

Viewpoint: Prosecuting rape and sexual assault cases

Recent research and reports have highlighted that the impact of sexual violence has to be an area of increased concern for all mental health professionals. Mental health service users are more likely to have been subject to sexual violence. In addition, there is the potential for the revictimisation of vulnerable service users. Bengsten- Tops and Ehliesson (2011) carried out a study involving 174 patients. 67% of this cohort had been the victims in adulthood. 39% had been threatened at some point, 51% had been assaulted and 32% had been the victims of sexual assault. 33 % of the cohort had been a victim in the previous twelve months – 15% had been subjected to sexual violence in that period. Women reported greater exposure to violence than men. These patient histories of trauma are often not acknowledged by professionals (Howard et al, 2010). If they are there is not an appropriate response (Nyamie et al, 2013). Khalifeh et al (2014) conclude that men and women who experience severe mental illness and are in contact with psychiatric services are 2-8 times more likely to experience domestic violence or sexual assault. .

In the report, *At Risk Yet Dismissed* (Pettit et al, 2013) 9% of victims reported crimes that had taken place in psychiatric settings. This study reveals the impact of violence. Participants reported that they felt fear, shame and embarrassment in the aftermath. The negative impact on mental health was also documented with participants reporting feelings of distress. In some cases, the mental health of victims deteriorated and the crime triggered a relapse and subsequent admission to hospital. This study also highlighted the concerns that individuals had that would prevent their reporting incidents to the police. A previous negative experience with the police was a factor here. The interviewees were extremely conscious that the fact that they had a mental health problem could potentially be used as a basis for discrediting their account. It is, particularly, regrettable that many thought that they might even be detained under the MHA if they reported a crime

We have written two recent papers that have examined the experiences of people with mental health problems, who have been victims of rape, sexual violence and assaults. In the first, we discussed the findings of the SCR that followed the death of Mrs A (Foley and Cummins 2015). Mrs. A was a talented violinist and attended the prestigious Chetham's School of Music in Manchester. An Inquiry has taken place into the school because of a

series of cases of the sexual abuse over pupils. Mrs. A was abused and sexually assaulted by a teacher Michael Brewer and his wife. The Brewers were both found guilty of sexual offences against her. Mrs. A took her own life after having given evidence against in the trial and before the verdict was returned. The case highlighted the huge barriers that victims of sexual assault still face in reporting incidents and then going the Court process to secure a conviction. The second paper, Foley and Cummins (2018) was based on FOI requests to police forces and MH Trusts. The FOI requests asked for recorded information about the number and nature of the rapes and sexual assaults that took place on mental health units over a five-year period. The paper highlighted the 'gap' of information in relation to recorded rape and may indicate that complainants with a history of mental illness are less likely to have their allegation recorded as a crime. Existing research then would indicate that adult inpatients, especially women, are at increased risk of sexual victimisation and are less likely to have their allegations recorded as a crime. When they do, they experience much higher rates of attrition than other rape cases (Ellison et al., 2015). Despite this background knowledge, the recording practices of both the police and NHS trusts remain hugely variable.

The interim report of the review of the Mental Health Act has further highlighted concerns about the environment on mental health units. It is important to emphasise here that those who are inpatients whether voluntary or detained under the MHA are owed a clear duty of care by all mental health professionals. The most fundamental of these is to ensure that individuals are physically safety during an admission to hospital. The recently published report outlined that in far too many cases, individuals did not feel safe or treated with dignity and respect during an admission to hospital. Service users and carers gave examples of a number of distressing experiences and unacceptable practice. These included witnessing or being subject to physical violence, verbal abuse and threats, bullying and harassment as well as sexual harassment and violence.

The above forms part of the backdrop to the CQC report *Sexual Safety on Mental Health Wards*. The report was the result of work that began following the inspection of a trust in 2017. The CQC then reviewed reports submitted through the NHS National Reporting and Learning System. . The CQC analysis looked at 60,000 reports from MH Trusts. It

discovered that 1,120 of these were sexual incidents. In addition, the CQC held four stakeholder events to explore these complex issues. They involved patients, staff, visitors and others. The CQC analysis concluded that 457 of these incidents could be categorised as sexual assault or sexual harassment of patients or staff. From the stakeholder events, the CQC concluded that

- *People who use mental health inpatient services do not always feel that staff keep them safe from unwanted sexual behaviour*
- *Clinical leaders of mental health services do not always know what is good practice in promoting the sexual safety of people using the service and of their staff*
- *Many staff do not have the skills to promote sexual safety or to respond appropriately to incidents*
- *The ward environment does not always promote the sexual safety of people using the service*
- *Staff may under-report incidents and reports may not reflect the true impact on the person who is affected*
- *Joint-working with other agencies such as the police does not always work well in practice*

The CQC will be working with all stakeholders to co-produce guidance to improve the overall responses to such incidents and ensure the sexual safety of patients. These issues, of course, apply across mental health and other services and are not limited to mental health units. As noted above, people with mental health problems are at greater risk of being victims of crime. The research also indicates that women who use mental health services are more likely than the general population to have been subjected to sexual violence and assault.

One of the consistent elements of social or vulnerability models of mental illness is that they recognise the potential impact of trauma. In addition, Sweeney et al (2016) note in their review of Trauma Informed Approaches (TIA) that mental health systems can be sites of initial trauma or further trauma. There are broad definitions of trauma but Sweeney et al quote the following one

Trauma refers to events or circumstances that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional and/or social well-being (SAMHSA, 2014)

Trauma can be a single event or a series of events. The definition is broad enough to include experiences of interpersonal violence, for example sexual abuse and physical assault as well social trauma such as inequality and marginalisation. Individuals may experience personal trauma whilst at the same time being caught up in community traumas. The reaction of authorities or public services to the individuals, families, groups or communities can compound trauma. This includes experiences of the arbitrary abuse of state power. The experiences outlined here demonstrate that mental health inpatient admission can be a form of trauma. Retraumatization occurs when a person experiences an event that triggers memories of a past traumatic event. This event then triggers similarly emotional responses - fear, anxiety, and depersonalisation - to those of the original event. Bloom and Farragher, (2010) argue that current mental health systems with their inbuilt focus on coercion and control have the potential to retraumatise survivors. This may occur via the use of physical restraint and seclusion.

The CQC report emphasised that mental health services need to be much more aware of the potential impact of sexual violence. Part of this response has to be robust systems for the recording of incidents as well as providing appropriate support to those who report incidents of sexual assault. This includes ensuring that service users feel able to report such offences in the first place and then sensitively handling the subsequent investigation. In particular, it is vitally important that individuals do not think that their reports will be dismissed based on their status as patients. Systems should provide additional support to ensure that reports of sexual assault are investigated fully.

There have been hugely significant changes to the law and services to support victim-survivors in this area. However, rape and other forms of sexual assault remain the most under-reported crimes (Brown et al, 2010). The attrition rate remains high and cases “fall out” of the CJS at various points. Institutional responses across a number of areas continue to be influenced by stereotypes of rape, rapists and their victims “Rape myths” continue to have powerful cultural influences at all levels of decision making. Given all of the above, it is with great concern that we read reports that prosecutors are being advised that they should not pursue so-called “weaker” cases in attempts to raise the successful prosecution rate in rape cases (<https://www.theguardian.com/law/2018/sep/24/prosecutors-rape->

cases-cps-crown-prosecution-service-conviction-rates). The advice was given to specialist rape prosecutors in training seminars. There are concerns that this is an undeclared change in policy. Those cases involving inpatients on mental health units or individuals with mental health problems will almost inevitably be seen as "*weaker cases*". It is a traumatic experience reporting rape and sexual assault. This trauma can be potentially deepened in cases where the survivor -victim has a history of mental health problems. The pressures may have a negative impact on the individual's mental health. In addition, there are many barriers to investigate such cases thoroughly and sympathetically. One of these is an ongoing belief that survivor-victims will not be seen as "*credible*" witnesses.

Paterson (2014) defined TIA as "*a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development*" Services need to be organised and delivered in ways that recognise that service users have potentially been exposed to various forms of trauma. Services need to ensure that they are ethically informed and safe. The CQC guidance and further work on sexual safety on wards is informed by such an approach. The concern is that the CPS advice runs completely counter to this. Moves to improve the prosecution of rape and sexual assault cases are welcome. They should not be implemented at the expense of one of the groups - people with mental health problems. This group is at most at risk of being assaulted but also of having their reports of such incidents dismissed. These are, in fact, cases where all involved need to provide greater support to those reporting such offences. The CPS guidance is going against the grain in that mental health services have recognized that much more needs to be done in this area.

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