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Developing a policy to deal with sexual assault on psychiatric in-patient wards

SUMMARY

Sexual harassment and assault on psychiatric wards is an ongoing concern. A number of incidents have been reported in the media. This

paper focuses on a policy drafted to deal with allegations of sexual assault or rape on an in-patient psychiatric ward. We aimed to produce a practical, easy-to-follow

guide for junior doctors and ward staff who may face complex and possibly contentious issues surrounding consent, capacity to consent and police involvement.

The problem

Thomas *et al* (1995) documented that 33% of female in-patients experienced unwanted sexual comments or molestation although the majority did not report this. Barlow & Wolfson (1997) stated that 56% of women had been pestered by men and that 8% had taken part in a sexual act against their will. In July 2006, the National Patient Safety Agency (2006) produced a report highlighting concerns about sexual assaults on patients in National Health Service mental health units. The media accused the Department of Health of 'sitting' on this report.

Consenting sexual activity on in-patient wards and what constitutes consent is always going to be a controversial issue. The fact is that in-patients are having physical relations. A study at Imperial College (Warner *et al*, 2004) found high levels of sexual activity among in-patients on acute psychiatric wards. Thirty per cent of the patients in the sample had engaged in some form of sexual activity. In a similar survey of chronic psychiatric patients in British Columbia, Canada, the figure was 38% (Welch *et al*, 1996).

Welch *et al* (1996) state that chronically hospitalised patients have a right to sexual intimacy and that staff therefore have a duty to accept the individual's sexuality, in an empathic, non-judgemental and humane manner. However, the hospital also has a duty to protect in-patients from possible harm arising from sexual encounters, and that sexual harassment and assault in any form should not be tolerated. An individual's mental state may affect their ability to consent and, even if they do consent, they may regret this later. How far we can enforce behaviour and protect patients from exploitation before we encroach on freedom of expression and Human Rights legislation is very difficult to determine.

The need for a policy

When patients are found engaging in, or report, sexual activity, staff must consider various factors. These include whether or not either or both individuals have capacity to consent to the act, if the behaviour should be deemed criminal and therefore whether the police should be involved.

Capacity to consent and its fluctuating nature pose dilemmas for staff. The spectrum from exploitation to assault needs careful consideration. Mental illness, learning disabilities, dementia or substance misuse can cause an imbalance of power and make a person more vulnerable to abuse or coercion and possibly incapable of consent. A policy is needed to guide staff, especially junior medical and nursing staff, through this process.

Subotsky (1993) recommended putting in place policies on consenting sexual activity and the prevention of sexual harassment and assault on in-patient wards, plus a procedure in the event of alleged or apparent sexual assault. Following this, the Royal College of Psychiatrists (1996) now recommends that all centres should have policies covering both sexual relationships and sexual harassment or abuse and that there should be procedures for monitoring and auditing incidents and allegations.

Actions in the event of an incident

Any alleged or apparent assault should be treated as a serious incident and the documented procedure followed. The fact that it occurred on a psychiatric ward must not alter how it is dealt with and it could be argued that, given our duty of care to protect people who are vulnerable, staff may need to take the lead in pursuing police



involvement. Staff need be very careful not to dismiss accusations or reports as delusions, exaggerations or deliberate untruths and to bear in mind that an assault may involve two patients or a member of staff and a patient.

In the event of a patient reporting an assault, staff having suspicions or someone witnessing an untoward incident, a senior member of the nursing staff and a doctor should be contacted. The most senior doctor and nurse present should be responsible for implementing the policy.

Any physical injuries and ongoing risks to the victim, other patients or members of staff need immediate attention. As obvious as it may seem, staff and patients may need reminding that sexual assault and rape are crimes and need to be reported to the police. In most circumstances, it would be inappropriate for the psychiatric doctor to perform a sexual assault examination; a forensic medical examiner or a gynaecologist with experience of forensic issues should do this.

If there is any likelihood that the police may be involved, the area needs to be cordoned off, as it may become a crime scene, and both patients advised not to shower or bath. The interviewing needs to be sensitive at the same time trying to ascertain some basic facts. The alleged perpetrator needs to be informed of the allegation and given an opportunity to explain their version of events. It should be explained to them that the police might be involved.

Locally, we are lucky enough to have access to 'The Haven', which provides medical, forensic and psychosocial support for victims of sexual assault. More information on national sexual assault referral centres is on the Metropolitan police website (www.met.police.uk/sapphire).

The risks of pregnancy and sexually transmitted diseases also need addressing. Our local primary health care trust have provided us with prescribing information and a proforma for post-coital contraception to be used by junior doctors. This is to avoid any delay in prescribing. Post-coital contraception is a safe and effective intervention that should be offered as soon as possible after a sexual assault to reduce the risk of pregnancy. The hormonal method is widely available through nurse-led clinics and pharmacies and has very few contraindications, so doctors from all specialties should be able to prescribe it. Advice on prophylactic antibiotics should be taken from the local Department of Sexual Health or sexual assault referral centre.

Determining capacity, consent and fitness to be interviewed

Careful clinical assessment of the person's mental state is essential to ascertain whether there is a disorder of attention, memory, language, thought form, thought content, perception, mood or control that is 'severe enough' to render the individual incapable of consent to activity or responsible behaviour (Welch *et al*, 1996).

The Royal College of Psychiatrists (1996) highlights the paucity of research into assessment of capacity to consent to sexual activity in contrast to consent to medical treatment. Abuse ranges from exploitation to overt assault and an imbalance of power in a relationship interferes with the ability to consent (e.g. staff–patient or a relationship involving an adult with severe mental illness or learning disability). Capacity to consent is dynamic and specific to the alleged offence.

With regard to the alleged perpetrator, Bayney *et al* (2003) draw attention to the fact that in some instances mentally disordered offenders do have responsibility for their criminal behaviour, since they have an understanding of what is right and what is wrong and they can exercise choice in their decisions. This may need to be brought to the attention of the police and possibly members of staff. The patient's consultant should prepare a report on the alleged offender and the offence to aid the police.

Incident documentation

Adequate documentation and reporting is paramount. Cole *et al* (2003) highlighted the inadequate recording of data in the event of sexual assaults and suggested that a number of factors led to this outcome. These included the fact that staff may be habituated to sexually aggressive behaviour by patients so that the behaviour does not provoke the same level of outrage that would be expected when perpetuated against less stigmatised individuals (Thomas *et al*, 1995). Other factors were staff attitudes to both the victim and perpetrator and either the victim or staff not wanting to pursue the legal path.

Cole *et al* (2003) made the recommendation that (as a minimum) an incident form should be completed, the assault mentioned in discharge summary, the assailant named and the assault reported to a line manager. Further suggestions in that paper included the development of a special incident form for sexual assaults that could be reviewed and audited and also that repeated allegations against the same person must be brought to the attention of their consultant.

Our policy implementation

Policies obviously help guide staff but it was felt that, in addition, a flow chart and guidance on judging consent would help more junior members of the team take appropriate action immediately. New policies need to be approved by the trust and then disseminated to clinical members of staff. Initial training of senior staff (matrons, lead nurses, team managers) will follow and then training of other staff can be undertaken. The policy will also need auditing. Specific trust staff should be assigned to each of these roles. Our policy is awaiting formal implementation by the trust but is currently being used as a proforma by the Health, Safety and Security Nurse Manager (Fig. 1 and Box 1).



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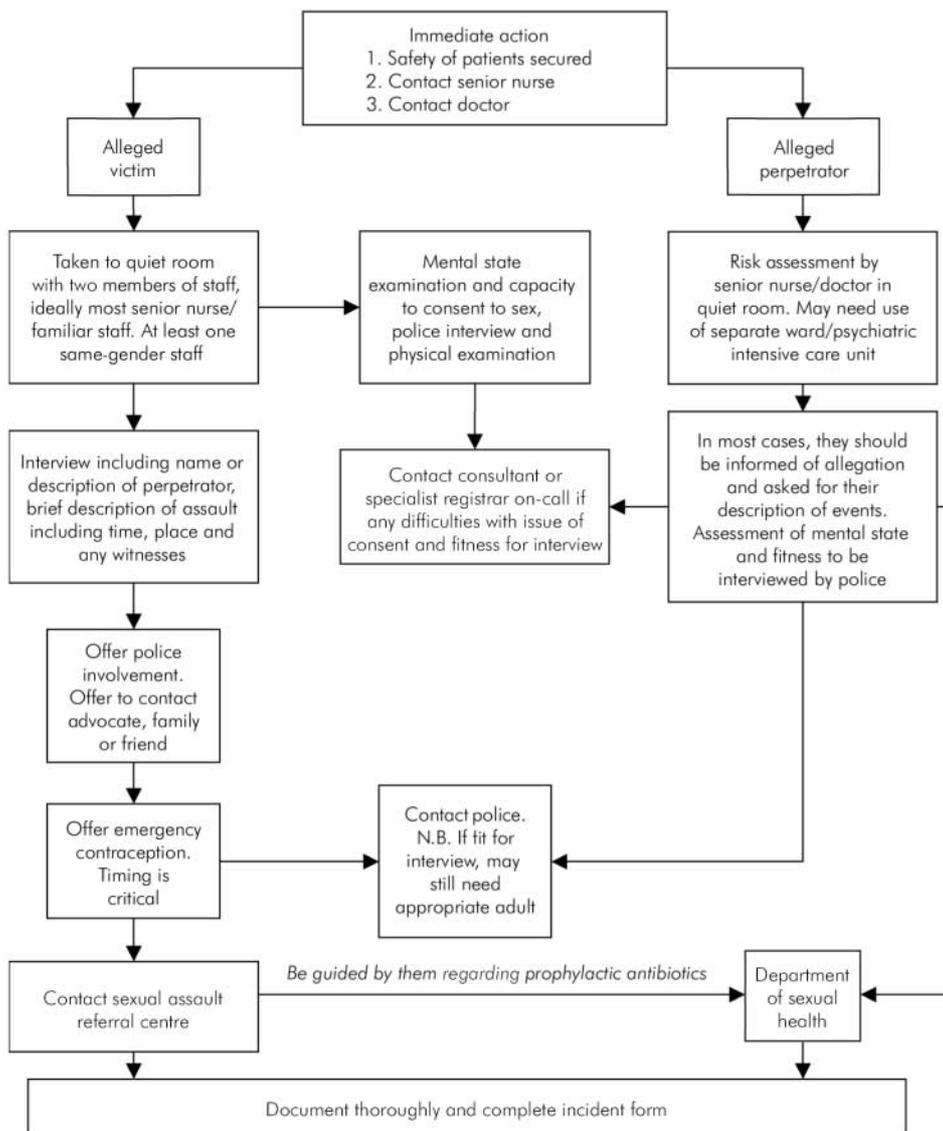


Fig. 1. Flow chart for alleged/suspected sexual assault. See Box 1 for guidance on use.

Box 1. Alleged/suspected sexual assault

The following is provided as guidance with the flow chart.

Testing capacity

(After Home Office (2000) proposals and Royal College of Psychiatrists (2001) response.)

1. Did the alleged victim understand the nature of the act, e.g. penetration?
2. Did they understand they had the right to say 'no'?
3. Had the person concerned understood the benefits and risks of such a course of action, e.g. that it should be pleasurable but can carry the risk of sexually transmitted diseases (STDs) or pregnancy and the ramifications of these?
4. Was the person able to balance these factors and communicate their wishes?
5. Were they free from duress (threats or inducement)?
6. Does their mental disability mean they are more easily threatened or induced to engage in behaviour that they normally would not have done?

If the answer to any of the above questions 1 to 5 is 'no' or the answer to question 6 is 'yes', the person concerned may have lacked capacity to consent to the activity

Fitness to be interviewed

Fitness to be interviewed by the police needs to be assessed for both the alleged perpetrator and victim (Gudjonsson et al, 2000; Bayney et al, 2003).

1. Do they understand the police caution? (perpetrator only)
2. Are they fully orientated?
3. Do they recognise key persons?
4. Do they understand the consequences of their answers and actions?
5. Could their answers be misconstrued?
6. Would conducting the interview worsen any existing physical or mental illness?
7. Could anything they say or do be considered unreliable in a subsequent court hearing?



Declaration of interest

None.

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Medical treatment under Part IV of the Mental Health Act 1983 and the Human Rights Act 1998: review of Article 3 and 8 case law

SUMMARY

Since the introduction of the Human Rights Act 1998, all courts and tribunals are obliged to interpret all laws and statute consistently and compatibly with the Human Rights Act. This

includes the Mental Health Act 1983 (and the 2007 amendments) and mental health review tribunals. Mental health case law has evolved with regard to medical treatment under Part IV (Consent to Treatment)

of the Mental Health Act being compliant with the Human Rights Act. Review and analysis of such case law can aid everyday clinical decision-making as well as improving knowledge of the Human Rights Act.

The Human Rights Act 1998 (Office of Public Sector Information, 1998) incorporates most of the European Convention on Human Rights into domestic law and sets out fundamental rights that all people are entitled to enjoy. Since the Human Rights Act came into force, all courts (including mental health review tribunals) must now ensure that domestic law is fully compliant with the Human Rights Act. This includes the Mental Health Act 1983 (Mental Health Act) (Jones, 2006).

The important judgment in *Herczegfalvy v. Austria* [1992] observed that '... the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with'. Human Rights Act jurisprudence has emerged with regard to individuals receiving treatment under the Mental Health Act. This article analyses important mental health law cases which have concentrated on treatment under the Mental Health Act and in particular relying on Articles 3 and 8 of the Human Rights Act.

Article 3

Article 3 is an absolute convention right and states that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'.

In the psychiatric setting, this Article is likely to be relevant to complaints arising from treatment and conditions of detention. Treatment can be construed as inhuman if it causes intense physical or mental suffering in the victim; and degrading if the object is to humiliate and debase the person which could adversely affect their personality. It may be found as degrading if it involves treatment which arouses feelings of fear, anguish, inferiority and that shows lack of respect for or diminishes their dignity (*Pretty v. UK* [2002]).

To violate Article 3, case law has concluded that 'ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3'. Furthermore, the 'assessment of this minimum is, in the nature of things, relative; it depends on the circumstances of the case, such as the duration of the treatment, its physical or