Women throughout the country are still admitted to psychiatric wards with mixed-gender living space. They should be able to expect their safety, privacy and dignity to be given a high priority by the trust and staff with whom they are in contact. However, sexual assault in psychiatric institutions is an issue of perennial concern (Garth, 1989; Tonks, 1992; Barlow & Wolfson, 1997). It is known that in psychiatric populations, childhood sexual abuse is associated with sexual and physical assault as an adult (Lipschitz et al, 1996). A 1995 study showed that 33% of women in-patients had experienced unwanted sexual comments or molestation although the majority did not report their experiences to staff (Thomas et al, 1995). This paper discusses the appropriate staff response to patients that do report assault.

Draft policies on preventing and responding to sexual assault on in-patient wards were published in 1993 (Subotsky, 1993). This was followed in 1996 by a policy document from the Royal College of Psychiatrists on sexual abuse in psychiatric settings (Royal College of Psychiatrists, 1996). It recommends that a clear policy for dealing with allegations should be a prerequisite and that staff should be properly trained in implementing the policy. It also recommends that adequate procedures must be in place to ensure that incidents are not being ‘hushed up’ and observes that a regular review of staff attitudes is important. It notes that it may be easy to dismiss patients’ complaints of sexual abuse or harassment, regarding them as delusions or exaggerated fears, and that the only way to minimise the occurrence of these acts in psychiatric settings is to deal with them appropriately. Local trust policy makes it clear that staff have a duty to report incidents ‘in-house’ and ensure that the service user is supported appropriately. Although both the College document and trust guidelines recommend staff training, neither specifies quantity, content or who should deliver it.

The NHS framework for mental health (Department of Health, 1999) acknowledges that while social and therapeutic activities will usually be mixed, there is an imperative both to ensure that single-gender day space is always provided and to achieve Patient’s Charter standards for segregated sleeping and toilet facilities across psychiatric wards. In 1995, this was noted on a standard form. There was little consistency between cases, and data recording was patchy.

In each case, Table 1 records verbatim the entries in the medical and nursing notes concerning the assault. It also records what else was done, such as adverse incident reporting or communicating with the general practitioner (GP), and what practical steps were taken in the aftermath of the assault.

Inadequate recording of data

Data on the frequency and seriousness of assaults upon patients in their care were not available to managers in this trust. Adverse incident forms were not completed uniformly and a systems failure meant that none of those that had been completed before April 1999 could be
<table>
<thead>
<tr>
<th>Gender</th>
<th>Diagnosis</th>
<th>Adverse incident in medical records</th>
<th>Medical records account</th>
<th>Nursing records account</th>
<th>Assault data and record-keeping</th>
<th>Subsequent steps and consequences</th>
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<tr>
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<tr>
<td>F</td>
<td>Depressive disorder F33.2</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Section 2 Man put arm around her, across her waist with his head in a kissing position while patient on the way to the toilet. Let go when patient shouted for help.</td>
<td>Increased to every 30 minutes. Discussed with husband about management of vulnerable people.</td>
<td>Patient advised to put complaint in writing.</td>
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</tr>
<tr>
<td>M</td>
<td>Schizophrenia F20</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Missing</td>
<td>Missing.</td>
</tr>
<tr>
<td></td>
<td>Date 1: claims to have been sexually assaulted in bed but too doped to know by who. Date 2: alleged forced anal intercourse following previous consensual intercourse.</td>
<td>Increased to close observations in day and one-to-one at night.</td>
<td>Patient advised to put complaint in writing by general practitioner.</td>
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<tr>
<td>F</td>
<td>Bipolar affective disorder. Currently manic F31.1</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not applicable</td>
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</table>

MHA, Mental Health Act 1983; STD, sexually transmitted disease.
*Case from search of incident forms.
retrieved from the computerised database. The handwritten forms were held in alphabetical order, based on patients’ names not the nature of the incident. It is also of concern that if the alleged assailant remained unnamed in the medical and nursing records, multiple allegations could be made against the same assailant over different admissions, with only the memory of long-serving staff to make the connection between current and previous assaults. Furthermore, the data on victims assaulted during a previous admission are not easily accessible to medical or nursing staff on the wards unless they read the handwritten entries throughout the case notes.

The NHS plan has recommended a full reporting scheme for adverse events, with a single national database. If this is achieved, it should address some of the concerns that are raised by the quality of the data-recording reported here. However, in the above series, adverse incident forms were completed in only half of the cases that were recorded in the medical notes. Only two of these six alleged assaults were reported to the police and only two of the discharge letters to GPs mentioned the assault.

Reasons for inconsistency

It does not seem that the quality of the data-recording was related to the severity of the assault, either in terms of details written in nursing and medical records, completion of adverse incident forms or informing the GP or the police. Staff may become habituated to sexually aggressive behaviours by psychiatric patients, so that such behaviour does not evoke the same level of outrage as would be expected when perpetrated against a less stigmatised group of individuals (Thomas et al, 1995).

Cases may be handled in a variety of ways in order to give a sensitive response to individual needs. However, variation may reflect staff attitudes towards the patient’s mental state and whether staff regard the assailant or complainant as a ‘trouble maker’. Staff may often find it difficult to know when to consider the behaviour of mentally disturbed adults as criminal. Also, there may be a tendency to dismiss such allegations as attention-seeking, depending upon the history of the previous relationship between the staff member and the patient.

Staff may rightly feel ambivalent about police involvement, hoping to spare their patients the ordeal of legal scrutiny. This concurs with a Mind survey (Pedlar, 2000) in which three-quarters of the professionals questioned considered there was a problem with denial of access to the criminal justice system for people with mental health problems. This was particularly so in cases of rape and sexual assault.

Clinical consequences of inconsistency

The local trust policy on sexual assault states that the system in place should acknowledge the validity of the woman’s experience. The use of increasing observations (although possibly intended as protective), coupled with increasing antipsychotic medication, is a particularly sensitive issue. It would be easy for the patient to misinterpret these actions as punitive, especially if procedural methods of demonstrating belief, such as completing an adverse incident form or discussing police involvement, are not performed at the same time. One patient, whose assault was witnessed by another, took her own discharge the next day and it may be that this decision was motivated by fear. Although she wished to make a complaint, it seems she was thwarted by her disturbed mental state and lack of someone to help her with this task.

Recommendations and limitations

The small number of cases in this series limits the generalisation of the conclusions about their management. The four cases found by examining case notes may be considered as representative, but they give no indication about management of alleged assaults that are not recorded in medical case notes. The two additional cases had already passed a threshold of sufficient concern to trigger completion of an incident form. However, the difficulty in collecting data on these cases, either across time or the whole patient group, highlights the ease with which assaults may be swept, if not under the carpet, then into the pages of handwritten continuation notes. National and local policies have not been put into practice in the management of these cases.

From consideration of this series, it is recommended that a minimum adequate response would be the completion of adverse incident forms; naming the alleged assailant in written records; mentioning the assault in the discharge summary and reporting to line managers. A specially designed incident form (above the requirements of the NHS plan), including time and description of the assault, and name of the alleged assailant and witnesses, could help clarify what is expected of staff in this situation. Without exception, this should be completed when there is an allegation of rape or sexual assault. Tick-boxes may be used to confirm that the relevant people had been contacted. Annual review of these forms may highlight weaknesses in layout or ward routine. Repeated allegations against the same person should be brought to the attention of those responsible for their care. This would enable rates and assault type to be monitored. The extent of the problem may then be assessed and protective interventions audited. Patients should feel safe on psychiatric wards, and any patient who has been frightened, injured or is at risk from infection or impregnation, should be encouraged to report the assault to the police. This would also relieve the staff from trying to ‘second guess’ the police response or themselves trying to assess the patient’s credibility. An appropriate adult needs to be present for all interviews with those who are mentally disordered (Home Office, 1995). A patient’s keyworker or social worker may do this. It is preferable that such workers have received appropriate training. The new Patient Advocacy and Liaison Service, due later this year, may be prepared to take on this role.
in 1995, city and hackney community NHS trust opened a segregated ward for women with severe mental illness who would be vulnerable on a mixed-gender ward (kohen, 1999). the privacy and safety provided by the unit and the positive response from families and the community makes the case for more single-gender wards. it is a pilot project that may be repeated by other trusts. meanwhile, both genders in mixed-gender wards should be cared for by staff who are vigilant for patients’ safety and trained to avert assault proactively. specific staff training upon recruitment, repeated at regular intervals, should lead staff to be confident about dealing with any assaults, and also ensure that the trust has information available to help prevent repetitions.

declaration of interest

none.

references


H. R. Rollin

Professor Sir ernst gombrich, OM

A ‘hands-on’ advocate of music therapy in mental hospitals

The outpouring of praise for the life and work of this remarkable man, who died this year, has been so fulsome that one might reasonably believe that the catalogue of his virtues had been exhausted. I would venture to suggest that two seemingly disparate virtues have been omitted or underplayed. I refer to his musicianship and his compassion. May I describe one occasion when these two virtues co-existed?

For many years before I retired in 1975, I was a consultant at Horton Hospital, Epsom, (now defunct) designed then for the treatment of most of the range of psychiatric disorders. The patients were of both genders, of all adult ages, of a variety of ethnic and religious groups and, because of the geographical distribution of our catchment area in London, there was an over-representation of refugees from Nazi Germany. It was, in effect, a strange microcosm characterised by one common factor – the unpredictability of its individual and collective behaviour.

Of the several forms of auxiliary treatments we had on offer at the hospital, the one which was a particular source of pride was music therapy. At the core of this most successful project, as it happens, was Sir ernst’s sister, Dea (Lady Forsdyke), a distinguished violinist and an inspired teacher-cum-therapist. It further happens that Sir ernst’s wife, Ilse (Lady Gombrich) was an eminent professional pianist and piano coach. The third limb of an outstanding family trio was no other than Sir ernst, himself a talented cellist. This unique ensemble played for their own delectation when time and occasion arose and, on very few occasions, for the delectation of others.

One of the major attractions of the music therapy project was to hold monthly concerts featuring members of the group for the entertainment of other patients at the hospital, any interested members of staff, and a surprisingly large number of patients’ relatives, who came mainly from London. All were welcome, and considering the limited number of available performers and the nature and degree of their mental ailments, our visitors seemed well pleased with the musical fare on offer. Even so, from time to time, as a bonus, the group and its attendant audience shared the pleasure of being entertained by professional musicians. I should explain that, at that time, I had the good fortune to enjoy the friendship of a number of professional musicians who, at my invitation, would play for us as a gesture of goodwill. The majority would waive their fee or agree a substantial reduction, or ask only for their expenses.

Working closely as I did with the group, I got to know Dea Forsdyke very well and, in the course of time,
Sexual assaults in psychiatric in-patient units: The importance of a consistent approach
Mary Cole
Access the most recent version at DOI: 10.1192/pb.27.1.25

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