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Responses to inpatient victimisation in mental health settings in England Wales

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Abstract

Mental health inpatients are known to be at risk of criminal victimisation but the experiences of this vulnerable victim population seldom receive mention in the victimological literature. Against this backdrop, this article explores to what extent and in what ways mental health inpatients report victimisation and provides the first systematic analysis of what the existing evidence base tells us about the subsequent responses of mental health services and criminal justice agencies. Identified knowledge gaps are problematized as impediments to evaluation of both policy and practice in this context. An agenda for future research is additionally sketched out.

Key words

victimisation, crime, inpatient, mental health, police

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Research over two decades has consistently depicted mental health wards as being potentially unsafe places. This literature demonstrates that both people receiving treatment and those providing treatment are potentially vulnerable to becoming victims of criminal acts. To date, the area that has attracted greatest attention is that of inpatient violence and aggression within mental health services, however, much that is written on this topic has focused on predicting who may become violent, the impact on mental health professionals and containment interventions to manage incidents (Hill, 2006; Flannery, 2005; Stevenson et al., 2015). Significantly less attention, meanwhile, has been paid within these debates to inpatient victims, their experiences of victimisation at the hands of fellow inpatients, non-clinical responses to these potential crimes and the involvement of the criminal justice process. At the same time, in England and Wales, bodies, including the Mental Health Act Commission (2006) and leading mental health charity Mind (2004, 2007), have voiced worries about the 'hidden' nature of crimes against mental health inpatients and the responsiveness of relevant agencies to reports of victimisation by this population. Such concerns echo those raised in relation to the victimisation of populations resident in other care and institutional settings, including disability residences, aged care facilities and prisons (Crossmaker, 1991; O'Donnell & Edgar, 1998; Clark & Fileborn, 2011). Against this backdrop, this article explores to what extent and in what ways mental health inpatients report victimisation and provides the first systematic analysis of what the existing evidence base tells us about the response of mental health services and criminal justice agencies when potential criminal offences are disclosed or otherwise identified. In mapping out the current state of knowledge in this area - as well as the relevant policy framework - our aim is to highlight where (significant) knowledge gaps lie and to problematize these gaps as impediments to evaluation of both policy and practice in this context. We additionally use this analysis to sketch an agenda for future research.

Before embarking on our discussion, it is important to underscore that we are duly sensitive to the fact that inpatients are also vulnerable to criminal victimisation by professionals working within mental health services (Davidson and McNamara, 1999; Williams and Keating, 2000; Melville-Wiseman, 2015). We nevertheless take the view that these cases – while no less deserving of attention - give rise to issues that demand dedicated consideration.

Dividing our discussion across three broad parts, in Part I, we provide an overview of relevant policy guidance and statutory obligations applicable in this context. In Part II we review findings from existing studies regarding the scale of victimisation experienced by mental health inpatients and the handling of reported victimisation by mental health services and criminal justice agencies. In Part III, we reflect on the implications of these findings and map out avenues for further research.

I. Policy Context

Inpatients in mental health settings are identified as 'vulnerable adults'[2] and, as such are subject to adult safeguarding procedures under the Care Act 2014 and accompanying guidance (Department of Health, 2016) - which in England replaced the Department of Health's former No Secrets guidance (Department of Health, 2000; see also Dunn, 2000). While detailed consideration of this statutory framework falls outside the scope of this paper, it is relevant to note that adult safeguarding is aimed at people with care and support needs who may be in vulnerable circumstances and is primarily directed at

[2] A 'vulnerable adult' is an individual who (a) has needs for care and support and; (b) is experiencing, or at risk of, abuse or neglect; and; (c) as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect – Care Act 2014 section 42.

protecting such persons from the risk of neglect or abuse. All patients are owed a duty of care which includes protecting personal safety whilst an inpatient. NHS Mental Health Trusts are additionally charged with establishing operational policies and procedures, backed by training, which facilitate an effective and timely response whenever a patient in their care is deemed at risk of 'abuse', or has experienced abuse, including potential crimes (Department of Health, 2016). These obligations extend to taking immediate action to ensure the safety of a vulnerable adult. Statutory guidance produced by the Department of Health (2016) makes plain, however, that safeguarding is not a substitute for 'the core duties of the police to prevent and detect crime and protect life and property' (para. 14.9) and lead responsibility for investigating 'abuse' that amounts to a suspected crime is firmly located with the police (para 14.91). There is, in short, an expectation that suspected crimes against mental health inpatients (whether perpetrated by fellow inpatients, staff, others) will be reported to senior managers and, in turn, that due consideration will be given to police involvement (Department of Health, 2016).

Meanwhile, official police guidance makes plain that that 'normal investigative procedures' should be followed when responding to complaints made by or against people in therapeutic settings (ACPO, 2010: para. 7.7) Officers are specifically directed to 'secure evidence in the normal way and seek as much background information and professional opinion as possible on the patient and their relevant history' (College of Policing, 2016). The mental health inpatient status of the alleged victim and / or offender is thus no bar to criminal investigation. While stated government policy in recent decades has appropriately placed an emphasis on diverting 'mentally disordered offenders'[3] away from the criminal justice process (Home Office, 1990), in respect to inpatient suspects, officers are explicitly reminded that '[n]othing in law prevents the criminal prosecution of

[3] Defined by the Mental Health Act 1983 - as amended by the Mental Health Act 1997 - as 'any disorder or disability of the mind'.

someone who is a patient in a mental health hospital where there is evidence of an offence and where it is in the public interest to charge a suspect' (College of Policing, 2016). Whether diversion best serves the public interest in any individual case is a question that is, in line with guidance, to be carefully weighed after police investigation.

When addressing how the police are to respond to allegations of crime against people with mental health issues, the guidance provides that officers should record all complaints received from this victim population (in accordance with Home Office Counting Rules[4]) and should 'ensure that investigations are as thorough as they would be for others, without assumptions about reliability' (College of Policing, 2016). To this end, officers are instructed that they should assess an alleged victim's suitability to give evidence in criminal proceedings on a case by case basis, as with any other potential witness, both in terms of the potential quality of the evidence and the impact on their ongoing health. The overarching message is that victims with mental ill health should have equal access to justice and be treated with respect and dignity:

> '…Their ability to report crime and have that investigation carried out fully must not be prejudiced by their additional needs. Officers and staff should not assume that mental ill health in any way equates to the potential unreliability of that person as a victim or witness' (College of Policing, 2016).

To do otherwise, it is acknowledged, risks violation of the European Convention on Human Rights (Article 3), as recently confirmed by the courts in FB v DPP [2009] EWHC 106 (Admin) (Ellison, 2015).

In the event a case is referred to the Crown Prosecution Service (CPS) for potential prosecution, prosecutors are first required to consider if there is sufficient evidence that

[4] The Home Office Counting Rules provide a national standard for the recording and counting of 'notifiable' offences recorded by police forces in England and Wales (known as 'recorded crime').

an alleged offence has been committed by the accused (actus reus) and that the offence was committed with the requisite 'guilty mind' (mens rea). Once a decision is taken that there is enough evidence to justify a prosecution, prosecutors are required to consider if this option – or alternatives, including diversion away from the criminal justice system - is in the public interest, weighing an alleged offender's health, welfare and treatment needs with the seriousness of the offence and or the persistence of offending (CPS, 2013). In cases involving alleged offenders receiving inpatient care, prosecutorial decision-making is to be informed by 'medical reports from the responsible clinician to explain the nature and degree of the mental disorder, and any relationship between the disorder and the treatment and behaviour of the offender' and 'any other relevant information from hospital staff, including the treatment regime and any history of similar and recent behaviour' (Crown Prosecution Service, 2008). Other factors to be taken account of include the views of a mental health professional on the probable impact of a prosecution on the alleged offender's health; the likely impact of a prosecution on future offending, the risk of causing harm to others and past offending history.

It is against this backdrop, then, that we now turn to review what the current evidence base reveals about the scale of victimisation experienced by mental health inpatients and the handling of reported victimisation by mental health services and criminal justice agencies.

II. Overview of existing research

Relevant publications were searched in the databases MEDLINE, PsychINFO, Criminal Justice Abstracts, Google Scholar and in grey literature spanning twenty-five years

(1992-2017). Articles were reviewed and the reference sections of the pertinent articles were combed for additional articles of relevance.

Inpatients' experience of victimisation: the scale of the problem

As mentioned, inpatient violence within mental health services is widely debated within the literature but often in relation to the impact on mental health professionals. While yet to attract the same level of attention, available evidence indicates that mental health inpatients also experience violence from fellow patients. Relying on anonymous questionnaires, Loubser et al. (2009) surveyed 900 inpatients across 139 wards and found that 25% of inpatients on Psychiatric Intensive Care Units (PICUs) had experienced physical assault at the hands of other inpatients as had 15% of their counterparts on acute wards. These figures sit alongside the findings of a second large-scale survey which found that 37% of inpatients (1386 inpatients across 120 acute wards, 25 psychiatric intensive care units, 25 forensic wards and 14 rehabilitation wards) reported 'being threatened, attacked and made to feel unsafe" while in hospital (Chaplin et al., 2006). Reporting similar findings, Mind's 2004 national survey of 335 current or recent inpatients recorded that approximately half (51%) of respondents reported experiencing verbal or physical threats during their hospital stay while 20% reported being the victims of a physical assault (level of injury not recorded). Fifty six percent of incidents of harassment or assault were perpetrated by an inpatient, 31% by a ward staff member (perpetrator in remaining cases unspecified). Adding to this evidence base, Jones et al. (2010) interviewed inpatients (n=60) recruited randomly from 60 psychiatric wards and found that just under half of the group (45%) had either witnessed or experienced violence or aggression on mental health units, either during their current stay or during previous episodes of inpatient care. Twelve participants reported being

the victims of ‘aggression’ by other inpatients, with incidents ranging in severity from being verbally abused, having their clothes ripped to being hit. Focusing on female inpatients, Janicki (2009) conducted a review of violent incidents in a women’s enhanced medium secure service[5] over the space of a year and found evidence of ten physical assaults by inpatients against other inpatients which resulted in physical injury (level of injury not recorded). The study drew upon reported incident data and thus excluded incidents that went unreported (or not recorded). Other studies, meanwhile, highlight the devastating impact violence can have on inpatients’ feelings of safety and security in hospital (Wood and Pistrang, 2004; Janicki, 2009). Inpatients interviewed by Quirk et al., (2004) for instance, described living ‘on a knife edge’ (Quirk et al., 2004: 2577) due to a perceived risk of violence on some wards and described resorting to evasive action to maximise their personal safety, including avoiding situations and individuals perceived as ‘risky’ or ‘dangerous’ (see also Janicki, 2009; Jones et al., 2010).

Sitting alongside this research, studies spanning over twenty years highlight the elevated vulnerability of female mental health inpatients to sexual violence and exploitation (Thomas et al., 1995; Barlow and Wolfson, 1997; Sainsbury Centre for Mental Health, 1998; Mind, 2004; Mezey et al., 2005; Scobie, 2006). In a survey of 309 acute psychiatric wards conducted by the Mental Health Act Commission in collaboration with the Sainsbury Centre for Mental Health in 1996, for example, 57 per cent of staff reported that women patients were ‘sexually harassed’. ‘Sexual harassment’ was utilised as an umbrella term to encompass disinhibited behaviour and remarks, ‘exploitation’ of vulnerable women, exposing/nudity of male patients and sexual assault (Warner and

[5] A women's enhanced medium secure service is a facility designed for female patients who require an enhanced level of treatment and care but in a medium secure setting because there is a higher risk of these patients self-harming and disengaging from the service.

Ford, 1998). In Mind's previously mentioned Ward Watch Survey (Mind, 2004), 18% of respondents reported having experienced 'sexual harassment' whilst an inpatient and 5% reported 'sexual assault' (definitions absent), while female inpatients interviewed by Mezey et al. (2005) claimed that unwanted sexual attention from male inpatients was so frequently experienced that they were constantly anticipating and watching out for potential threats. On a larger scale, the National Patient Safety Agency (NPSA) (2007)[6] reported 887 recorded 'patient safety incidents' related to sexual safety involving mental health service users during the period October 2006 to September 2007. Of these, 44 incidents were found to describe an allegation of rape or 'sexual assault'. Other sexual safety incidents recorded notably included incidents classified as 'touching' (n=115) - conduct which could, in the absence of lawful consent, also amount to an unlawful sexual assault (Sexual Offences Act 2003). These studies predate Government moves to eliminate mixed sex wards from the NHS (Chief Nursing Officer and Deputy NHS Chief Executive, 2011). Evidence nonetheless suggests that this goal remains elusive with male and female inpatients continuing to share communal spaces even if they do not share sleeping accommodation or bathroom facilities, thereby leaving female inpatients at continued risk of sexual violence. Bearing this out, in 2014, for example, The Guardian newspaper obtained data from police forces under the Freedom of Information Act 2000, recording 1,615 sexual assaults in British hospitals between 2011 and 2014. While most police forces were unable to confirm a breakdown of the type of hospitals where rapes and sexual assault had been reported, the Metropolitan police (which accounted for 20% of all reports) confirmed that sexual violence was a significant problem in mental health units, with a substantial proportion of alleged victims identified as vulnerable due to a history of mental distress (The Guardian, 31 December 2014).

[6] The national NHS patient safety team is now part of NHS Improvement.

This body of research is notably consistent with findings from other jurisdictions, including the United States (Berland and Guskin, 1994; Frueh, et al., 2005; Grubaugh et al., 2007; Broderick et al., 2015) and Australia (Burdekin et al., 1993; Davidson, 1997; Victorian Mental Illness Awareness Council, 2013) where the vulnerability of mental health inpatients to physical and sexual violence has been similarly documented.

While less reported in the research literature, there is evidence that the victimisation of inpatients by fellow inpatients extends to the theft of personal possessions. In Jones et al.'s aforementioned study, for example, 25 respondents (42%) claimed that they had property stolen from them, or knew others who had had their property stolen. The most common items to be taken were clothing, money, cigarettes and toiletries. Some respondents talked about their personal strategies to protect their property:

> 'I keep my property safe by getting my clothes out of the laundry as soon as possible when they are dry and I lock my money up in the lockers provided' (Jones et al., 2010: 127).

Reporting Offences

Only a handful of studies were found to have considered whether inpatients had gone on to disclose their victimisation to staff, the police or a third party and only three supply quantitative data on reporting by this victim population. Of these, Mind's Ward Watch Report (Mind, 2004) found that that fewer than half of inpatients (37%) who had experienced 'verbal abuse, violence, or sexual harassment' while in hospital had informed a staff member. A second survey by the charity reported a slightly higher disclosure rate with 55% of inpatients indicating that they had told a member of staff

following assaults or threats (Mind, 2007). Neither study provides information which would allow safe connections to be drawn between reporting and perpetrator status (e.g. staff versus inpatients) or reporting and offence type. Barlow and Wolfson (1997) found that 39% of female inpatients who had experienced 'sexual assault or harassment' while in hospital had reported these incidents to nursing staff. While figures on reporting are not provided, most victims of theft in Jones et al.'s study, indicated that they felt that having things stolen was part of life on the wards, and nothing could be done about it (Jones et al., 2010).

Barriers to reporting. The under-reporting of crime is a well-recognised phenomenon among the mainstream victim population in England and Wales, and internationally (Tarling and Morris, 2010). We also know from wider research that individuals with a history of mental distress are often reluctant to disclose victimisation to others for a host of reasons, including fear of being disbelieved or even blamed for offences due to the stigma that surrounds mental illness, fear of the trial process, worries that a report may be misinterpreted as a sign of deteriorating mental health and an absence of advocacy support (Mind 2007; Koskela et al., 2016). It has also been shown that prior negative experiences with the police – including during times of mental health crisis - can act as a powerful deterrent to reporting victimisation within this population, with some victims reporting a perception of less favourable treatment due to their mental health status and a general lack of empathy and sensitivity attributed to poor levels of mental health awareness within police forces (Pettitt et al., 2013). Studies point to additional and substantial barriers to the reporting of crime in inpatient settings, many of which are fear based: fear of retaliation from assailants with whom patients continue to be in close contact, fear of being dismissed as delusional or attention seeking; fear about being perceived as 'difficult' by staff as a consequence of making a complaint and fear about

the possible negative implications this might have for services received (Thomas et al., 1995; Mind, 2004, 2007). The following exemplars capture some of these fears:

> 'I did not report my experiences of harassment and sexual assault to staff because I felt that they would not be interested, would do nothing'

> 'I was too frightened that staff would not listen to me and that if the patient involved found out I would be beaten up' (Mind, 2004: 10)

In addition, some inpatients have relayed that they saw little point in reporting incidents which they blamed on the perpetrator's mental ill-health (Mind, 2004) while victims of sexual violence have – in common with the general population - cited embarrassment, shame and self-blame amongst reasons for non-disclosure (Thomas et al., 1995; Barlow and Wolfson, 1997). Study findings also suggest that the initial reactions of nursing staff can also sometimes act as a potent barrier to pursuing complaints (Mind, 2004; Wood and Pistrang, 2004; Koskela et al., 2016). Inpatients interviewed by Woods and Pistrang (2004) (n=9), for example, indicated that they had not approached ward staff in relation to violent incidents as they felt that no action would be taken which they, in turn, related to feeling neither listened to or understood by staff. These findings, in turn, sit alongside and potentially at odds with surveys by Chaplin et al. (2006) and Jones et al. (2010) in which inpatients expressed broad satisfaction with the way nursing staff had responded to violence between inpatients on mental health wards.

Hospital handling of suspected crimes

Even fewer studies were found to have examined hospital handling of inpatient complaints of victimisation and these are furthermore restricted to the personal accounts of inpatients. Amongst these, inpatients cited in Mind's Ward Watch Report (2004) were asked about the about the responses they had received from ward staff following disclosure and a significant majority (70%) indicated that they were dissatisfied with the way their report had been handled. Inpatients complained, as in the following exemplars, that their reports had not been acted upon or, in some instances, even recorded by staff:

> 'They did absolutely nothing when I was sexually molested and didn't even write it down'.
>
> 'The ward manager did not attempt to interview witnesses, did not provide feedback on the investigation and provided nothing in writing to me' (Mind, 2004: 10)

These findings notably prompted the charity to accuse hospitals of fostering a culture in which inpatients' complaints were ignored and potential criminal offences were all too often swept 'under the carpet' (Mind, 2007). A second survey by the charity (Mind, 2009; for discussion see Whitelock, 2009), recorded similar complaints of inaction from former inpatients:

> 'Abuse by mental health patients towards other patients, especially on wards, isn't taken seriously. Staff say we have to avoid these patients but it isn't always possible'.

Elsewhere and consistent with these findings, inpatients interviewed by Kumar et al. (2001) (n=6) branded hospital complaints procedures 'confusing' and claimed that violence was often overlooked by senior staff. In a more recent study, inpatients

interviewed by Pettitt et al, (2013; discussed in Koskela et al, 2016) (n=9) described receiving unsympathetic and disbelieving responses from staff on wards following the disclosure of offences which discouraged them taking complaints forward. Several inpatients even described being actively prevented from reporting to the police by staff who, they claimed, frustrated their attempts to let them see an advocate or telephone the police directly as in the following account of female inpatient:

> 'I went to the staff and I told them what happened [being raped by another patient] in the morning. And they basically just dismissed it. They wouldn't let me make a phone call. They wouldn't let me see an advocate. They wouldn't let me talk to the police. They wouldn't let me go to A&E so I could get myself medically checked out […] And they refused to let me off the ward which was very frightening because being a voluntary patient I assumed that I had rights to come and go as I wanted' (Koskela et al., 2016: 1022).

Police Referral and Investigation

Turning to police responses to inpatients' allegations of crime, we found that only two studies had set out to record whether offences were ultimately referred to the police alongside outcomes of any subsequent police investigation. Of the 44 allegations of rape and sexual assault recorded by the NPSA in 2007, all but one incident had been reported to the police; 20 incidents by a member of staff and 23 by the patient themselves (NPSA, 2007). Follow up invited responses from the Directors of relevant Mental Health Trusts indicated that all were 'investigated internally' (NPSA, 2007). The nature of these investigations is not expanded upon, however, with the report simply noting that in 'most cases the allegations were withdrawn or lacked sufficient evidence to pursue further action' (NPSA, 2007: 16). The degree and nature of police (or prosecutorial) involvement

in these cases is therefore unclear. Also, left undetermined is the significance of victim withdrawal in this context given that victims of sexual violence are known to frequently withdraw allegations for a range of reasons (e.g. fear of retaliation, feeling disbelieved, fear of the criminal trial process, lack of advocacy support) entirely unconnected with the genuineness of the complaint (Kelly et al., 2005). Elsewhere, Janicki (2009) records that 14 out of 45 recorded incidents of physical assault by inpatients (31%) were brought to police attention but does not report how many of these involved inpatient victims. Data revealed that only four of these cases had been 'processed by the police', (2009: 33), resulting in the perpetrator receiving an adult caution. The study did not seek to explore the decision-making process which led to cases being referred to the police. It is therefore unclear whether responses reflected the wishes of the alleged victim or other considerations, relating, for example, to the alleged perpetrator's mental ill-health. Notably, neither study provides information on the nature or extent of support made available to the inpatients who had made complaints of victimisation (e.g. access to Victim Support, counselling, rape crisis or other support services). A separate review of 200 NPSA incidents involving 'aggressive and disruptive behaviour' by inpatients (directed at mental health professionals and inpatients) within mental health units conducted by Scobie (2006) found evidence of five incidents (2.5%) being referred to the police, although the report notes that incident data relied upon were patchy and the actual number of potential crimes brought to police attention may in fact have been higher. Again, the report is silent on the factors underpinning the decision to involve the police in the wake of such incidents. Of potential relevance, the report notes that of the 200 incidents, 'the majority … resulted in no or low harm' (Scobie, 2006: 34), however, 'harm' is critically left undefined in this context.

Similar findings have been reported outside of England and Wales. For example, in Northern Ireland, Young et al., (2009) conducted a survey of annual incidents of assault

meeting the legal definition of battery across three acute mental health hospital wards. Of the 245 recorded physical assaults, 87 (36%) were assaults by inpatients against other inpatients. Seven individuals notably accounted for 57 (23%) of all assaults. The nature and extent of any injury sustained by victims is not recorded. Of these 245 recorded assaults, 10 were referred to the police (4%); in three instances by inpatient victims. Three of these ten contacts resulted in a police interview which ultimately resulted in two police cautions and one transfer to a medium secure unit pending prosecution. The study does not record whether the alleged victims in these cases were inpatients or staff members, nor did it seek to explore the reasons for infrequent reporting to the police. In a New Zealand study, Kumar et al. (2006) explored the rates of referring mental health inpatients to the police for possible prosecution of acts of 'physical or verbal aggression' drawing upon the case files of patients and unit's log of ward incident forms over a two-year period. Data were available for 31 incidents directed at staff or other inpatients. Only three cases resulted in police involvement, each of which involved physical assaults on staff. Charges were laid in each of these cases but only one resulted in a criminal conviction. Owing to the small sample size, there were no identifiable patterns or common factors associated with the decision to report the incident to the police.

Turning attention back to England and Wales, while not linked to the reporting of specific incidents, Janicki (2009) invited nursing staff and inpatients to comment on the potential gains to be made from involving the criminal justice process in response to physical assaults by inpatients. Both groups expressed the belief that such action could be beneficial in deterring inpatients from committing subsequent assaults, thereby enhancing safety on mental health units, but notably suggested that these effects were often undermined, in practice, by a delayed police response and a perceived reluctance

on the part of criminal justice agencies to pursue allegations against assaultative inpatients.

Only one study reports the corresponding views of police officers. On interviewing senior officers (n=10), Brown (2006) reports some uncertainty regarding the role and responsibilities of the police in responding to alleged offences committed by mental health inpatients in hospital settings linked to what officers regarded as the limited likelihood of such cases proceeding to prosecution. Doubts were raised as to the public interest in pursuing action against inpatients, for example, especially if the individual was detained under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) while the capacity of inpatient complainants to provide reliable and credible evidence in support of a prosecution was also, significantly, cast into doubt. At the same time, officers indicated that the processing of complaints would be highly dependent on the views of the alleged victim but failed to identify factors which might underpin inpatient victims' willingness to support a criminal prosecution. For example, officers neglected to acknowledge the possibility that inpatient victims who are co-resident with their assailants may be reluctant to agree to testify against them for fear of retaliation. It remains unclear how far the views expressed by those interviewed reflect broader perceptions within the police in England and Wales, especially amongst frontline officers. It is notable, for instance, that none of the senior officers in question could recall receiving formal mental health awareness training.

Likewise, we found a single study designed to shed light on police decision-making in cases involving inpatient complainants. Williams et al. (2009) analysed a random sample of 100 crime reports from 246 reported from mental health institutional settings (low and medium security hospitals and residential care settings) in London over one year (the reports involved allegations of 'violence or aggression'). The researchers found that cases were significantly more likely to be 'no-crimed' by the police (i.e. classified as no

crime having taken place) where initial calls were made by mental health service users (73%) as opposed to mental health professionals (44%) and were significantly less likely, if recorded as a crime, to progress through the criminal process (figures not provided). Strikingly, not a single call made by a mental health service user resulted in an arrest, interview or charge, meaning that the alleged perpetrator received no follow up on the allegation.

Evident within police files, the researchers report, was a common (and erroneous) assumption made by the police – and significantly by some mental health practitioners – that a suspect with mental health issues ruled out resolution via the criminal justice process. Further police action was either deemed not to be in the public interest, or the suspect was considered 'not suitable' for criminal justice follow-up. When alleged inpatient victims received mention, meanwhile, it was not to record their accounts or views - which were notably absent from Crime Reporting Information System (CRIS) reports - but rather to raise doubts about their credibility as potential witnesses and their ability to withstand the rigours of the criminal trial process. Conflicts also reportedly arose between police and mental health practitioners with the researchers noting gaps in expectations and understanding of each other's role which meant there was no consensual agreement regarding shared goals and no partnership work which 'sometimes left individual victims to carry the burden of the case they had reported and to decide what to do next' (Williams et al. 2009: 361).

It remains to be determined whether these findings reflect broader patterns of attrition (i.e. drop out) in criminal cases involving inpatient victims as the police, Crown Prosecution Service and the courts in England and Wales do not routinely monitor or keep records of victims of crime who have identified mental health problems (or other disabilities) and case outcome data for this population is therefore lacking. William et al.'s 'snap-shot' study has yet to be replicated in other police force areas or extended to

decision-making within the Crown Prosecution Service or criminal courts. Significantly, no studies to date have explored inpatients' experience of reporting crimes directly to the police or victims' subsequent interactions with the police or other criminal justice actors.

III. Discussion: implications and future directions

Extant research thus confirms that mental health wards can be highly volatile environments where inpatients are at risk of criminal victimisation, including physical and sexual violence at the hands of fellow inpatients. Against this backdrop, the existing evidence base, such as it is, raises, we submit, unsettling questions about the ability of inpatient facilities to protect inpatients in their care, the confidence of inpatient victims to report crimes, the sensitivity and care shown to inpatients who do disclose and the extent to which reported crimes are subject to appropriate and timely investigation by the police with the co-operation and support of NHS Trusts.

No less striking, however, are the gaps in knowledge that this review brings into sharp focus. It is plain, for example, that there is still much to be learned about the nature and extent of inpatient victimisation across mental health units in England and Wales given that any data based on recorded or reported incidents currently available is likely - due to under-reporting- to significantly underestimate the scale of the problem. Given what we know about substantial barriers to the reporting of sexual offences within the general population, for example, (Myhill and Allen, 2002; Kelly et al., 2005) one might reasonably assume that recorded figures of rape and sexual assault in mental health settings are bound to represent the 'tip of the iceberg'.

Equally evident and noteworthy is a dearth of knowledge around the general management and reporting of alleged crimes against inpatients within mental health services. Notable by its absence, for example, is research evaluating the implementation

and operation of triggered adult safeguarding procedures introduced by the Care Act 2014 in mental health care settings. Also understudied are the criteria being used within mental health services to decide when to refer incidents to the police for potential criminal investigation. The wider literature contains occasional references to 'local joint working agreements' developed by individual hospitals in collaboration with local police forces which aim to reach consensus on indications for police involvement and protocols for information sharing (Bayney and Ikkos, 2002; Lawn and McDonald, 2009; Wilson et al., 2012). Our review of available evidence nevertheless indicates that there has been no attempt to establish, through dedicated research, the extent of such protocols across mental health units nationwide, the content of the guidance they contain or their implementation in practice. The basis of decision-making in this context thus remains opaque and, critically, beyond public scrutiny.

It is worth noting in this context that the Mental Health Act Commission - endorsing the development of local protocols for police intervention on inpatient units (2006: para 4.141) proffered guidance in a 2006 report stating that some criminal behaviour is 'so serious that there should be never be any question of not reporting it'. Under this heading the Commission listed homicide, attempted homicide, rape or serious sexual assault, arson and physical assaults resulting in 'serious harm'. In other instances, policies should allow a certain amount of discretion, the Commission posited, and added that matters to be duly taken account of include the needs and wishes of (alleged) victims and the making of an effective record of any incident for legal and future risk assessment purposes. In specific reference to incidents of theft, the Commission urged that staff should recognise the requirements of justice and support patients in making complaints to the police (Mental Health Act Commission, 2006: para 4.141). With a deficit of research - and indeed, debate on this topic - over a decade on, it is yet to be determined whether and how this guidance has informed the policies of individual Mental Health

Trusts or their implementation (or otherwise) on the ground. Anecdotally, there are reports that mental health professionals are often reluctant to invoke the criminal process, in practice, fearing adverse publicity for hospitals (Smith and Donovan, 1990; Carson, 1992) or adverse implications for inpatient 'offenders' and their ongoing treatment and care if this route is taken (Coyne, 2002; Bayney and Ikkos, 2003; Dinwiddie and Briska, 2004; Page and Meiklejon, 2004; Wilson et al., 2012). It is additionally easy to anticipate concerns relating to the health and well-being of inpatient victims given the stress – and indeed, trauma - often associated with criminal justice involvement. In the absence of hard data, the extent and the effect (if any) of such concerns on decision-making and practice in this arena remains at present, however, a matter of conjecture.

Of course, police referral will only become a 'live' issue if inpatient victims first feel sufficiently safe and supported to report incidents and secondly, if (suspected) crimes are appropriately identified as such by mental health staff. As we have highlighted, these are areas where practice within mental health services has been (fairly or otherwise) heavily criticised, which makes the absence of more recent empirical inquiry all the more significant, we suggest, and lamentable.

Turning to the criminal process, meagre research efforts similarly rule out meaningful evaluation of the current criminal justice response in this arena. In respect to inpatient victims, public policy statements certainly demonstrate a commitment to promoting equal access to justice for all victims with mental ill-health. However, as we have shown, police and prosecutorial responses to allegations from inpatients have yet to be subject to sustained scrutiny. Wider research notably suggests that victims living with mental distress in the community often confront significant barriers in accessing the support they need both to overcome the consequences of crime and to participate fully in the criminal process (Pettit et al., 2013). Victims within this population have, moreover, specifically

expressed a perception of stigma and prejudicial attitudes existing within the police service and concerns about not being taken seriously or believed due to their mental health status (Mind, 2007; Koskela et al., 2016). Such reports inevitably raise concern about the potential barriers confronted by mental health inpatients who are after all amongst the most marginalised and stigmatised groups in society (Goffman, 1963; Crisp, 2004; Thornicroft, 2007). The troubling truth, however, is we simply do not know how this population currently fares in encounters with the criminal justice process.

It has been suggested more generally in respect to allegations involving inpatient suspects, that responding officers may implicitly (and falsely) associate deviant behaviour with mental disorder and conclude – without undertaking appropriate investigation - that 'inpatients are immune from legal action because they have little or no responsibility for their actions' (Bayney and Ikkos, 2003: 362. See also Smith and Donovan, 1990). With a policy emphasis placed on diverting 'mentally disordered offenders' away from the criminal justice process (Home Office, 1990), more specific claims have been made that officers are sometimes unsure about their role when called to respond to alleged criminal acts by inpatients (Brown, 2006). For instance, Bayney and Ikkos (2003: 361) observe:

'…police training has focused on an understanding of methods of diversion of [offenders] with mental illnesses from the criminal justice system to the mental health system. When there is a suggestion, therefore that a particular offender may move in the opposite direction i.e. from the mental health to the criminal justice system, uncertainty may result'.

How this asserted uncertainty influences the police response in this context is, however, impossible to assess given the lack of relevant research. What can be noted, on the other hand, is that inpatient victims are not the only protagonists to be problematically

marginalised within the research literature – we simultaneously know very little about criminal justice responses to inpatients accused of criminal offences. This knowledge gap is of no less a concern and demanding of attention given the vulnerability of this population (Canton, 2016).

Future research directions

It follows on from this discussion, then, that there is a pressing need for more robust data on both the nature and prevalence of inpatient victimisation. As noted, police forces in England and Wales do not routinely monitor or keep records of victims of crime who have identified mental health problems. We suggest that this situation be corrected and that forces explore ways of recording reports from mental health units specifically so national collation and analysis of data can be undertaken. We also suggest that further consideration to be given to how reporting systems for 'patient safety incidents' might be adapted to separately record incidents involving potential crimes recorded by Mental Health Trusts.

Relatedly, we would identify a need for further qualitative research in inpatients settings to shed additional light on the extent and reasons for (apparent) underreporting of crimes by inpatients to allow consideration of how reporting barriers might best be overcome. Such research would usefully extend to the operation and perceived adequacy (from the perspective of both inpatients and staff) of support systems in place for inpatient victims (and those accused) following the making of an allegation in line with statutory safeguarding procedures. We would also urge that additional attention be given to individual Trust policies and criteria for police referral in relation to suspected crimes. Examination would not only facilitate external scrutiny, comparison and appraisal of local protocols but would also, critically, provide a basis for informed debate regarding the

need for national guidance in this area. To enhance understanding of current practice, qualitative discussions with clinical staff working in mental health units could beneficially explore perceptions of the criminal justice process, including perceived advantages and disadvantages of police involvement (including from a therapeutic and ethical perspective) and potential motivators and barriers to police referral.

To address identified gaps in our understanding of the criminal justice response in this context, we would highlight scope for research aimed at gathering data on the passage of cases involving alleged inpatient victims and suspects through the criminal process and the factors that influence case outcomes. Such an investigation would usefully explore the span and consistency of existing training across police forces and within the CPS and the perceived need for additional specialised support in dealing with these inevitably complex and challenging cases. Given tensions highlighted in the literature, criminal justice actors' experiences of working in partnership with mental health services, for example, in relation to information sharing, also warrant further study. Finally, we would urge that future research prioritise giving voice to those who have experience of engaging with the criminal justice process as both inpatient complainants and suspects.

Concluding remarks

Recognising that mental health inpatients are potentially vulnerable to criminal victimisation by fellow inpatients, this article has examined what available evidence reveals about the subsequent response of mental health services and criminal justice agencies in England and Wales. The most striking finding to emerge is the extent of a lack of systematic evidence gathering to date. We have mapped resultant knowledge gaps and presented these as major and troubling barriers to meaningful evaluation of policy and practice in this area. In offering reflections upon future avenues for inquiry, we

hope that this review will serve as a spur and platform for both further targeted research and discussion.

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