes.

The 'hegemonic masculinity' (Connell 1987) and the controlled use of violence which prevails in psychiatric secure units with its female population exemplifies a broad pattern of physical violence, psychological intimidation which provides a stark yet chilling context in which everyday decisions are made, lives controlled and bodies and minds broken. The process of normalization and routinization underpins and gives meaning to the self-perception of the individual and the perceptions of the significant others in the power networks of the institution.

As a comparison to the prison system, the work of Sim (1990) makes the point that prisons sustain, reproduce and indeed intensify the most negative aspect of masculinity, moulding and re-moulding identities and behavioural patterns whose destructive manifestations are not left behind the walls when the prisoner (or even patient) is released. Disempowerment on the inside can be mirrored on the outside. A gendered reading of the hierarchies of the female psychiatric secure unit moves therefore beyond bio-psychological models and organisational imperatives.

What we need to point to is how the maintenance of order/security both reflects and reinforces the pervasive and deeply embedded discourses around particular forms of masculinity. The mortification which women undoubtedly experience in their daily lives does nothing to alleviate the problems that the majority will face on their release into the community. Rather in its very 'celebration of masculinity' (Scraton et al. 1991), the psychiatric secure unit, like other state institutions such as prisons, materially and symbolically reproduces a vision of order in which 'normal womanhood' remains unproblematic, the template for constructing everyday social relationships between men and women prisoners/patients/professionals working with them.



## **7. CONCLUSION**

Mental health professionals who work within the boundaries of accepted practices organised around dominant discourses of power, authority and domination which underline, underpin and give meaning to the working lives of the majority of professionals/managers both on the ground in psychiatric units and within the bureaucracy of the state, legitimise hegemonic masculinity. Further, ideologies and behaviour which legitimises disempowerment can be tied to issues of masculinity. Attempting to step outside a disciplinary culture results in alienation, stress, lack of promotion and overt hostility from the majority. Psychiatric units have been exclusively male environments (Pilgrim 2014). The debate rages on but injustices still remain based on gendered power relations that hinders rather than facilitates real empowerment.

## **References**

- [1] Adshead, G., & Morris, F. (1995). Mental health. Another time, another place. *The Health Service Journal*, 105 (5439), 24.
- [2] Allen, H. (1987). Rendering them harmless: The professional portrayal of women charged with serious violent crimes. *Gender, crime and justice*, 81-94.
- [3] Bartlett, A., Somers, N., Fiander, M., & Harty, M. A. (2014). Pathways of care of women in secure hospitals: which women go where and why. *The British Journal of Psychiatry*, 205(4), 298-306.
- [4] Bartlett, P., & Sandland, R. (2007). *Mental health law: Policy and practice*. (3<sup>rd</sup> Ed.). Oxford, United Kingdom: Oxford University Press.
- [5] Bartlett, A., & Hassell, Y. (2001). Do women need special secure services? *Advances in Psychiatric Treatment*, 7(4), 302-309.
- [6] Bland, J., Mezey, G., & Dolan, B. (1999). Special women, special needs: a descriptive study of female special hospital patients. *The Journal of Forensic Psychiatry*, 10(1), 34-45.
- [7] Bowden, P. (1985). Psychiatry and dangerousness: A counter renaissance. *Secure Provision*, 265-87.
- [8] Burrow, S. (1991a). The special hospital nurse and the dilemma of therapeutic custody. *Journal of Advances in Health and Nursing Care*. 1(3), 21-38
- [9] Burrow, S. (1991b). Special hospitals: Therapy versus custody. *Nursing Times*. 87(39), 64-66.
- [10] Burrow, S. (1993). Inside the walls. *Nursing Times*. 89(37), 38-40.
- [11] Burrow, S. (1998). Therapy versus security: Reconciling healing and damnation. In T. Mason & D. Mercer (Eds) (pp. 171-187). *Critical perspectives in forensic care: Inside out*. London, United Kingdom: MacMillan Press.
- [12] Burstow, B. (2006). Understanding and ending ECT: A feminist imperative. *Canadian Woman Studies*, 25(1,2), 115-122.

- [13] Carlen, P. (1983). *Women's imprisonment: A study in social control*. London, United Kingdom: Routledge & Kegan Paul.
- [14] Centre for Mental Health (2011). *Pathways to unlocking secure mental health care*. London, United Kingdom: Centre for Mental Health.
- [15] Committee of Inquiry into Complaints about Ashworth Hospital, & Blom-Cooper, S. L. (1992). Report of the Committee of Inquiry Into Complaints about Ashworth Hospital: The Case Studies. London, United Kingdom: HM Stationery Office.
- [16] Connell, R. W. (1987). *Gender and power*. Sydney, Australia: Allen and Unwin.
- [17] Cowie, J., Cowie, V. A., & Slater, E. (1968). *Delinquency in girls*. London, United Kingdom: Heinemann.
- [18] Dale, C. (1995). Changing the nursing culture in a special hospital. *Nursing Times*, 91(30), 33-35.
- [19] Dell, S. (1980). Transfer of special hospital patients to the NHS. *The British Journal of Psychiatry*, 136(3), 222-234.
- [20] Department of Health (1999). Secure futures for women: Making a difference. London, United Kingdom: Department of Health.
- [21] Department of Health (2000). Safety, privacy and dignity in mental health units: Guidance on mixed sex accomodation for mental health services. London, United Kingdom: Department of Health.
- [22] Eaton, M., & Humphries, J. (1996). *Listening to women in special hospitals*. Twickenham, United Kingdom: St. Mary's College.
- [23] Exworthy, T. & Gunn, J. (2003). Taking another tilt at high secure hospitals. The Tilt Report and its consequences for secure psychiatric services. *British Journal of Psychiatry*, 182, 469– 471.
- [24] Genders, E., & Player, E. (1987). Women in prison: the treatment, the control and the experience. In P. Carlen & A. Worrall (Eds.). *Gender, crime and justice*. (pp. 161-175). Milton Keynes, United Kingdom: Open University Press.
- [25] Gostin, L. O. (1986). *Institutions observed: towards a new concept of secure provision in mental health*. Oxford, United Kingdom: Oxford University Press.
- [26] Harrison, K. (2012). *Dangerousness, risk and the governance of serious sexual and violent offenders*. London, United Kingdom: Routledge.
- [27] Hemingway, C. (1996). *Special women? The experience of women in the special hospital system*. Aldershot, United Kingdom: Ashgate Publishing.
- [28] Lombroso, C. (1895). *The female offender*. London, United Kingdom: T. Fisher Unwin.
- [29] Mason, T., & Mercer, D. (1999). *The sociology of the mentally disordered offender*. London, United Kingdom: Longman.
- [30] McCabe, J. (1996). Women In Special Hospitals and Secure Psychiatric Containment. *Mental Health Review Journal*, 1(2), 28-30.

- [31] Naylor, B. (2014). Gender, mental health and crime. In P. Taylor, K. Corteen & S. Morley (Eds.). *A companion to criminal justice, mental health and risk*. (pp. 111-112). Bristol, United Kingdom: Policy Press.
- [32] Oeye, C., Bjelland, A. K., Skorpen, A., & Anderssen, N. (2009). Raising adults as children? A report on milieu therapy in a psychiatric ward in Norway. *Issues in Mental Health Nursing*, 30(3), 151-158.
- [33] Parry-Crooke, G., & Stafford, P. (2009). *My life: In safe hands? Dedicated women's medium secure services in England*. Available from: <http://www.ohrn.nhs.uk/resource/policy/WMSSEvaluationFinalReport.pdf>
- [34] Pilgrim, D. (2014). *Key Concepts in mental health*. London, United Kingdom: Sage
- [35] Pollak, O. (1950). *The criminality of women*. New York, NY: A.S. Barnes.
- [36] Bertram, M and Powell, J.L. (2005). Reforms, Rights or Wrongs? A Foucauldian Exploration on New Mental Health Bill in UK. *International Journal of Sociology and Social Policy*, 25, 12, 176-189
- [37] Reed, J. (1992). *Department of Health and Home Office. Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London, United Kingdom: HM Stationery Office.
- [38] Reed, J. (1994). *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder*. London, United Kingdom: HM Stationery Office.
- [39] Rowett, C., & Vaughan, P. J. (1981). Women and Broadmoor: Treatment and control in a special hospital. In B. Hutter & G. Williams (Eds.) *Controlling women: The normal and the delinquent*. (pp. 131-153). London, United Kingdom: Croom Helm.
- [40] Sarkar, J., & di Lustro, M. (2011). Evolution of secure services for women in England. *Advances in Psychiatric Treatment*, 17(5), 323-331.
- [41] Scraton, P., Sim, J., & Skidmore, P. (1991). *Prisons under protest*. Milton Keynes, United Kingdom: Open University Press.
- [42] Sim, J. (1990). *Medical power in prisons: The prison medical service in England 1774-1989*. Milton Keynes, United Kingdom: Open University Press.
- [43] Smart, C. (1989). *Feminism and the power of law*. London, United Kingdom: Routledge.
- [44] Stafford, P., & Women in Secure Hospitals (WISH) (1999) *Defining gender issues: Redefining women's services*. Available from: [http://www.womenatwish.org.uk/wp-content/uploads/2010/03/Defining\\_Gender\\_Issues.pdf](http://www.womenatwish.org.uk/wp-content/uploads/2010/03/Defining_Gender_Issues.pdf)
- [45] Stanko, E. A., & Hobdell, K. (1993). ASSAULT ON MEN Masculinity and Male Victimization. *British Journal of Criminology*, 33(3), 400-415.
- [46] Stevenson, P. (1989). Women in Special Hospitals. *Openmind*,
- [47] Taylor, P. & Williams, S. (2014). Sentencing reform and prisoner mental health. *Prison Service Journal*, 211(Jan), 43-49.
- [48] Thomas, W. I. (1923). *The unadjusted girl*. New York, NY: Harper and Row.

- [49] Tilt, R. (2000). *Report of the review of security at the high security hospitals*. London, United Kingdom: Department of Health.
- [50] Wahidin, A., & Powell, J. L. (2001). The Loss of Aging Identity: Social Theory, Old Age, and the Power of Special Hospitals. *Journal of Aging and Identity*, 6(1), 31-48.
- [51] Waterhouse, R. (1994, 31<sup>st</sup> January). Drugs ‘bedlam’ at high security hospital: Medication doses reviewed after spate of disturbances involving patients. *The Independent*. Available from: <http://www.independent.co.uk/news/uk/drugs-bedlam-at-high-security-hospital-medication-doses-reviewed-after-spate-of-disturbances-involving-patients-rosie-waterhouse-reports-1410622.html>
- [52] Wilczynski, A. (1997). Mad or bad? Child-killers, gender and the courts. *British Journal of Criminology*, 37(3), 419-436.
- [53] Worrall, A. (1990). *Offending women, female lawbreakers and the criminal justice system*. London, United Kingdom: Routledge.

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