Women and Power: Drayton Park Women's Crisis House

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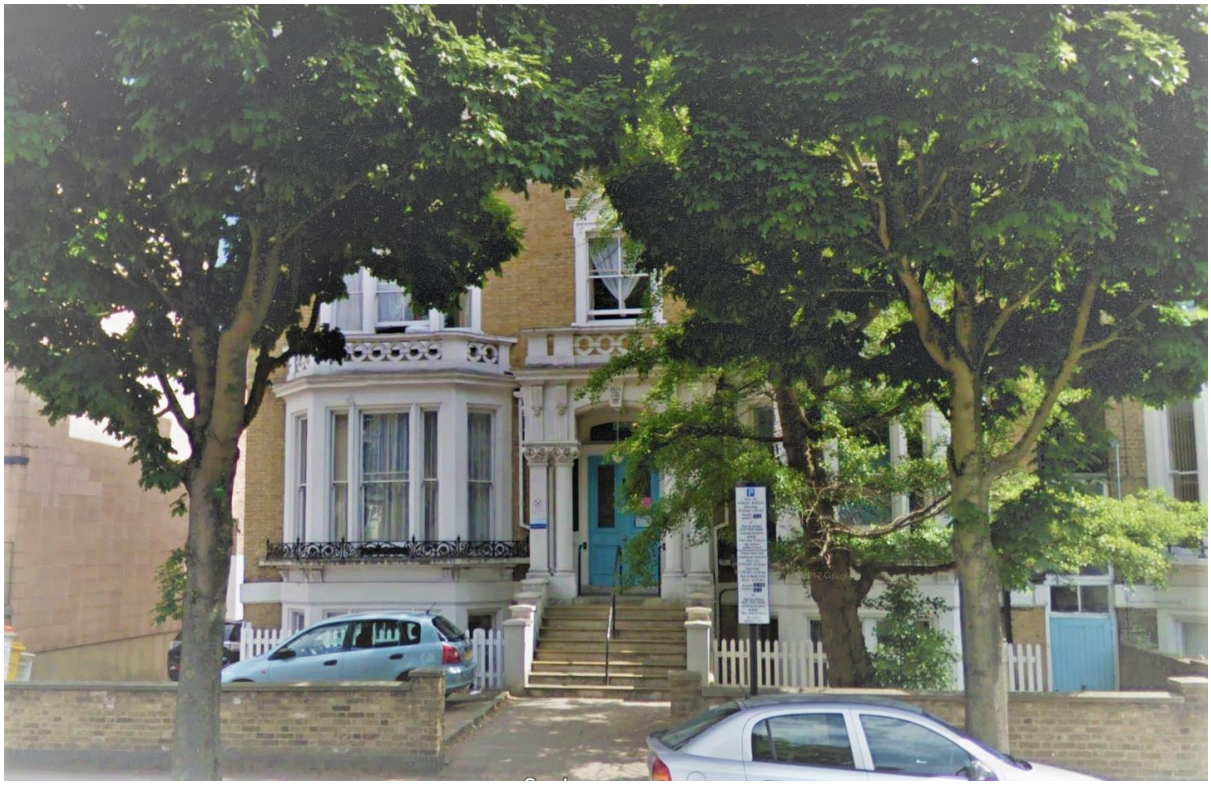

Here we have a soft space
Women alongside women
Healing the unspeakable
With warmth and wisdom

From *Shirley's Wise Words,* a poem written at Drayton Park

One morning three of us had a conversation about a house. Tears were shed: good ones.

Shirley McNicholas is Women's Lead for Camden and Islington NHS Foundaiton Trust in London and Founder/Manager of Drayton Park Women's Crisis House. Andie Rose is a member of the Camden & Islington Women's Strategy Group and someone who has stayed in the house. Anne Cooke is a clinical psychologist and academic**.** The house we were talking about, 32 Drayton Park, is a large Victorian villa which looks much like its neighbours in a typical North London street. Part of the UK's National Health Service, for over twenty years it has offered an alternative to hospital for women experiencing mental health crises. It is run on trauma-informed,

feminist and systemic principles, and furnished in a homely, 'Ikea' style, with an airy living and dining space at the back overlooking the garden. Each resident has her own en-suite room which she can lock, and there are cosy rooms for individual conversations and even massage. In line with our brief for this chapter, our conversation covered why Drayton Park was needed, how it got off the ground, what it's like, obstacles the team have overcome, Andie's and other women's experiences of the project, evidence that it helps, what the 'active ingredients' are likely to be, thoughts about the future and critical reflections. We titled the chapter in homage to Professor Mary Beard, whose new book of that name Shirley had just read on the train and brandished about animatedly from time to time.

Anne: What's Drayton Park like?

Andie: I'd heard of it years before I first went there. Some of my friends had been there and had recommended it. After ten years of hospital admissions, mainly under section, I was referred to Drayton Park. I wasn't quite sure whether they'd take me given my history of admissions, but I needed to be in a women-only environment and to feel safe. Drayton Park is for women only, with women-only staff. It was a daunting and confusing experience going for my first assessment. The house was big and had a very homely feel, with no sense of being remotely 'psychiatric'. My first thought was 'Will they be able to cope with me here?' My second was 'How will *I* cope being here? Will I just end up back in hospital with the same old medical model approach, the same old medication, restriction of freedom and generally less control of my life?'

After what seemed like a lengthy assessment (I couldn't understand why they wanted to know so much about ME rather than just my 'symptoms') I was accepted at Drayton Park. I didn't realise at the time just how life-changing my contact with this place would be, not only in how I view my crises but in other aspects of my life. Drayton Park is one of just two places that have helped move me forward towards getting the therapy I needed.

It wasn't an easy first stay. At first, I was overwhelmed by how much staff wanted to check in with me. I remember my first night. A member of staff called Michelle asked me to leave my door open so she could check on me regularly. Because of my past hospital experiences I automatically assumed I was on 'close observations' and left the door propped open with a chair. I was expecting staff to sit there and watch me throughout the night as they do in hospital. I'd always felt this was really intrusive, especially when the staff were male. When Michelle came to check on me she looked surprised that I'd left the door wide open and asked why. Was I afraid? I explained, and she told me that she'd just meant leave it unlocked. It was my first night and they wanted to be able to check I was OK. She emphasised that I could make my room as safe as I wanted to and make it my own. It was *my* room, my *private* space and I had the key. I couldn't quite get my head around this.

That was back in February 2004. I've had other admissions over the years since then. Each time I feel bad coming back to the 'steps of shame' – my name for the steps leading to the front door because here I am having a crisis again. But once over the threshold, the warm welcome from staff helps to alleviate most of my anxiety about returning.

Drayton Park by Tanya Raaybe

The house is comfortable and you can tell that every effort has been made to make it homely – a luxury compared to the hospital environment. You have your own en-suite room. There's a healing room which has lovely aromatherapy oils and you can get a massage from two different body therapists three times a week. The garden is big with quiet corners where you can sit and relax. A member of staff once helped me to ground myself by walking barefoot on the pebbly path. That was a different take to the usual hospital one of offering meds to 'bring me back' when I get anxious or dissociate. There's a cook on site who caters for most dietary needs – the weekly roast dinners seem to be the most popular!

On your first day you agree a plan with staff, detailing who your workers will be and your timetable for the week including reviews of your stay. The way you do this jointly with staff feels empowering. There have been times where I've had no idea what I really wanted or expected from a stay at Drayton Park, but I knew that was ok

too and no pressure was put on me. The staff offer regular one-to-one sessions twice a day, but you can also approach them whenever you want to, for example if you feel distressed or suicidal, and they always make time for you. They also spend time around the house and so can see if someone perhaps isn't doing too well, and check in with her.

After many years of using Drayton Park I can now reflect on the benefit of having such a richness of diversity among the women who work and have worked there. They each have their own way of working. My experience has been different every time, and each time I've taken something different from it. However, the most important aspect for me is always the therapeutic relationship you have. Each time you build another layer of trust to help with that particular crisis. It's such a huge relief to talk about my issues as a woman, to a woman, in a women-only safe space.

The staff listen to me without fear or judgement. I've been given confidence to find my voice and be heard. Before discovering Drayton Park I'd tried for several years to access the right therapy but kept getting turned down because of my past 'psychiatric history'. But Rachel (one of the deputy managers) together with the local day hospital manager encouraged and supported me to try again. They took on the challenge where others had been reluctant. With their help and support I was finally accepted for psychotherapy. That has been the most effective treatment for me – it continues to be what I call my 'dialysis'.

I remember another staff member, Julie, helping me with my housing issues when I was going through a difficult time. She understood where I was coming from and gave me the confidence to stand my ground with what was a real challenge in asserting my rights.

Each staff member has different skills but they share the same values. They work in what I call the Drayton Park compassionate way. They meet you where you're at. They understand and respect that things can be different each time, but keep the consistent, compassionate care going. They want to know what's happened to you, who you really are despite the 'symptoms' playing havoc in your mind. The focus is on the person, the soul. They respect all aspects of you, whoever you are. No judgement, no shame, no expectations, just the opportunity for you to work out what's going on for you and find ways forward. It's not rocket science – it's humanity.

Anne: It sounds as if staff attitudes - and the ideas they draw on in their work - are central. Shirley, how do you recruit people?

Shirley: What we're most interested in at interview is people's values and motivations. We need to hear a convincing account of why the person wants to work with women, why they care. Then once someone's appointed they become part of a very supportive framework. As you'd expect, each team member has individual

supervision, but in a sense the team also have constant supervision because we all work from the same office, including managers and senior staff. It isn't for everyone: we talk to each other all the time, checking in with plans for individual women. We take referrals in the office as well, so again we're listening and coaching new staff until they're confident about the process.

On top of this and the usual mandatory training, the team also take part in training on domestic and sexual abuse. Once a year we also have a team day on trauma-informed working. The team days are an important chance to stop and remind ourselves of what we're trying to do and the rationale behind it. Staff have to be able and willing to work with the same women on multiple occasions whilst keeping an open heart. So having regular space to refresh ourselves and our motivation is vital. The things we do make a real difference to women's lives, and our job is to keep doing them well even if we've done them a hundred times.

Andie: Drayton Park is a special place, and I'd love to see other places set up and follow this model. I found my feminist voice here, and became a member of the Women's Strategy Group: a group of eight women who have used the local mental health services and work with Shirley to help improve services for women.

Anne: I know you've talked to many other women who use Drayton Park, Andie. What do they say about it?

Andie: The thing you hear most often is 'We're so lucky to have this place'. People say what a difference it makes having their stories and experiences heard and validated. They talk about the one-to-one sessions and say they feel listened to. They mention the team and the fact that they offer support even after you leave. They talk about the quiet, calming space which gives you an opportunity to focus on the important issues and hopefully start a fresh journey of healing.

Anne: Going back to when Drayton Park first opened, why was a crisis house needed?

Andie: I needed it because I wanted to be out of the hospital environment and in a women-only space that felt safe and didn't retraumatise me. The unwanted attention from men that you often get in hospital made me worse and I never felt safe. I also didn't feel it was appropriate to have male staff watching me throughout the night, nor to have medication forced on me by groups of male and female staff. Those things just raised my anxiety and exacerbated my crises. The different approach taken at Drayton Park was evidence to me that the hospital restrain-and-inject procedures were unnecessary and often made me worse.

Shirley: In the early nineties there was a lot of dissatisfaction with mental health services, and particularly with services for women. There were many reports of

women being assaulted and intimidated in mixed services. According to the Guardian, over 500 sexual attacks are reported every year in UK hospitals, and many more go unreported (Williams, 2014). Women were avoiding services out of fear. There was no provision for women with children. People were recognising the need for women-only services and pressure groups were forming, including here in London the Women's Mental Health Network. National Mind was running a campaign called 'Stress on Women'. The report about it was called 'Eve Fights Back' (Darton, Gorman & Sayce, 1994).

At the same time, evidence was accumulating that it is possible to offer safe crisis care to women within a less restrictive environment (Perkins, Nadirshaw, Copperman & Andrews, 1996; Copperman & Knowles, 2006). Hospital services were stretched and people were looking for innovative ways to create capacity.

Locally, several things came together to make Drayton Park possible. Firstly, the two London boroughs (local authorities) that the NHS trust covers, Camden and Islington, both had a history of social justice politics. Islington had a dedicated Women's' Equality Unit. Secondly, Rabbi Julia Neuberger was the Chair of the Trust at the time. She had a keen interest in women's issues, and was very supportive of the project. So was the local service manager Claire Murdoch, who has since gone on to be National Mental Health Director at NHS England. Both were keen for the Trust to be a pioneer, and to develop a women's crisis house. They put in a successful funding application to the 'London Implementation Group' - a body responsible for developing London's NHS services. Both local authorities agreed to top up with funds to develop and open the service.

I was appointed as Project Development Worker, and what made a huge difference was being in post for a year before the service actually opened. It meant I could research things properly, visit other services, gather feedback from service users, and prepare reports making recommendations about how the service should be designed. One of the most important things I did early on was to set up a working group to plan and develop the service. We called it the Sanctuary Management Advisory Group and it was made up of women who used services, people from the voluntary sector, and a few key professionals from the Trust and other statutory services who had a vision and a passion for change. The group argued strongly for the service not to operate with the traditional multidisciplinary team, but instead to have a women-only team which could provide a range of emotional and practical responses. They also argued for it to be able to accommodate children with their mothers. The advance thinking we were able to do meant that when we opened, from the word go there were very clear processes in place that provided consistency and containment (Bion, 1970) both for the staff and for the women using the service. The policies also provided reassurance to senior management that the Advisory Group were taking the issue of risk very seriously and that the staff knew what we

were doing. The advisory group eventually became the Drayton Park Women's Forum.

Anne: Well that was over twenty years ago and Drayton Park still seems to be thriving. Andie has described her experience of it, can you briefly describe it from your point of view?

Shirley: We are a residential crisis service and take referrals 24 hours a day over the phone. The fundamental criterion for accepting a referral is that the woman is likely otherwise to be admitted to hospital. This criterion is important in enabling the Trust to continue to offer this alternative: it reduces pressure on inpatient beds. It also increases the Trust's cost-effectiveness - a stay in a crisis house is more cost-effective than a stay on an acute admission ward (Howard et al., 2010).

We offer an assessment at the house as soon as possible, often within hours. If a woman is offered a place it is usually for one week in the first instance. During that time she has intense support from a women-only team who are skilled in mental health interventions, in containing and managing risk, in working with disclosures of childhood abuse and in safeguarding. The team includes body therapists – shiatsu and aromatherapy massage - and we can also accommodate young children with their mothers. While someone is with us we work hard with her, her supporters and other services to make sure that a robust support plan is in place for when she goes home. The average length of stay is 21 days and the majority of women safely return home. On occasion, women are transferred to hospital during or at the end of their stay if the risk is so severe that it can't be contained in a voluntary community setting. I'd say that happens about once a month.

Anne: What are the guiding ideas that underpin your approach at Drayton Park?

Shirley: Drayton Park offers an alternative to hospital for women in acute crisis. It has operated since its inception on the principles of a 'trauma informed environment' (Elliot et al., 2005) and these founding principles have been honoured over the 21 years it has been running. Trauma-informed approaches have evolved over the last twenty years and Drayton Park has been part of that development, working to embed the principles of the approach in day-to-day practice (Sweeney et al., 2016).

The team have training in the trauma-informed model and techniques (Sweeney et. al., 2016). A core component is 'routine inquiry'. That means that at every initial assessment, we ask whether the woman has experienced or is experiencing any form of trauma. If the answer is yes, we provide an opportunity to speak about it and space to be heard. The national data regarding the high levels of trauma and abuse in the lives of women coming to mental health services (Read et.al, 2018) are borne out in the disclosures made daily at the service. Our model of care is threaded

through all aspects of the service, from its philosophy to how we open a bedroom door.

Anne: Tell me more about that. How is the trauma-informed approach reflected in your policies?

Shirley: Well there are lots of components to it. I'll go through them in turn.

Firstly, we are a women-only staff team. Over the years women had been campaigning for a women-only service, provided by women. Staff are appointed on the basis of their skills, attitudes, knowledge and experience rather than professional qualifications. The majority of staff over the years have either come from the voluntary sector or are looking to be psychologists or therapists in future. Others have been nurses who want to practice in a collaborative and therapeutic way and want to have a voice. When I worked as a nurse, a long time ago, I noticed that many nurses did not feel empowered as therapeutic practitioners. When I set up the service, very few nurses applied for the positions. I assume this was partly because they were not designated as nursing posts. This has changed over the years as the service has become established and nursing colleagues have applied and want to work with a different model. However it is very important that the team continues to be made up of staff from a variety of backgrounds and with a variety of experiences.

Secondly, as I explained earlier, women who use services have been involved from the beginning. They contributed in a major way to the design of the service and are involved in its ongoing management. In 1996 the advisory group morphed into the 'Drayton Park Women's Forum', which consisted of women who used the service. In 2000 it became the Trust-wide Women's Strategy Group, using experience from the service to support women across the Trust. We are trying to extend some of the same principles to other services, for example the new women's PICU (*Psychiatric Intensive Care Unit, a locked ward*). Andie is a core member of this group together with seven others, all women who have used services.

Andie: I've been involved with the Women's Strategy Group ever since my first encounter with Drayton Park. As a service user I've seen a lot of change in the services and experienced first-hand the slow disintegration of our priceless NHS. Despite this, when I attend the meetings – which are usually held at Drayton Park - it's so reassuring to see the familiar faces of the women who are the backbone of the service there. They have inspired so many with the feminist model of working with women in crisis. **Drayton Park isn't just a Women's Crisis House – it's about Women and Power!**

Shirley: Thank you Andie! Getting back to how the trauma-informed approach is reflected in our policies: thirdly, staff are trained and supervised in the approach including the impact of domestic and sexual abuse on mental health.

Fourthly, we accept self-referrals as well as referrals from mental health workers. Women refer themselves by phone and the process is the same as for professionals. We use the same form and ask the same questions.

Fifthly, as I mentioned, our initial assessment includes routine inquiry about past and current trauma.

Anne: Say more about that? I always wonder why *all* mental health assessments don't include that. On the other hand, a criticism I hear of the trauma-informed approach is that it can become a bit one-size-fits-all: seeing everything in terms of trauma. There's a risk of imposing explanations just as much as medical model services do: 'any explanation as long as it's trauma'. As someone said to me, "*But what about those of us who have severe problems but haven't experienced trauma? We're sick of being told that our problems must be due to some kind of trauma we've forgotten. I hear voices but I haven't been abused or traumatised*". How does Drayton Park approach that issue?

Shirley: Just because we ask the question that doesn't mean we expect the answer always to be yes. As with all mental health services, we ask a range of routine questions such as: Do you feeling like harming yourself? Do you have any suicidal feelings? Of course they aren't relevant for everyone but we know that they are for many people who approach services. For the same reason we enquire routinely whether women have experienced any form of abuse or trauma. Our experience bears out what we know from research evidence (e.g. Khalifeh et. al, 2014) and from accounts by many service users and survivors (e.g. Filson, 2016), namely that these are relevant questions for many women. We understand that for some the answer will be no, and also that others will choose not to answer, or not to tell. In those cases we would never tell someone that the issues she is facing are due to trauma. What you are doing is opening the door and saying to people: this is a place you *can* tell. If (and *only* if) someone does, we help her to explore possible connections between what has happened to her and how she is feeling.

Going back to my list of ways in which the trauma-informed model informs our practice, number six is that we don't use 'care plans'. Instead we have 'Agreement Plans' like the one Andie described. The format was developed by the original advisory group. Each plan starts with ten standard, typed statements that are common to everyone, for example 'You will have access to staff 24 hours a day'. The next part of the plan is an individual one drawn up by the woman and her worker together. It includes the issues she wants to address, the names of her named and associate workers, how she would like to arrange the two one-to-one sessions each day, a safety plan if she feels at risk, agreements about prescribed medication and other substances, and contact with children. It's an agreement plan rather than a care plan because we do things *with* rather than *for* or *to* the woman. This is the foundation of the Drayton Park model. We are part of the Trust IT systems and we

upload the Agreement Plan in the care plan section of the person's electronic notes. This ensures that it is available to other colleagues and can used as a reference in other services.

Seven: As Andie mentioned, we offer an opportunity, twice a day, to talk one-to-one. This isn't therapy but includes everything from filling out benefits forms to sharing heart-rending stories of childhood sexual abuse. The team help women to develop and try out coping strategies, grounding techniques and ways of managing dissociation, flashbacks, voices, terror and urges to self-harm. We recognise that different things help different people, so it's vital to support each woman as she tries things out and develops strategies that work for her.

Sitting/Quiet Room

Eight: We've developed our own self-harm policy on the basis of feedback from women staying. Women are often skilled in using alternatives to self-harm. In the early days of the project we agreed a policy which includes staff keeping clean blades that women can use when nothing else is working. Although this seems dramatic and risky, it had a paradoxical effect, as the women knew it would: the knowledge that they could come for a blade meant that self-harming behaviour reduced. Women were also learning to trust others with their injuries. Our non-judgmental approach enabled many women to show their scars and wounds to

someone else for the first time. Again, although it felt counter-intuitive to those staff more used to working in settings which intervene by force if necessary to keep someone safe, we found a way of working that didn't involve taking control away from the woman. We worked with each woman to be as safe as she could be, trusting her judgement but also being aware of our limits and being honest about them. It has been a very rare occasion where working with someone in this way has not been possible.

Andie: My self-harm reduced over the years of going to Drayton Park. The staff's approach wasn't punitive like I had experienced in most hospital admissions. I was encouraged to approach staff if I had urges to harm myself. This did take a while, as I had to feel safe with them before I could talk. When I did begin to, I was able to slowly understand what had led me to that point. Gradually I was able to open up more - trust was being built. It helped that the staff were open to discussion about self-harm and not afraid or anxious about it. I never felt punished like I had in hospital, where staff set off alarms once they discover you'd self-harmed, and sometimes cancelled your leave or threatened to move you to a locked ward (back in the days when there was such a thing as an *unlocked* ward). That always made me feel worse.

Shirley: I'm so glad you've found Drayton Park helpful Andie!

Anne: I think you'd got to number eight in your list of aspects of Drayton Park's trauma-informed philosophy, Shirley?

Shirley: Yes. Number nine is that we manage risk by psychological rather than physical containment (Bion, 1970). We don't do 'observations' to contain risk: instead we have 'contacts', where we verbally check in with the woman and try to have at least a brief conversation, a human contact, either face to face or sometimes by phone. The team contain risk, and in turn we contain each other's anxieties – the principle of psychological containment applies to the staff too. It's a household of women – there's talking all the time! We're constantly updating each other, debriefing, keeping things focused and held.

Our tight working structure is also very containing. We all use the same format to guide referral-taking and assessment conversations. There's a framework for managing risk on a day to day basis that includes completing a 'contact form' for each 24-hour period. At the beginning of every day we write the names of all the women currently using the service. Next to each name is a list of time slots (for example 9am – 10am) starting at 7am and going on until midnight. These are the same every day and for every woman. It doesn't mean that the whole team run to find every woman at exactly 7am, but they do make contact within a 60 minute time frame. This 'holds' (Winnicott, 1945) the team and means that we regularly contact and talk to every woman. Staff sign to say they've had contact and that the woman is

safe. If they don't have contact, it's flagged in the team for a decision. I swear that my tombstone will say 'Is the contact form up to date?'! Each contact is an intervention in itself, part of our structure of psychological containment both for the women and for the team. Women know that whatever else happens, someone will regularly come and find them. For the staff, as I mentioned we're all in one office so reporting back after contacts gives us an opportunity to share anxieties and decisions, and to support each other. We make most decisions as a team, so as a staff member you're never solely responsible for something. For example, workers always take a break in an assessment conversation to talk to other team members. There's always someone to share ideas and worries with. That's what makes our work possible. It also means we can make decisions straight away – no waiting for a weekly review meeting, for example. The shift team are empowered to make decisions and to be the therapeutic agents. The institution respects people's skill and life experience. That gives people job satisfaction. That mixture of tight structures and team working is what makes the job possible.

Number ten is that we positively promote diversity both in the team and the building. We try to ensure that our artwork, posters and leaflets speak to women from all walks of life. We want women who are staying to find images that they can relate to and to make them feel welcome here. We have noticeboards focused on issues affecting particular women, for example a Black women's one and an LGBTQI one.

LGBTQI noticeboard

Number eleven is home cooked food. Women often tell us what a difference it makes having our chef cooking their meals for them. They like to know who the chef is, talk to the person and feel it is personal. Nourishment is so important and cooking for someone is a nurturing thing to do. It's a very different experience to having ready-made food delivered on plates from a central kitchen. The chef is a very important person in the team.

Number twelve is our 'knock three times' policy. One thing women often find difficult in hospital is that even if you have a single room it's often not really treated like yours. People barge in, including when you're getting dressed. Like Andie said, that feels disrespectful and can make you feel unsafe. Here, when a member of staff goes to someone's bedroom door, we knock once and wait five or ten seconds for an answer. If there's no reply we knock again, saying the person's name, and wait. If there's still no reply we knock again, say our name, the person's name and that we are going to use our key to open the door. This procedure allows the person to get dressed or off the toilet, and means we don't retraumatise someone who, for example, has been abused in their bedroom and had no power to say no. The Trust Women's' Strategy Group is currently working to get this policy adopted by every 24-hour setting, and it's being piloted in the new women's PICU (locked Psychiatric Intensive Care Unit).

Number thirteen is that we welcome children. Drayton Park is relatively unusual in that children can stay here with their mothers. This can be a challenge, of course, but many mothers have the main or sole responsibility for their children, and even if they are in acute distress many will wait until they are sectioned rather than leave their children. Fathers and other men in women's lives are also welcome to visit and be part of plans if the woman wishes.

Finally (fourteenth!) the service is provided in a homely, domestic setting with ordinary furnishings that you'd find in a house. We try hard to achieve this despite needing to stick to NHS policies about infection control, fire and ligature risks, which is sometimes a challenge. Women often comment that it's like a 'home from home'. The fabrics are warm and soft, and there's carpet on the floor which muffles noise. Both of those are important when working with traumatised women in crisis. The environment itself plays a huge role in enabling people's recovery.

Drayton Park has continued to thrive despite the many challenges we've experienced over the 21 years we've been open. The extensive development phase before opening allowed for very strong foundations to be built which have enabled the service to develop and flourish even though times have been hard for the NHS. We've lost some funding over the years due to NHS cuts and have had to limit some of our provision, for example cutting down on the groups we provide. It's only because the service has proved to be an effective alternative to hospital that we have survived. The Trust is committed to the service and has always supported us in

reorganising our resources so that we can continue to do what we are doing. The Trust also values having women's services and Drayton Park contributes to the Trust's positive reputation.

Anne: It must have taken real resolve and strength to keep the service going – indeed thriving - for so long when it's so counter-cultural in the NHS. I think the wider NHS culture may have diverged from yours even more in recent times. Things seem to have become increasingly stretched, medicalised and focused on managing immediate risk. Can you maybe say something about how you have overcome resistance and obstacles over the years?

Shirley: Well the first thing to say is there have been a lot! In the beginning it was senior men failing to see the need for a women's service and laughing at us in meetings, saying things like 'Do you think massage is going to cure schizophrenia then?' People stereotyped us as 'a bunch of lesbians' and spread rumours that men weren't allowed in the building. There's been a lot of misogyny and many challenges to the service's power base. For example, before the service started we secured agreement for it to run without a consultant psychiatrist. The service users who were part of the advisory group had fought hard to ensure that it was a real alternative to hospital, not just in the physical environment, but in the type of staff who would deliver it and the guiding ideas that they would draw on. However, I think some in the Trust found that idea threatening, and when the service opened a consultant psychiatrist was assigned to us anyway. When that person moved on we successfully argued for the funding to be used for three weekly sessions from a female GP instead. That worked brilliantly. We were able to look after women's physical health as well as their mental health, something there's been a lot of emphasis on recently. Sadly, we lost the money for that a while ago. Even now, every time a new senior manager starts in the Trust they ask why we don't have a psychiatrist, and we have to explain and argue our case. It isn't that a psychiatrist couldn't be helpful, it's the impact that their power and influence would be likely to have on the dynamics of the team, perhaps on the culture (which famously 'eats strategy for breakfast') on the guiding ideas, and on service users' confidence that the service offers a genuine alternative.

I also have to keep arguing the case for employing staff on the basis of experience, skills and attitudes rather than a specific qualification such as nursing. The national nursing establishment exerts pressure for certain roles or tasks to be reserved for qualified nurses. We aren't anti-nursing but that would limit who we could employ. Even if only the senior posts were reserved for nurses, that would affect not only the culture but the possible career trajectories (and therefore the attractiveness of the job) for non-nurses. The key to overcoming all these challenges has been to design and articulate a robust and safe alternative. I do understand the need to protect the boundaries of a professional group, and the NHS has to ensure it is employing staff who are appropriately qualified. However job descriptions, person specifications, the

recruitment process and staff contracts all provide assurance and protection for those who come to our service.

We do employ specialist staff on a sessional basis, including massage therapists who between them provide about twelve massages a week. This is an extremely popular part of the service and many women say that it is hugely helpful. Many have never had body work before. Often people ask to continue it after they leave and are referred on to low cost centres in the community as part of onward planning. We can also refer women to a counsellor who is with us one day a week. She is very experienced and can contain a high level of distress and trauma. She can offer up to 16 sessions, so continuing after the woman goes home if needed. This allows a significant piece of work to be done, and sometimes helps women prepare to engage in longer term therapy outside the statutory system. We try to promote this possibility to BME women in particular because we know that statistically they are less likely to have been offered talking therapy or counselling (Jeraj, 2015). For women who have disclosed abuse for the first time as this can be an opportunity to speak more about what happened to them while they are still in the place where they first disclosed. There is something about that connection to the house and the service that women value; there is a safety in that even though disclosing past abuse can feel very dangerous. The counsellor is experienced in working through trauma from historical abuse. Other women who often find the counselling invaluable include those who are considered high risk and have not been offered counselling in other settings for fear that the emotional work of therapy might increase the risk beyond what the service can contain. Throughout the year we also host poetry workshops run by Leah Thorn (http://www.leahthorn.com/) for women who have used the service. All of this adds to the richness of the trauma-informed environment that we are able to offer.

Drayton Park by Tanya Raaybe

Anne: Talking of people leaving, apart from the possibility of continuing with counselling, what support do you offer after women go home? I know for example that the first two weeks after leaving hospital can be really hard and are a peak risk time for suicide attempts (Wise, 2014).

Shirley: Every Wednesday we run a one-hour support group for women who've stayed here. Often women come back to the group for a few weeks after they leave. They say it makes a huge difference not having to go 'cold turkey' from the support we offer. Most come just for a few weeks but there's no time limit, and some people come for years. The group is facilitated by staff, and numbers vary from four to about eighteen women. It's not only the women who benefit – the Trust and community do too, as it's often enough to support someone and so reduces demand on other services.

Anne: Sounds great. I'm sure that many people who read this chapter will want to come and visit the service. Can they?

Shirley: Once a year we have an open day, which is brilliant for networking with other services and women's groups, and celebrating the life of the service. It's open to anyone who wants to come.

Andie: We also celebrate International Women's Day with whatever themes women choose – this year our theme was Women and the Menopause! Guests are always welcome.

Anne: That all sounds brilliant but nowadays we're often asked for formal evidence of effectiveness for any service. Is there any for Drayton Park?

Shirley: Yes, it's been quite extensively evaluated. In addition to the regular service user feedback that we collect, a number of formal evaluations have been published (Killaspy et. al., 2000; Johnson et. al., 2004; Howard et. al., 2010). The results suggest that many women choose a crisis house over hospital if they are offered the option. Once here, most prefer it, and it's also more cost-effective for the Trust as I mentioned earlier.

We're also continuously developing the service on the basis of feedback and in the light of experience. It's important to be honest and to acknowledge that like any service, we sometimes make mistakes and get things wrong. Sometimes we fail to offer someone a place when on reflection we probably should have. This kind of work is never an exact science, and it's important to acknowledge when you've got something wrong and reflect on this as a team so we are less likely to make the same mistake again. Women also have high expectations of our service and they tell us when they feel we haven't met them. We've even had some formal complaints. I feel strongly that it's important to listen carefully to the feedback and act on it. For example at one point there was a theme in the comments about the model not being followed at night. The policy is that women can make their own decisions about when to sleep, but some staff were telling women who were in the communal areas at night to go back to bed. We took the feedback about that seriously and wrote a new night guide for staff which is also available to residents.

Anne: I guess we need to stop soon but there are a couple of things I really wanted to ask. Shirley, you've been at Drayton Park for over twenty years. What motivates and sustains you to keep going?

Shirley: I was given a once-in-a-lifetime opportunity to develop a service from scratch with a group of amazing women. I was then privileged to be asked to manage it. Every day is different, and every day I'm inspired by something one of the team does or by one of the women staying. I'm indebted to the members of the Women's Strategy Group who are a supportive network for me. I was never interested in working in 'management' as such, but my role gives me the power I need to protect the service, and the creative freedom to keep developing it in response to feedback from the women here. Many of my Drayton Park colleagues over the years could easily have got more senior positions elsewhere, but they've stayed here because of the job satisfaction and their commitment to our goals.

In addition to my work here I've been active in helping the Trust improve its service to women more broadly, and a few years ago I was designated Women's Lead for the Trust. That role has allowed me to spread my wings, to get involved in providing training, and to lead on projects such as our domestic abuse programme which we run in collaboration with the organisation AVA (Against Violence and Abuse: https://avaproject.org.uk/). Really, what more could I want? I believe completely in what we are doing and every day I see the difference it makes to women's lives.

Anne: How do you see the service developing in future?

Shirley: There are four things I'd like to see. Firstly, I'd like us to build on the trauma-informed approach so we keep focused on this model. It is important to never rest on your laurels. Reflecting and revisiting principles on a very regular basis is essential for a health service. Secondly, I'd like to develop a clearer and more comprehensive training programme for staff within the service. Ideally it would be accredited so women could have something tangible to take with them when they leave that validates their learning and experience. For example we could perhaps offer something like a Certificate in Trauma Informed Women's Mental Health Practice, perhaps in partnership with a university. Thirdly, I'd like to involve more volunteers to offer informal support and contact to women, for example going on walks or doing gardening. The staff have to be very focused on their role so unfortunately rarely have the time to do that sort of thing. Fourthly, I'd like to encourage more research. I'm really glad that Hannah, a trainee from your programme, recently interviewed women for her thesis about their experiences of Drayton Park and their thoughts about how it compares to hospital (Prytherch, 2018).

Anne: She passed and we're meeting soon to talk about getting it published! OK the last thing that Gary asked us to include in this chapter was some critical reflection. What do the two of you think? Is there anything you would have done differently if you could go back, or something you would change if you could?

Shirley: We should have bought the house next door years ago and turned it into women's resource centre. The team are sure that if we had a day service as well, we could increase the number of women we divert from going into hospital and have a stronger base for women to flourish. I also wish we had more resources to support children coming to stay in the house, for example we used to have a local mobile crèche we could pay sessionally, but it's no longer available.

Andie: I'd like to have access to a day service and a crisis line staffed by the women I've worked with and with whom I've built a trusting relationship.

Anne: What do you think has kept Drayton Park going and enabled it to thrive where other crisis houses have come and gone? Why do you think there aren't more crisis houses?

Andie: I hope to see other crisis houses for women open. But for Drayton Park I think it's been Shirley's compassion and her unwavering commitment and determination, together with other longstanding and dedicated staff and the ever-strong army of kick-ass women from the Women's Strategy Group. We're always on hand to ensure Drayton Park won't be going anywhere. The women who've used Drayton Park also hold the thread firmly together. Its strength comes from us all – forever and always ready to fight the good fight!

Shirley: Time for lunch I think!

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