Correspondence

Mixed sex wards

Sir: Recent reports of rape, assault on and sexual harassment of women, in mixed psychiatric wards have led to discussions in the lay and medical press about the need for separate sex wards in psychiatric hospitals (Tonks, 1992; Pocock, 1993) and the mental health charity MIND has called for women to be given the choice of single sex wards (Tonks, 1992).

We report the results of a survey of the opinion of psychiatric in-patients aged 18–65 years about mixed sex wards in a new psychiatric hospital. The hospital has mixed wards with single, double and six-bedded rooms. There were 56 admissions in the study period and 49 (87.5%) of these agreed to participate in the study.

Fifteen (30.6%) patients expressed the view that they should have been offered a choice of separate sex wards. They would have preferred this choice because it would have offered them more privacy. Ten (20.4%) patients felt strongly that they should have been in single sex wards and of these eight were female and two were male. Seven (14.2%) felt physically threatened by other patients within the mixed ward setting and one (2%) patient reported that she had been raped within the hospital building by another patient. This incident was brought to the attention of the ward staff.

Twenty (40.8%) patients did not expect to be admitted to a mixed ward and were surprised to find that the ward was mixed. These included 12 female and eight male patients. Seven of these 20 patients had no previous admissions and the remainder had admissions into other psychiatric hospitals. Twenty-five (51%) patients would have preferred single sex bathrooms and toilets. The reasons cited for this included cleanliness, privacy, culture and religion. One patient reported that she had found a male patient peeping through the keyhole.

Our study suggests that a substantial proportion of patients admitted to mixed sex wards in our hospital would have preferred to be admitted to single sex wards. A smaller but not insignificant proportion felt threatened by the mixed ward environment and half the patients would have preferred single sex bathrooms and toilets.

The development of mixed sex wards was part of the drive to humanise psychiatric wards and to improve the quality of life of patients. However, the developments have proceeded without the opinion of patients or their relatives being taken into account. Our results suggest that a substantial number of patients may not be in agreement with their hospital carers.

In an article in the *Daily Telegraph*, Pocock (1993) describes his embarrassment at being the only male patient, for a period, in a mixed ward. The embarrassment was mutual, for a number of the female patients also found his presence embarrassing to them. The author admitted that there may be advantages to a mixed ward but that there can also be "more than a loss of dignity".

The belief, among managers, appears to be that patients from ethnic minority groups are the ones who object most to sharing a ward with the opposite sex, on grounds of custom, culture or religion (Pocock, 1993). Our study suggests that while this may be true, native British patients also object to mixed wards. Even when there is no traditional separation of the sexes, it is clear that the vulnerability of disturbed patients to be exploited by others must be recognised and adequate steps taken to prevent sexual abuse within hospitals. Part of the strategy must be to review the policy on mixed sex wards and at least to provide facilities for those who have a conscientious objection to being treated within mixed wards. Managers and health planners ought to be aware of the preference of patients and take account of this when planning psychiatric hospitals.

POCOCK, T. (1993) Nurse, there's a woman in my ward. *The Daily Telegraph*, Tuesday, April 13, 15.

TONKS, A. (1992) Women patients vulnerable in mixed psychiatric wards. *British Medical Journal*, **304**, 1331.

ABDUL PATEL, MONICA DOSHI and FEMI OYEBODE, *The Queen Elizabeth Psychiatric Hospital, Edgbaston, Birmingham B15 2QZ*

The cost of Mental Health Review Tribunals

Sir: The article by Blumenthal & Wessely (*Psychiatric Bulletin*, May 1994, **18**, 274–276) which carefully and convincingly describes how at least £12,000,000 per year is spent on Mental Health Review Tribunals is, indeed, timely. It is essential that people who are compulsorily detained have access to independent examination of their cases; perhaps they should have this as a right, rather than 'on application'. Cost, in terms of money and time, is only one cost, there is the cost of *not* working with other patients and the cost of losing rapport in what is still an

adversarial situation. However, £12,000,000 is a lot of money; are we spending it wisely and appropriately? Should we detain people when there are insufficient facilities for what is considered adequate treatment (Eastman, 1994)? It may be argued that *all* compulsorily admitted patients should have a tribunal or a managers' appeal. This would very greatly increase numbers and costs. Further, if all patients incapable of giving consent (e.g. those with confusion) were compulsorily admitted there would be a vast increase in demand for tribunals and appeals. Under these circumstances a form of rationing would have to be introduced as, quite apart from costs, the service just could not cope with the work such numbers would produce.

Has there been a similar study to look at the cost of managers' appeals? Further studies on tribunals and appeals should determine why appeals are made; it may be on the advice of a fellow patient or of an enthusiastic member of staff, who has the individual patient's right (or other matters) at heart, not the overall costs and running of the service.

The Mental Health Act Commission, on its annual visit, collects figures for population served, admissions, sections, tribunals and appeals, cancellations and outcomes. (The word 'success' is not to be used concerning tribunals or appeals; success is that a fair and proper hearing was given, not that a particular decision was made). The processing and publication of such data would help individual units or regions to consider their rates.

Perhaps the day will come when there are 'preliminary screeners' for tribunals and appeals. Such a person would look at *every* case and could then choose as many cases as could be 'afforded' which would then be passed on to subsequent, more detailed, hearings.

EASTMAN, N. (1994) Mental health law; civil liberties and the principle of reciprocity. *British Medical Journal*, **308**, 43–45.

M.T. MALCOLM, *Clatterbridge Hospital, Bebington, Wirral L63 4JY*

Sir: I was delighted to see the recent article by Blumenthal & Wessely (*Psychiatric Bulletin*, May 1994, **18**, 274–276) pointing out the cost of Mental Health Review Tribunals and calculating that the total cost of these tribunals are £12,274,380 per annum.

It has long been my contention that these tribunals are of no real benefit to patient care and waste a great deal of the time of doctors and social workers. I have noted the bizarre situation whereby psychotic patients of mine are asked shortly after admission on section 2 and section 3 of the MHA if they would like to appeal against their section. Being psychotic they have no insight into their mental illness and so take up the offer of appeal against section. They are assisted in so doing by the Legal Advice Project at the hospital.

At the tribunal itself the lawyers use an adversarial principal which makes me appear to be an unreasonable person who is seen to be locking away patients and depriving them of their civil liberty. This is far from the case, as like most psychiatrists, I compulsorily admit patients only when necessary, and always in their best interest.

Money is being poured into Mental Health Tribunals which could be used to fund better community care. The 1959 Mental Health Act provided a perfectly good system of appeal using Mental Health Review Tribunals, but it was less frequent and did not involve the additional burden of managers' hearings.

The 1983 Mental Health Act uses a legalistic and expensive system which is of no benefit to patients and the College should take urgent steps to reform it.

R.S. STERN, Modern Community Mental Health Team, *Springfield Hospital, 61 Glenburnie Road, London SW19 7DJ*

General practice training for psychiatrists

Sir: I was interested to read Burns *et al*'s paper on general practice training for psychiatrists (*Psychiatric Bulletin*, May 1994, **18**, 286–288), having been one of the 18 trainees who took part in the placements, and thought a 'user's perspective' might be worth recording. I was probably unusual in actually volunteering for the post as it certainly was one of the 'hard to fill' spots on the rotation at the time. My reasons for volunteering were two-fold. One was a glimmer of interest in general practice as a career, the second was that I had been involved in regular liaison meetings with the practice to which I would be attached in my preceding psychiatric registrar post.

I valued the six month placement enormously. The partners were all extremely accommodating to my psychiatric training needs, even allowing me to attend additional family therapy commitments. I found my opinions on psychiatric issues being valued, while it was still expected that I would be a 'normal' GP trainee and not the resident psychiatrist. My general medical skills improved, my awareness of minor psychiatric morbidity increased and the pressures this created for GPs understood far better. It was actually quite difficult at times to decide who should be referred on to mental health professionals and I became slightly more sympathetic