
THE RIGHT TO BE SAFE

Ensuring sexual safety in acute mental health
inpatient units: sexual safety project report

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COMMISSIONER'S MESSAGE

All people have the right to be safe when accessing acute mental health inpatient treatment. Health services have clear obligations to uphold this right and to ensure a safe environment. However, complaints to the Mental Health Complaints Commissioner (MHCC) indicate that many people have not been, or felt, safe in these environments.

Complaints about sexual safety breaches in acute mental health inpatient units provide a vital window into the gravity and impact of these incidents. Sexual harassment and sexual assault are violations of people's human rights that can cause immeasurable trauma and, along with other types of sexual safety breaches occurring in these environments, are significant avoidable harms that must be addressed. This report identifies the need for sexual safety to be recognised as a human rights issue and to receive priority attention, in accordance with Victoria's broader violence prevention strategies.

The issues of sexual safety in mental health services are longstanding. Despite a number of initiatives over many years, ranging from guidelines and training to the creation of women-only and gender-safe areas, complaints made to the MHCC and reported by services show that breaches of sexual safety continue to occur. However, we are now in a unique position to use the information gained from complaints to identify what more must be done to address these avoidable harms.

While this project draws on data from 90 complaints identified over a three-year period, one sexual safety incident in a mental health service is one too many. We must never lose sight of the trauma and harm that can be caused by a lack of sexual safety in these environments.

In addition, sexual safety breaches may constitute sexual crimes, and services have a duty of care, both to potential victims and to people at risk of offending, to prevent these breaches from occurring.

This report endeavours to honour the preparedness of people to make complaints about highly personal and distressing experiences and the desire for their complaints to lead to improved outcomes for others. The recommendations aim to draw together and build on the efforts of many individuals, organisations and mental health services, as well as the Department of Health and Human Services and successive governments, to address the issues of sexual safety.

The project has identified the need for a comprehensive sexual safety strategy to plan, coordinate and monitor action for preventing and responding to breaches of sexual safety in Victoria's acute mental health inpatient units. The success of this strategy will depend on strong leadership and governance, changes in culture and practice, improvements in unit infrastructure and design, and a clear policy directive for mental health services on requirements and actions to ensure sexually safe environments. This strategy will also benefit from integration with broader efforts to strengthen options for community-based treatment and supports, which may prevent or reduce admissions to acute inpatient care.

We acknowledge that implementing many of the project recommendations will be a long-term endeavour. This report identifies actions that can be implemented immediately and others that can be implemented over time to ensure the sexual safety of all Victorians receiving acute mental health inpatient treatment and care.

Dr Lynne Coulson Barr

ACKNOWLEDGEMENTS

The Mental Health Complaints Commissioner (MHCC) acknowledges the significant contribution of the many people who have spoken up about their experiences of not being or feeling sexually safe in acute mental health inpatient units. Speaking up about any negative experience of services can be challenging.

The distress associated with experiencing breaches of sexual safety can make speaking up even more difficult. However, many people and families have spoken up because of their concern about how their own care was managed, but perhaps even more strongly because they want to ensure that other people do not have similar experiences.

People told us that they want to see 'cultural and actual change' and that they 'don't want this to happen to someone else'.

Sexual safety in acute mental health inpatient environments, and women's safety in particular, has been an area of longstanding advocacy for many individuals and organisations. The Women's Mental Health Network Victoria, the Victorian Mental Illness Awareness Council and many other organisations and individuals have advocated over many years to ensure that women are able to access sexually safe services. Because of these endeavours, sexual safety has been recognised as a critical issue by successive governments and the Department of Health and Human Services. While this report identifies a need for stronger leadership, coordination and oversight of responses to sexual safety, these will be built on a foundation of genuine commitment to ensure safer services that has been demonstrated through policy development, training and funding for capital improvements over many years.

The MHCC also acknowledges the dedication of mental health service staff and their efforts to ensure that people receive safe, effective mental health treatment. The views of people working in services about current gaps and risks in service provision, as well as their creativity and ideas of how to ensure that people are and feel safe while accessing mental health treatment, have made valuable contributions to this work.

The broad range of stakeholders who have contributed to this work must also be acknowledged. A full list of people consulted for this project is included at Appendix 1.

The project reference group and investigation panel members have provided invaluable expertise, support and guidance to the project. Members contributed significant time and endeavour to participating in, reviewing and commenting on aspects of the project, and have enriched it by their observations and suggestions from the perspectives of lived experience, service provision, academia and input from the Office of the Chief Psychiatrist. The MHCC's Resolutions and Review Team also played a critical role in this project by providing a supportive process for people to make complaints about sexual safety breaches, and working with services to effectively respond to people's individual concerns and to identify service improvement actions.

Ms Rachel Vague, MHCC Project Lead and primary author of this report, and Ms Bee Mitchell-Dawson, MHCC Investigation Panel Chair and

Deputy Commissioner at the time of the project, deserve particular acknowledgement for their significant contributions and work on this project.

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NOTE ON LANGUAGE

The MHCC recognises that people with lived experience of mental illness prefer different terms to describe themselves. Many people use the term 'consumer' for people accessing mental health services, and this term is used in the *Mental Health Act 2014* and in many policy documents and guidelines. This report variously uses 'person', 'individual', 'people', 'people accessing mental health inpatient treatment' and 'people with lived experience' to reflect a 'people first' approach to language.

This report refers to 'woman/women' and 'man/men' in preference to 'female(s)' or 'male(s)', in recognition that experiences of sexual violence are socially produced and, as such, are more influenced by gender than biological sex. 'Women' should also be read to include girls.

This project raises the issue of the inconsistency with which matters of sexual safety are discussed both in policy and practice. This has affected the consistency, clarity and appropriateness of responses to sexual safety breaches, and these issues are discussed throughout this report. For the purposes of this report the following terms and definitions are used. These terms have been adapted from policy and guidelines from Victoria and other jurisdictions and, in some cases, Victorian legislation.

Allegation of a breach of sexual safety: a statement from a person that they do not feel or are not sexually safe, including experiences of sexual activity, sexual harassment and alleged sexual assault.

Breach of sexual safety: an experience in which a person is not, or does not feel, sexually safe, including experiences of sexual activity, sexual harassment and alleged sexual assault.

Chief Psychiatrist's Guideline: the Chief Psychiatrist's *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* guideline (Department of Health 2009).

Co-production: a co-production approach sees people with lived experience involved in, or leading, defining the problem, designing and delivering the solution, and evaluating the outcome, either with professionals or independently (Roper, Grey & Cadogan 2018).

Gender-sensitive practice: practice that recognises and responds to the differences, inequalities and specific needs of men and women and acts on this awareness.

Perpetrator: a person who has breached another person's sexual safety. The use of this term does not necessarily imply intent, because breaches of another person's sexual safety can result from sexualised behaviours associated with a person's illness.

Sexual activity: any activity of a sexual nature (including touching, intercourse, oral sex) that occurs between people.

Sexual assault: any behaviour of a sexual nature that is unwanted, making the victim feel uncomfortable or afraid. This includes rape, abuse, harassment and indecent assault. This behaviour can take various forms including unwelcome kissing, or touching in the areas of a person's breasts, buttocks or genitals. Indecent assault can also include behaviour that does not involve actual touching such as forcing somebody to watch pornography or masturbation.

Sexual crime: Sexual crimes are generally defined as a sexual activity that a person has not consented to, whether or not it involves physical or emotional force. It can refer to a broad range of sexual behaviours that make the victim feel uncomfortable, frightened or threatened and can include: touching, fondling, kissing, being made to look at or pose for pornographic photos, voyeurism, exhibitionism, sexual harassment, verbal harassment/innuendo, rape, incest, intrafamilial child sexual crime and/or stalking.

Sexual disinhibition: poorly controlled behaviour of a sexual nature where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations, at the wrong time or with the wrong person.

Sexual harassment: any unwelcome or unwanted sexual behaviour that makes the individual feel offended, humiliated or intimidated. This includes unwelcome sexual advances, unwelcome requests for sexual favours or other unwelcome/inappropriate conduct (including staring, leering, suggestive comments/jokes).

Sexual safety: in this report, this is defined as feeling and being sexually safe in acute mental health inpatient environments, including being free from sexual activity, sexual harassment and sexual assault. It expands on the definitions used in sexual safety guidelines that are discussed in section 1.3.1 'What is sexual safety?'.

Sexual safety incidents: incidents where a person is not or does not feel sexually safe, including experiences of sexual activity, sexual harassment and alleged sexual assault. This language is used in other jurisdictions and is accordingly used in some places throughout this report, although this report prefers the term 'sexual safety breaches'.

Sexual violence: sexual activity that happens where consent is not obtained or freely given. It occurs any time a person is forced, coerced or manipulated into any unwanted sexual activity such as touching, sexual harassment and intimidation, sexual abuse, sexual assault and rape.

Single-gender or mixed-gender units: used in preference to single-sex or mixed-sex units, in recognition that gender identity should guide placement in a particular unit rather than biological sex.

Women-only areas: describes areas designed to provide some gender segregation within acute inpatient units. Some services describe these as gender-safe or gender-sensitive corridors or areas.

See the glossary for other terms and abbreviations used in this report.

EXECUTIVE SUMMARY

The *Mental Health Act 2014 (Vic)* (the Act) requires services to be provided in a way that upholds people's dignity and rights, promotes therapeutic outcomes and supports people in their recovery. People accessing acute mental health inpatient treatment are acutely unwell and may also be in these environments compulsorily. They may be particularly vulnerable to the behaviours of others in a closed environment or at risk of behaving in ways or making decisions that they would not otherwise if they were well.

Ensuring people's safety, including sexual safety, in acute mental health inpatient units is a fundamental prerequisite to achieving the objectives and meeting the mental health principles of the Act and upholding people's human rights.

Reviews, surveys and advocacy reports over many years have consistently identified that many people do not feel, or are not, sexually safe when accessing acute mental health inpatient treatment. Themes highlighted include people not feeling safe, or experiencing sexual harassment and alleged sexual assault. Similar themes were noted in complaints to the MHCC over the first two years of operation, and were the impetus for this project. Sexual safety has been defined in this project to include feeling and being sexually safe in these environments, including being free from sexual activity, sexual harassment and alleged sexual assault. Significantly, breaches of sexual safety are rarely experienced by people accessing general health services and must be treated as unacceptable in any environment.

The MHCC's project has been informed by an analysis of complaints made to the MHCC, as well as those made directly to services and reported to the MHCC. The project also considered the findings of four MHCC investigations into sexual safety breaches, a comprehensive review of national and international literature, and wide-ranging stakeholder consultations. The project was undertaken as part of the MHCC performing one of its key functions under the Act, which is to identify, analyse and review quality, safety and other issues arising out of complaints and to make recommendations for improving the provision of mental health services.

This project has focused on acute mental health inpatient units because of the higher risk of sexual safety breaches occurring between people accessing inpatient treatment. In longer term mental health settings, the level of risk and the considerations as to whether sexual activity is appropriate are different. Though outside the scope of this project, consultations did identify the need for services to be provided with guidance on ensuring sexual safety in these settings. Reports of breaches of sexual safety in longer term care environments must always receive a similarly rigorous response from mental health services.

The project has focused on key themes and issues identified through analysing complaints about sexual safety in acute inpatient environments, in particular sexual safety breaches involving other people accessing treatment (77 per cent of complaints). This is not to understate the seriousness of complaints about staff. Rather, this recognises that the steps required to respond to complaints about staff are clear, and acknowledges that there are existing regulatory and legal mechanisms for addressing allegations against staff. In contrast, responses to sexual safety breaches by other people accessing services were highly variable in the complaints reviewed and, in many cases, concerning.

Because of the variability in reporting and categorising incidents relating to sexual safety, it is not possible to gain a clear picture of the prevalence of sexual safety breaches or whether these have increased or decreased over time. Incident reporting is addressed in the recommendations of this report, with a view to understanding the true prevalence and nature of these breaches and better informing prevention strategies.

What we do know is that people are increasingly prepared and supported to speak up and make a complaint about their experiences. People have said they want to see 'cultural and actual change' and 'don't want this to happen to someone else'. We are mindful that the complaints received do not represent the full spectrum of people's experiences, and this report includes a section on the need to recognise and respond to the diverse and individual needs of people accessing inpatient treatment, particularly the sexual safety concerns of lesbian, gay, bisexual, transgender and intersex (LGBTI) people. Little is known about the experiences of young people or older people in relation to sexual safety. Approaches to ensure sexual safety need to encompass the full lifespan and empower people of all ages to speak up about their concerns. In addition, it is likely that the experiences of men are under-reported and this also warrants consideration.

Project findings

The project highlighted a number of key patterns in complaints made to the MHCC and to services:

- Most complaints about sexual safety relate to men breaching the sexual safety of women.
- Intensive care areas (ICAs) are high-risk areas for sexual safety breaches.
- Over three-quarters of complaints identified other people accessing services as alleged perpetrators. It is important to note that, in a context where all people accessing services are acutely unwell, services have a duty to both parties to prevent both the harm associated with any breach of sexual safety and the potential ramifications for a person identified as perpetrating any breach of sexual safety.
- Complaints made to the MHCC and mental health services were most commonly about alleged sexual assault, followed by broader concerns about gender safety.

The findings of this project indicate that it is difficult for mental health services and staff to prevent all sexual safety breaches in a mixed-gender acute inpatient environment, particularly in ICAs. Staff, no matter how diligent, cannot constantly observe all people accessing treatment. The need to continuously monitor and intervene to ensure people's sexual safety in these environments may also detract from the capacity of staff to engage therapeutically with people accessing treatment.

In addition, for some people (for example, people with a history of sexual trauma or people from particular cultural or religious backgrounds), providing mixed-gender acute inpatient treatment may present inherent challenges to feeling safe. For this reason, one recommendation of the project is to trial single-gender acute inpatient units, with an initial focus on women-only units. However, project findings also indicate that there are many actions and practice changes that can be taken to ensure people feel and are sexually safe in a mixed-gender environment.

Recommendations

The overarching recommendation of the project is for the Department of Health and Human Services to develop a comprehensive sexual safety strategy that plans, coordinates and monitors action to prevent and respond to breaches of sexual safety in Victorian acute mental health inpatient units. This strategy needs to draw together and expand on existing approaches and be underpinned by a clear policy directive for mental health services on requirements and actions to ensure sexual safety. It must also reflect the principles of:

- human rights: applying the principles and objectives of the *Mental Health Act 2014 (Vic)*, the *Charter of Human Rights and Responsibilities Act 2006 (Vic)* and relevant standards
- violence prevention: applying the principles of primary, secondary and tertiary prevention
- trauma-informed care and supported decision making: recognising the prevalence of trauma among people accessing acute mental health inpatient treatment and developing systems that respond to likely trauma in assessment, treatment and recovery planning and actively seek to avoid re-traumatisation
- recognising and responding to diversity: understanding the diversity of needs and the particular risks and challenges that are associated with a person's gender, sexuality, culture, disability, age and background
- working with people with lived experience and peer support to develop approaches for supporting people to feel and be safe while accessing acute mental health inpatient treatment.

The project also makes recommendations for practice and service improvements including:

- addressing **governance** issues by establishing clear reporting and monitoring mechanisms to better identify and respond to sexual safety breaches, and ensure accountability for their prevention
- ensuring **leadership** supports best practice in preventing and responding to breaches of sexual safety
- implementing **trauma-informed care** as a primary prevention strategy in recognition of the prevalence of trauma among people accessing acute inpatient mental health treatment and the re-traumatising impacts of sexual safety breaches
- developing plans for minimum **infrastructure** requirements to support sexual safety in mixed-gender environments and piloting and evaluating single-gender units
- developing a plan to improve the safety of **ICAs** and developing alternative strategies for supporting people who are particularly at risk in these environments
- ensuring **orientation** to the inpatient unit clearly outlines that sexual activity is not permitted in the inpatient unit
- ensuring **risk assessments** evaluate vulnerability and perpetrator risks as well as the overall environment of the inpatient unit, and clearly link to plans for managing identified risk
- developing specific guidance and approaches for managing **open disclosure** in relation to sexual safety breaches, ensuring cultural, religious, communication and other needs are responded to, and that staff are supported in conducting open disclosure
- developing clear guidance on the duty of services to **report** a suspected or alleged sexual assault to Victoria Police, consistent with guidance in other service settings
- developing clear guidance for mental health services in collaboration with Victoria Police on **responding** to sexual safety breaches, including preservation of evidence, documentation, reporting and review mechanisms

- providing clear guidance to mental health services in relation to **investigating** and reporting sexual safety breaches that ensures people accessing services receive responses that are consistent with those in other service settings
- ensuring **incident reporting** mechanisms and requirements are integrated and consistent with standards in other service settings, and allow for patterns in reported incidents to be identified for quality improvement
- ensuring observations and reports are clearly and accurately **documented** at the time of the sexual safety breach
- ensuring **discharge planning** clearly identifies the nature of any breach experienced, as well as planning for future admissions and an outline of necessary support and referral for the person, their family and/or carers.

This report identifies the need for a cohesive approach to implementation that measures, monitors and responds to trends in sexual safety breaches and identifies areas requiring support and intervention to ensure a sexually safe environment.

Ensuring sexual safety in acute mental health inpatient environments is not an easy task, particularly in mixed-gender units. However, the fundamental right of people to feel and be safe while accessing treatment must be the guiding principle behind all approaches to implementing cultural, organisational and practice change.

RESPONSE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services acknowledges the immense body of work that has informed *The right to be safe: ensuring sexual safety in acute mental health inpatient units*.

The department especially acknowledges those who have contacted the Mental Health Complaints Commissioner, and those who have contributed their personal experience and perspective to improve our mental health services and the future experiences of others.

——— Victorians expect that health services are places where everyone, including people with mental health problems and mental illness, is safe. This report emphasises that, despite significant endeavours over the last decade, we still have work to do in terms of ensuring that Victorians feel safe when they access our mental health acute inpatient units. —————

The department will develop a comprehensive sexual safety strategy that responds to the recommendations, including mandating appropriate design guidelines for new mental health infrastructure, establishing clear reporting and monitoring mechanisms and developing a plan to improve the safety of Intensive Care Areas. The strategy will support and strengthen existing key projects, particularly those already underway in the Office of the Chief Psychiatrist, such as further development of the Chief Psychiatrist's Guideline on Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units and Gender Sensitive Training. The strategy will also bring together a range of work being undertaken by health services that aims to reduce, prevent and better report issues and incidents concerning sexual safety in Victoria's acute mental health inpatient units.

The department will drive an implementation plan for the sexual safety strategy to ensure a continued and sustained commitment across all mental health services to quality and safety standards. Cultural, practice and service design change is required to provide treatment spaces and approaches that are consistent with a contemporary understanding of sexual safety and gender sensitivity. This requires a collaborative effort from the department, health services, the Mental Health Complaints Commissioner and the many other stakeholders who interact with our mental health services.

The department looks forward to working closely with the Mental Health Complaints Commissioner and mental health services to review and address the findings in this report. The challenges reflected in the report demand our ongoing commitment to change on many levels, and robust departmental and service leadership will be essential to achieving the progress we seek. Working together, we will ensure that improvements to safety continue to be made. We remain dedicated to ensuring that all mental health services are safe for consumers and staff.

The department welcomes the strengthened focus on sexual safety provided by the release of this report, and thanks the Mental Health Complaints Commissioner for her recommendations.

SECTION 1 BACKGROUND AND OVERVIEW

1.1 ABOUT THE MENTAL HEALTH COMPLAINTS COMMISSIONER

The Mental Health Complaints Commissioner (MHCC) is an independent specialist statutory body established under the *Mental Health Act 2014* (the Act) to safeguard the rights of people receiving public mental health services, to resolve complaints and to recommend service improvements.

A key principle in developing the Act was to ensure compatibility with human rights obligations as set out in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter) and the *International Convention on the Rights of Persons with Disabilities* (ratified by Australia in 2008), which obliges governments to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities (including mental illness), and to promote respect for their inherent dignity' (United Nations 2006, p. 4).

— A fundamental objective of the Act is to protect the rights and dignity of people receiving mental health services, placing them at the centre of their treatment and care. The MHCC was established as a key component of the safeguarding, oversight and service improvement mechanisms of the Act, which were introduced to ensure rights are protected and the mental health principles are upheld.

The establishment of the MHCC also responded to community feedback that identified the need for a complaints body that was independent, could provide specialised processes for people raising concerns about mental health services, and could drive improvements in the safety and quality of those services. Creating an accessible, supportive and timely specialist complaints body also recognised the multiple barriers people with mental illness may experience in making a complaint.

The MHCC has broad powers to deal with complaints about designated mental health services (as set out in the Mental Health Regulations 2014) and publicly funded mental health community support services. To strengthen oversight, the Act also introduced the requirement for all public mental health services to provide a biannual report to the MHCC detailing the number of complaints they have received and the outcomes of these complaints.

The MHCC has a function under the Act to identify, analyse and review quality, safety and other issues arising out of complaints and to make recommendations for improving the provision of mental health services to mental health service providers, the Chief Psychiatrist, the Secretary to the Department of Health and Human Services (the department) and to the Minister responsible for mental health services (s 228(j) of the Act). The Commissioner also has broad functions to provide advice to mental health service providers on any matters relating to complaints (s 228(e) of the Act). This report is an outcome of the MHCC undertaking these functions and fulfilling its service improvement role under the Act.

While complaints can only present one part of the picture of service provision, they do provide an important window into people's experiences and indications of where improvements can be made. The establishment of the MHCC has provided a flow of information about mental health service provision that was not previously available and enables information from complaints to be used to identify key areas of concern. Since the MHCC was established, Victoria has recorded significantly more mental health complaints than any other jurisdiction and has been highlighted nationally as an example of the advantages of a specialist approach to mental health complaints (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2017b). The MHCC is therefore in a unique position to identify lessons from complaints that can lead to service improvements that address issues raised directly by or on behalf of people accessing mental health services.

1.2 PROJECT OVERVIEW

1.2.1 PROJECT BACKGROUND AND PURPOSES

Over the MHCC's first three years of operation to 30 June 2017, the MHCC identified concerning themes in complaints that involved issues of sexual safety. These included complaints about people not feeling or being sexually safe in acute mental health inpatient environments, or experiencing sexual activity, sexual harassment or alleged sexual assault while in these environments.

While the nature of these complaints varied, the gravity of many of these complaints and the variability in service responses to these complaints indicated a need for closer examination of these issues.

It is also likely that complaints relating to sexual safety are significantly under-reported due to well-documented concerns about people's reluctance to raise concerns about sexual harassment and assault. Services may under-recognise and under-report some issues that are reported directly to them, including concerns raised about the failure to provide a gender-safe environment or concerns about sexual harassment. This highlights the importance of this project in using complaints and issues to identify areas for service improvement that can prevent sexual safety breaches and ensure a safe environment for all.

In accordance with the MHCC's functions under the Act, the MHCC undertook this project to perform a detailed analysis and review of the safety, quality and other issues identified in complaints relating to sexual safety in mental health acute inpatient environments. The intended outcome was to develop recommendations for mental health service providers, the Chief Psychiatrist, the Secretary to the department and the Minister for Mental Health on ways to ensure sexual safety in acute inpatient environments.

The purpose of the project was to:

- identify the common factors that contribute to breaches of sexual safety in mental health inpatient environments and the context in which sexual vulnerability arises – for example, environmental factors including unit design and service culture, consumer experience of previous trauma, risk assessment of others who may present a sexual risk to others and any other factors
- identify the impact of sexual harassment and assault in mental health inpatient environments on the consumers who experience it, as well as their families, and how a trauma-informed approach to care can minimise this impact

- make findings about the common themes arising from complaints made to the MHCC in relation to gender and sexual safety, taking into account the literature and experience of consumers and families on issues of sexual safety

- make recommendations as appropriate to the Chief Psychiatrist and the Secretary on ways to ensure sexual safety in mental health inpatient environments at the systemic level

- make recommendations to mental health service providers about actions that can be taken at the individual service level to ensure sexual safety in mental health inpatient environments

- make recommendations to improve service responses to reports about sexual safety issues or sexual assaults, including review, assessment and appropriate action in relation to alleged perpetrators.

A reference group was established to guide the project. Members contributed their experience and perspectives in:

- preventing sexual assault and harassment within acute mental health inpatient units
- providing gender and sexually safe care within acute mental health inpatient units, including trauma-informed care
- lived experience as a consumer in an acute mental health inpatient unit
- lived experience as a carer
- workforce interventions to influence change
- women's experiences of acute mental health inpatient units.

The project was also informed and supported by the MHCC's ongoing engagement and consultations with key stakeholders including the department, the Office of the Chief Psychiatrist, the Victorian Mental Illness Awareness Council (VMIAC), Tandem, the Office of the Public Advocate, Independent Mental Health Advocacy (IMHA) and the new offices of Safer Care Victoria and the Victorian Agency of Health Information.

See 'Acknowledgements' for information on the membership and significant contributions of the reference group.

1.2.2 PROJECT METHODOLOGY AND COMPONENTS

The project comprised:

- an analysis of complaints to the MHCC and those reported directly by services ('local complaints')
- findings of the four investigations that the MHCC completed in 2017–18 relating to breaches of sexual safety
- a review of the literature, research, policies, standards and initiatives
- consultations with key stakeholders and people with relevant experience and expertise.

1.2.2.1 Analysis of complaints

As well as the complaints made to the MHCC, the MHCC also receives data about complaints made directly to mental health services. Under s 267 of the Act, mental health services are required to provide the MHCC with a biannual report on the number and outcomes of complaints they have received locally ('local complaints'). MHCC and local complaints were reviewed for issues that raised concerns about sexual safety according to the project definition (see 'Note on language') and that occurred in acute inpatient units of public clinical mental health services. One of the key challenges in conducting this data analysis was the variability in how complaint issues were described and categorised by services and gaps in the data. Nonetheless, 90 complaints were identified from the MHCC's complaint data for the three-year period of 1 July 2014 to 30 June 2017. This comprised 40 local complaints, 23 oral complaints to the MHCC and 27 written complaints to the MHCC.

Difficulties extracting outcome data from the Victorian Health Incident Management System (VHIMS) affects the quality of complaints data reported by services. Despite the MHCC implementing strategies to improve this data collection, significant data gaps remained in complaints received through the local complaints reporting process. For this reason, the MHCC requested additional outcome data from services for complaints identified as in scope for the project.

The additional outcome data included fields such as whether the complaint was reported to the Chief Psychiatrist or to Victoria Police, what referrals and support were offered to the person, what actions were taken to ensure safety, and any service improvements made as a result of the complaint. Despite this additional step, the nature of complaints and difficulties in data collection meant that information gaps remained across all areas. A comprehensive analysis was nonetheless undertaken and is included as Appendix 2. Given the extent of data gaps, figures used in this report include both a raw number and a percentage to indicate the frequency of particular issues in the data that was available.

Monash Alfred Psychiatry Research Centre (MAPrc)* was engaged to conduct the analysis of the de-identified complaints data and to assess:

- themes in the nature of the complaints reported (including whether the complaint involved concerns about the failure to provide a gender-safe and -sensitive environment, or if it was primarily about sexual harassment, sexual activity or alleged sexual assault)
- factors that contributed to the incident that was the subject of the complaint
- local service responses and complaint outcomes.

In summary, the complaints analysis found the following:

- Most complaints (47 per cent, $n = 42$ of 90) were about alleged sexual assaults, with 38 per cent ($n = 34$ of 90) about gender safety, 13 per cent ($n = 12$ of 90) about sexual harassment and 2 per cent ($n = 2$ of 90) about sexual activity.
- The alleged perpetrators were identified as other people accessing inpatient treatment (co-consumers) in 77 per cent ($n = 65$ of 85) of complaints, with 22 per cent ($n = 19$ of 85) about concerns raised regarding the behaviours of staff.
- 80 per cent ($n = 68$ of 83) of complaints were in relation to the experiences of women.
- Men were identified as single perpetrators in 83 per cent ($n = 49$ of 59) of complaints and participating in a further 7 per cent ($n = 4$ of 59) of sexual safety breaches.
- In 62 per cent of complaints ($n = 34$ of 55), complaints were made by the person who had experienced the sexual safety breach, with family members, carers and support people reporting in 38 per cent ($n = 21$ of 55) of complaints.

* The data analysis was undertaken by Ms Sacha Filla, Ms Caroline Gurch, Ms Emorfia Gavrilidis and Professor Jayashri Kulkarni of MAPrc. Qualitative and quantitative analyses were conducted in accordance with appropriate statistical procedures.

- Almost all (96 per cent, $n = 86$ of 90) complaints were about people's experiences in adult mental health services (this may partly reflect the higher numbers of people accessing these services and higher complaints rates compared with aged or youth services).
- A history of trauma was identified in 94 per cent ($n = 16$ of 17) of complaints where information about whether a person had experienced previous trauma was available.
- 87 per cent ($n = 34$ of 39) of complaints where information about other vulnerabilities was available indicated another vulnerability (most commonly sedation ($n = 12$) but also three cases of previous sexual assault in an acute inpatient unit).
- A small number (14 per cent, $n = 7$ of 50) of complaints were assessed as relating to the person's mental state (assessed either from the service response or from a later withdrawal of the complaint by the person, specifically stating that the concerns had been related to their mental state at the time).
- Most incidents occurred in intensive care areas (ICAs) (40 per cent, $n = 19$ of 47) or bedrooms (34 per cent, $n = 16$ of 47), with six incidents occurring in a women-only area.
- Reporting and referral rates in relation to alleged sexual assaults were of significant concern, with 39 per cent ($n = 17$ of 44) reported to Victoria Police, 11 per cent ($n = 5$ of 44) resulting in a referral to Centres Against Sexual Assault (CASA), and family members and carers notified in only 26 per cent ($n = 12$ of 46) of instances. Information about whether an allegation of sexual assault was reported to the Chief Psychiatrist was often not provided; however, it is noteworthy that in the eight complaints where this information was provided, not one of these was reported to the Chief Psychiatrist as required by the Chief Psychiatrist's Guideline.

While the majority of the complaints related to incidents occurring between people accessing inpatient treatment, a significant minority of complaints ($n = 19$) were about the actions of staff. This represents complaints about the distress associated with the use of restrictive or coercive practices, as well as direct allegations of sexual harassment or assault against staff. Some of the former complaints related to concerns about the way people experienced interventions including restraint, seclusion or the provision of intramuscular injections, which were experienced as extremely distressing, particularly when the person had previous experiences of trauma (for discussion of the links between sexual safety, trauma-informed care and minimising the use of restraint and seclusion see section 2.3.3). These are relevant issues for the project, and eliminating or modifying restrictive and coercive practices must be considered in service approaches to providing trauma-informed, sexually safe care.

Other complaints related to allegations of sexual harassment and assault against mental health service staff. However, while some of these complaints raised serious allegations about staff behaviour, the steps required to prevent, investigate and respond to these concerns appear to be clearer for services than when responding to incidents and allegations of sexual harassment or assault between people accessing inpatient treatment. There are also clear regulatory and legal mechanisms to address incidents and allegations involving staff. There were individual instances where the investigation into the complaint could have been conducted with more independence, rigour and transparency, and this has been considered in forming project recommendations. However, the majority of the difficulties for services appeared to be in preventing and responding to incidents occurring between people accessing inpatient treatment.

Incident reports were not sought for this project. One issue that this project has identified is the level of under-reporting of particular kinds of complaints, particularly gender safety and sexual harassment, as well as inaccurate categorisation of other kinds of incidents including alleged sexual assault. It was therefore considered that access to incident reporting data was not likely to provide a reliable comparator to complaints data for the purposes of this report. However, this report makes a number of recommendations for improving the consistency and utility of incident reporting, as well as recommending that the MHCC and the department work closely to compare trends in complaints and incident reporting to identify trends requiring departmental intervention and support. Work is already underway to enable this.

1.2.2.2 Investigations

During the 2017–18 reporting period, the MHCC completed formal investigations under Part 10, Division 4 of the Act into four complaints involving a range of sexual safety incidents including sexual activity, harassment and alleged sexual assaults. These investigations involved the exercise of the Commissioner's powers to examine in detail the circumstances leading up to the incident that resulted in the complaint, the response to the initial allegations and to any complaint made by the affected person or their family, as well as the follow-up care provided. Investigation processes included extensive examination of clinical records and service documentation, and interviews with the consumer at the centre of the complaint, family members and mental health service staff. Interviews with service staff included staff involved in direct care provision and response to the incident, service leadership and consumer and carer consultants. Each consumer who experienced the sexual safety breach was supported to participate in

the investigation, and provide the account of their experience and its impact, together with their views on what could be done to prevent similar incidents occurring for other people. Family members were similarly supported to participate in the investigations.

Investigation panels were convened for each investigation and included members with senior clinical and operational experience in acute mental health inpatient service provision, and expertise in issues related to sexual safety (see Acknowledgements, p. 3). Each investigation resulted in extensive findings and recommendations for service improvement actions as well as actions to address the individual concerns raised in the complaint. The findings and recommendations of the four investigations have informed this report.

Panel members Professor Jayashri Kulkarni, Ms Joy Barrowman, Associate Professor Bridget Hamilton, Ms Sandra Keppich-Arnold and Ms Jo Ryan contributed their considerable expertise and experience to these investigations.

1.2.2.3 Consultations

A key part of the project was to seek advice and input via consultations with organisations, peak bodies, services and individuals, all of whom had expertise in, experience in or direct knowledge of either preventing or responding to concerns about sexual safety in mental health inpatient environments. We sought views about how sexual safety concerns are addressed and managed by services in acute mental health inpatient environments. We consulted more than 100 people about these issues, including people with experience of accessing and providing services, professional bodies, government and advocacy and human rights organisations.

A full list of the consultations is set out at Appendix 1.

1.2.2.4 Literature review

Two commissioned literature reviews also informed the project. The first was undertaken to help analyse the themes from complaints in the context of the available evidence about sexual safety in mental health inpatient units, specifically considering the causes and impact of sexual vulnerability, harassment and assault, as well as evidence-based strategies to improve gender and sexual safety in those environments. This review considered national and international academic literature and 'grey' literature including reports generated by advocates and people with lived experience of accessing mental health services, as well as relevant standards in mental health service provision. This literature review was undertaken by Professor Jayashri Kulkarni and Dr Jasmin Grigg of MAPrc.

Dr Haley Peckham from the Centre for Psychiatric Nursing was commissioned to undertake the second literature review. This review provides an overview of the neurobiology of trauma and the implications of the high rates of trauma in people accessing mental health services.

The findings from these literature reviews have informed and been incorporated into this report.

Key project statistics

100+

people consulted, including people with lived experience, families and carers, service providers and staff, professional bodies, peak bodies, government and advocacy organisations

90

complaints analysed:
23 oral complaints to the MHCC
27 written complaints to the MHCC
40 complaints reported by services

200+

pieces of research, grey literature, policy and standards reviewed

4 formal investigations that involved:

3700+

pages of clinical records reviewed

170+

pages of complaint, investigation and incident related documents reviewed

1200+

pages of services policies, guidelines, training resources, handouts and posters reviewed

54

interviews undertaken as part of the four investigations conducted by the MHCC with people accessing treatment, families/carers and mental health services staff

1.3 SEXUAL SAFETY AND MENTAL HEALTH SERVICES

Standards for health and mental health services, as well as human rights instruments, are clear that people have the right to a safe environment when accessing treatment.

However, people accessing mental health services, particularly women and advocates including mental health service staff, have long raised concerns about sexual safety in these environments. Women have reported experiences ranging from feeling unsafe and threatened, to being exposed to the sexualised behaviours of others, to sexual harassment, engaging in later-regretted sexual activity, and experiencing sexual assault while an inpatient.

— These themes have been consistent across several decades and have appeared throughout the course of this project, indicating that women's experiences have not changed significantly despite investments in infrastructure and training.

Experiences of sexual assault while accessing treatment is an issue that overwhelmingly, if not exclusively, affects people accessing mental health services (Department of Health and Human Services 2016c). **People accessing mental health services have the same right to be safe while accessing treatment as people accessing other health services**, and this project identifies a number of strategies to ensure this.

1.3.1 WHAT IS SEXUAL SAFETY?

Definitions of sexual safety vary. The Chief Psychiatrist's Guideline defines sexual safety as:

... a state in which physical and psychological boundaries of individuals are maintained and respected. Individuals can promote their own sexual safety by engaging in protective behaviours, assertive communication and respectful relationships. Systems can promote sexual safety by developing and operationalising policies and procedures which:

- support the right to physical and psychological safety
- encourage the monitoring of professional boundaries
- encourage and provide professional development
- respond appropriately to breaches in boundaries.

(Department of Health 2009, p. 7)

This is a system-focused definition, which may be useful in setting a framework for the broad system approaches that are necessary to ensuring sexual safety. Similarly to the Victorian definition, the New South Wales document *Sexual safety: responsibilities and minimum requirements for mental health services* defines sexual safety by focusing on the boundaries between people, describing it as 'the recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people' (New South Wales Ministry of Health 2013b, p. 2).

These kinds of boundary-focused definitions, while conceptually useful, may be less helpful in supporting staff and people accessing inpatient treatment to recognise and name the behaviours that constitute a lack or breach of sexual safety (including potentially criminal behaviours) and the steps required of services to prevent, identify and respond to breaches. One of the themes noted in this report has been the lack of consistency with which mental health service staff are able to identify, name and respond to issues including potentially criminal activity such as sexual harassment and sexual assault, and to also recognise the impacts of these behaviours on people accessing treatment. It is therefore critical to specifically name and think about these behaviours in defining sexual safety.

This project defines sexual safety as feeling and being safe in acute mental health inpatient environments, including being free from sexual activity, sexual harassment and alleged sexual assault.

1.4 IMPACTS OF SEXUAL SAFETY BREACHES DURING ACUTE INPATIENT TREATMENT

Literature consistently reports the gravity of the impacts of sexual safety breaches, for both mental and physical health, including the long-lasting impacts of trauma.

While there is limited direct evidence about the impact of sexual safety breaches occurring in acute mental health inpatient units, it can be extrapolated from related research that these impacts may be more significant than for the general population. One reason for this may be that, given the high prevalence of previous trauma in people accessing public mental health treatment, it is likely that any sexual safety breaches will be in addition to previous traumatic experiences and may compound the initial trauma and its impacts. The information below is a summary of the impacts of sexual safety breaches. A more detailed discussion of trauma and its impacts is provided in section 2.3.3.

1.4.1 MENTAL HEALTH CONSEQUENCES

There is clear evidence that experiencing sexual violence of any kind, whether as a child or as an adult, has significant and long-lasting effects on health and mental health (see section 2.3.3). The literature does not identify specific research conducted into the mental health consequences of sexual safety breaches in an acute inpatient environment. However, it can be extrapolated from related research that being sexually assaulted while accessing acute mental health treatment could lead to more significant and enduring harm and distress for people with mental illness than for people in the general population. In the community, when compared with those from the general population, women with serious mental illness are significantly more likely to report adverse psychological effects (92 per cent compared with 64 per cent from the general population) and are significantly more likely to attempt suicide (53 per cent compared with three per cent from the general population) following sexual assault (Latalova, Kamaradova & Prasko 2014).

The literature highlights the way in which sexual violence can result in self-harm and suicide attempts, along with feelings of worthlessness, hopelessness, shame and guilt. However, these negative impacts may be seen to result from a relapse of the person's illness rather than recognising that such behaviours can be triggered by trauma or post-traumatic stress resulting from the experience of sexual assault (Khalifeh et al. 2015).

—— It is clear that re-traumatisation, interference in treatment and effect on recovery are all potential longer term consequences (Ford et al. 2003) of breaches of sexual safety.

1.4.2 HEALTH CONSEQUENCES

There are a number of clear health consequences – both immediate and longer term – when sexual activity or sexual assault occurs in the mental health inpatient environment. Immediate consequences include the risk of injury, sexually transmissible infections and, for women, pregnancy (Scobie et al. 2006). The literature also highlights the significant long-term adverse consequences of sexual violence, particularly against women, on a person's wellbeing and recovery, including impacts on physical health (Latalova, Kamaradova & Prasko 2014). Further, an extensive body of research now links adult chronic disease to adverse experiences in early life (Shonkoff, Boyce & McEwen 2009) and the effects from cumulative traumas including sexual assault in adulthood, which may further influence the development of chronic disease (see section 2.3.3).

1.4.3 PUBLIC HEALTH IMPACT AND COST

Trauma has a negative, often lifelong impact on individuals. The long-term effects of unrecognised trauma contribute to long-term poverty and high costs to healthcare systems (Davis & Maul 2015). People accessing inpatient mental health treatment with a history of sexual assault and trauma are four times more likely to be receiving the disability support pension, three times more likely to have experienced divorce, and to have experienced a significantly greater number of previous mental health admissions (McFarlane et al. 2006). The far-reaching consequences, and costs, of sexual violence against women is clear and includes tangible costs associated with medical care, mental health service use, mental health medication use, loss of economic productivity and costs associated with the criminal justice system (Post et al. 2002). The intangible costs of rape and sexual assault include psychological suffering, post-traumatic stress disorder and the emergence of other mental health conditions, suicide attempts and completion of suicide, generalised fear of victimisation and other negative outcomes including lowered self-esteem, feelings of powerlessness, concentration difficulties and the development of phobias (Post et al. 2002). *Free from violence: Victoria's strategy to prevent family violence and all forms of violence against women* (Department of Premier and Cabinet 2017) notes the broad impacts of violence against women (which includes sexual violence) as including impacts on physical and mental health as well as social and economic impacts. The strategy also notes the substantial social and economic costs to the community in failing to prevent violence against women.

1.5 BRIEF HISTORY OF SEXUAL SAFETY IN MIXED-GENDER ACUTE MENTAL HEALTH INPATIENT UNITS

Until the 1960s, mental healthcare in Victoria was provided in single-gender units. At this time, inpatient units were integrated for a number of reasons including, it has been stated, better managing the behaviours of men (Gerrand 1993). It must be noted that at the time that these units were integrated to mixed-gender units, the context of care was considerably different. People were likely to receive treatment for longer periods of time rather than the extremely short stays (currently averaging less than nine days (Department of Health and Human Services 2018a)) currently associated with acute mental health inpatient treatment.

However, the significant impact of mixed-gender treatment on women in modern acute inpatient unit environments has long been acknowledged. While men can also experience sexual violence or intimidation in these environments, women are noted as being particularly at risk of sexual harassment, intimidation and sexual assault (Davidson 1997; Graham 1994; Stamp 2009; Victorian Women and Mental Health Network 2007; Women's Mental Health Network Victoria (WMHNV) 2017), and women's experiences has been the focus of much of the research and commentary in this area. Concerns that have been consistently raised over time include the following:

– Women who are exposed to unwanted and inappropriate sexual attention from men accessing services results in intimidating and traumatic experiences of care. This includes exposure to sexual assault, intimidation, harassment, sexual activity and a lack of trauma-informed care (Stamp 2009; Victorian Women and Mental Health Network 2007). Staff identification of and responses to this behaviour have also been noted as problematic for women, with women reporting their view that behaviour is excused on the basis of the perpetrator's illness. A recurrent theme is fear of making a complaint due to a fear of being placed in an ICA, often an area where women feel less safe (see section 2.3.5) (Victorian Women and Mental Health Network 2007).

– More recently, VMIAC published the results of a small study noting that almost half (45 per cent) of the women participants reported sexual assault while accessing acute inpatient treatment, while 67 per cent reported sexual or other harassment and 85 per cent reported feeling unsafe during hospitalisation (VMIAC 2013).

– The WMHNV (2017) has recently published the results of a small survey of women's experiences in mixed-gender acute inpatient units that indicated continuing themes of fear, traumatisation from the inpatient admission and witnessing or experiencing violence while an inpatient (see section 2.3.4.1 for a detailed account).

– Community Visitors in Victoria have reported issues of sexual safety in acute mental health inpatient units in successive annual reports, highlighting the need for the risks to sexual safety be recognised and addressed to prevent incidents and associated trauma (Office of the Public Advocate 2017).

These issues have been acknowledged and prioritised by successive Victorian governments, the department, the Chief Psychiatrist and mental health services, with many initiatives identified to improve women's safety. However, complaints to the MHCC indicate that these concerns continue, and there is a need to consider different approaches to ensuring sexual safety for all people accessing acute mental health inpatient treatment.

1.6 STEPS TAKEN IN VICTORIA IN RELATION TO SEXUAL SAFETY IN MENTAL HEALTH SERVICES

In recognition of the impacts of breaches of sexual safety in acute inpatient environments and the obligation of services to provide a safe treatment environment, the department and the Chief Psychiatrist have implemented a range of initiatives.

- ‘Gender sensitivity and safety in adult acute inpatient units project’ (Department of Human Services 2008): The report on this project identified a range of issues about the treatment and care of people accessing mental health acute inpatient treatment, including a need for clearer policy and guidelines to promote more consistent and responsive practice.
 - *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units guideline* (Department of Health 2009, updated in 2012) (referred to in this report as the ‘Chief Psychiatrist’s Guideline’): This was developed in response to the above report. This guideline provides detailed guidance to clinical mental health services on managing and responding to concerns about sexual safety. This project has identified some gaps and areas requiring clarification in the guideline, and these are addressed through the recommendations in this report.
 - *Service guideline on gender sensitivity and safety* (Department of Health 2011a): This applies to mental health and alcohol and other drugs settings. This guideline provides a high-level overview of considerations for services in providing gender-sensitive and trauma-informed care, including considerations for services operating mixed-gender bed-based services.
 - Funding and rolling out training for mental health services on providing gender-sensitive care. While this training has been widespread, themes from complaints, as well as a recent consultation process on implementing the training and guidelines, indicate that many staff lack clarity about their role in ensuring sexual safety on acute inpatient units.
 - Targeted funding to mental health services through the Safety of Women in Mental Health Care Initiatives and subsequent capital grants for improvements to service infrastructure including creating women-only areas including lounges, courtyards and bathrooms, and investing in infrastructure such as lockable bedroom doors and swipe-band access to women-only areas.
 - Sexual safety has been identified as a priority focus by the Chief Psychiatrist, with work being undertaken in 2017–18 to review the Chief Psychiatrist’s Guideline, to design a new reporting framework and to commission ‘gender-sensitive safe practice manager’ workshops conducted by the WMHNV (Department of Health and Human Services 2017b, p. 4).
- Despite the significant improvements to infrastructure in some services enabled by this funding, many services continue to face significant challenges with unit design not adequately supporting safety. Themes from complaints, consultations and research indicate that where women-only areas exist, they are often not maintained due to demand for beds (see section 2.3.4), practices that do not prioritise sexual safety, or because services lack important infrastructure to support effective implementation (including swipe-band access to women-only areas). Importantly, ICAs have not generally addressed the issue of women’s safety, and these environments continue to pose significant safety concerns for people identified as vulnerable within acute mental health inpatient units (see section 2.3.5).
- In addition to and despite the training provided, people report that they do not consistently experience care that is gender-sensitive and that prioritises sexual safety by taking appropriate action to identify and respond to expressed concerns. It appears that not all staff have had the opportunity to undertake training in key principles that would help them implement sexually safe and trauma-informed care insofar as it can be implemented within a mixed-gender environment. Strategies to support learning and development and influence cultural change are required. Both the MHCC and the Chief Psychiatrist have identified concerns about sexual safety in acute mental health inpatient units, with both offices working collaboratively on ways to address these issues through their respective roles.

1.7 APPROACHES TO SEXUAL SAFETY IN OTHER JURISDICTIONS

The need to address sexual safety in mental health services has prompted other jurisdictions to develop policy directives and guidelines and to consider creating gender-safe areas or single-gender inpatient units.

Lessons can be drawn from other jurisdictions to prevent and better respond to sexual safety breaches within Victorian acute mental health inpatient units. This report recommends a range of measures considered in other jurisdictions, most significantly the development and adoption of a policy directive outlining the minimum requirements of mental health services, and moving towards greater separation of men and women accessing mental health services including piloting and evaluating a women-only acute inpatient unit.

An overview of approaches adopted in other jurisdictions is outlined below.

1.7.1 NEW SOUTH WALES

New South Wales has provided clear policy direction for mental health services that outlines responsibilities and minimum requirements for the ‘establishment and maintenance of sexual safety of mental health consumers’ (New South Wales Ministry of Health 2013a, p. 1). This includes mandatory requirements for mental health services to ensure the sexual safety of people accessing inpatient treatment, including requirements to:

- develop sexual safety standards that define appropriate behaviour for the context of the particular setting

- provide clear advice to people accessing inpatient treatment about their rights and responsibilities regarding sexual safety, including the standards for that service setting and how to raise concerns
- ensure relevant staff have received training to enable them to effectively prevent and respond to sexual safety incidents, including risk/vulnerability assessment, and how to take a sexual assault history
- build or strengthen partnerships with sexual assault services, police and other stakeholders
- regularly audit gender-sensitive practice to identify areas for improvement
- ensure risk assessments include an assessment of sexual vulnerability and that these assessments are integrated into care plans
- respond to disclosures in accordance with the policy directive
- ensure information about alleged breaches of sexual safety is not disclosed except with the consent of the person, except in defined circumstances
- ensure staff have the opportunity to debrief following a sexual safety breach
- follow reporting processes as set out in the policy directive and accompanying guideline.

In contrast with the Chief Psychiatrist's Guideline in Victoria, the New South Wales policy directive applies to non-acute and residential settings and community mental health settings, as well as acute inpatient mental health settings. The policy directive sets out specific responsibilities for each setting, which for acute mental health services include the responsibility to:

- support people to be free from pressure to engage in sexual activity while in an acute environment and to ensure that sexual safety standards highlight that sexual activity is not supported in an acute setting due to the vulnerability of the people involved, as well as that of any people who may witness the activity
- consider how changes to the physical environment may support sexual safety.

This policy directive includes self-assessment/audit and monitoring checklists for local health districts and individual services to guide assessment of whether the minimum requirements have been met.

The policy directive is complemented by the New South Wales *Sexual safety of mental health consumers guidelines* (New South Wales Ministry of Health 2013a).

This document provides detailed guidance to services on considerations and approaches to implementing the policy directive across areas including:

- defining sexual safety, including defining sexual safety incident types, and outlining rights and responsibilities and relevant legislation
- fostering a culture that supports sexual safety, including the role of training and education for staff, people accessing inpatient treatment, families and carers, promoting a culture of safety, and the importance of collaboration with people accessing inpatient treatment, families and carers and other professionals including general practitioners, sexual assault services and police
- preventing sexual safety incidents, including sexual harassment and assault (including risk assessment, the role of gender sensitivity and physical infrastructure, and maintaining appropriate professional boundaries), sexual activity and sexual disinhibition
- responding to suspected or alleged sexual safety incidents, including consideration of capacity and consent
- reporting and recording requirements
- considerations for vulnerable groups.

While these guidelines have the benefit of specifying four types of 'sexual safety incidents' to guide responses and reporting, the definition of sexual activity attempts to cover consensual sexual activity in a range of settings, which is problematic when applied to an acute inpatient mental health setting, notwithstanding that the policy specifies this as an 'inappropriate setting' for sexual activity (New South Wales Ministry of Health 2013b, p. 11).

In addressing the physical environment, this document also considers the guidance provided by the *Australasian health facility guidelines* (Australasian Health Infrastructure Alliance 2015) and outlines suggestions for mental health services to improve the physical environment to support sexual safety (including establishing single-gender corridors, women's lounges, family visiting areas, lockable bedroom doors, nurse call buttons, clear signage and sensory motion detectors). While some of these are major changes that are difficult for mental health services to implement without support, and this is acknowledged in the guideline, practical steps such as clear signage can prevent inadvertent access to single-gender areas and therefore more effectively support safety.

1.7.2 WESTERN AUSTRALIA

Western Australia's most notable difference from the Victorian policy context is the implementation of mandatory reporting to the Chief Psychiatrist of all 'sexual contact' or alleged sexual assault involving people accessing both inpatient and community-based mental health services (for community-based services, this applies where the sexual contact or activity occurred on the premises of the service). Sexual contact and alleged sexual assaults are included as 'notifiable incidents' under Part 9 of Western Australia's *Mental Health Act 2014*. Sexual contact is defined as any sexual activity or behaviour between people over the age of 16 where 'mutual consent has been granted' (Department of Health 2015, p. 4). Reports must outline the steps taken to ensure immediate safety as well as providing advice about whether sexual assault services and police have been involved in the response, and providing a reason if this has not occurred (Department of Health 2015, pp. 12–13).

1.7.3 UNITED KINGDOM

The United Kingdom (UK) has adopted a comprehensive approach to reducing and eliminating mixed-sex accommodation across all bed-based physical and mental health services. This has been a priority for the UK since 1997, when the £100 million Privacy and Dignity fund was established to support services to make infrastructure changes.

The stated rationale for providing single-sex accommodation in the UK was that single-sex accommodation better supports the privacy and dignity of people accessing treatment (Department of Health 1997). The following principles have been applied in the UK to achieve the goal of eliminating mixed-sex accommodation:

Men and women should not normally have to share sleeping accommodation or toilet facilities. Irrespective of where patients are, staff should always take the utmost care to respect their privacy and dignity. Single-sex accommodation can be provided in:

1. *Single-sex wards (i.e. the whole ward is occupied by men or women but not both)*
2. *Single rooms with adjacent single-sex toilet and washing facilities (preferably en-suite)*
3. *Single-sex accommodation within mixed wards (i.e. bays or rooms which accommodate either men or women, not both; with designated single-sex toilet and washing facilities preferably within or adjacent to the bay or room).*

(NHS Institution for Innovation and Improvement 2007, p. 4)

While this approach has some similarities to the women's areas or corridors implemented in Victoria, it has more stringent requirements that are supportive of safety, including the requirement for bays or rooms to accommodate either men or women (as opposed to the practice of men being accommodated in women-only corridors due to demand for beds) and requirements for bathrooms to be ensuite or designated as men's or women's. In addition, NHS trusts were also held accountable for policy implementation, requiring trusts to report any accommodation of a person within a mixed-sex area, with the possibility of funding being withheld for any person who was not accommodated in a single-sex area (Department of Health 2010).

The implementation of single-sex accommodation in the UK has not been comprehensively evaluated for its effect on ensuring sexual safety. There is some limited evidence that it reduces the number and severity of incidents and that providing single-gender accommodation is at least equal to mixed-gender accommodation, and may have some benefits (Hawley et al. 2013) (see section 2.3.4.4).

1.7.4 SOUTH AUSTRALIA

Similar to the UK, South Australia has moved towards providing same-gender accommodation across general and mental health inpatient services on the basis that this better preserves and promotes the privacy and dignity of individual patients (Department for Health and Ageing 2014).

— This policy provides that all patients should be able to access same-gender accommodation facilities and should not have to move through mixed-gender areas to reach their own accommodation or bathrooms.

While it does contain some exemptions on the basis of clinical need (and this includes high dependency units), the guideline provides that people accessing mental health services will generally be accommodated in same-gender rooms.

South Australia Health has also provided a policy directive for *Reporting and management of incidents of suspected or alleged sexual assault of an adult, or sexual misconduct by an adult* that applies to mental health services (South Australia Health 2015b). The aim of this policy directive is to provide 'a consistent process for the reporting and management of suspected or alleged incidents of sexual assault or misconduct' (p. 3). This policy requires services to report all incidents of suspected or alleged sexual assaults to the police and to the health department and sets out 'the duty of care and legal obligation to provide health care in a way, and in an environment, that promotes personal safety and minimises risk of sexual assault or sexual misconduct' (p. 4).

1.7.5 QUEENSLAND

Queensland's *Sexual health and safety guidelines – mental health, alcohol and other drug services* (Queensland Health 2016) contains similar guidance and categorisation of incidents to the New South Wales *Sexual safety of mental health consumers guidelines*, and similarly applies to a range of settings including drug and alcohol services. It includes similar types and definitions of sexual safety incidents and sets out monitoring and evaluation requirements for services. Queensland's guidelines include goals to: 'improve recognition of factors impacting on the sexual safety of clients; identify and appropriately respond to sexual safety risks, appropriately respond to allegations of sexual assault and establish a service culture which promotes sexual health and sexual safety' (Queensland Health 2016, p. 1)

1.8 CURRENT REQUIREMENTS OF MENTAL HEALTH SERVICES TO ENSURE SEXUAL SAFETY

A number of policy directions and human rights obligations require services to take steps to ensure the sexual safety of people accessing acute mental health inpatient treatment and to effectively respond to breaches of sexual safety. Relevant considerations from legislation, policy guidance and standards are set out in this section.

1.8.1 LEGISLATION

1.8.1.1 *Mental Health Act 2014 (Vic)*

The objectives and principles of the Act are highly relevant in considering the responsibility of services to ensure sexual safety in a way that is compatible with their obligations as public authorities to uphold and promote the human rights of people accessing treatment. Relevant objectives include 'to protect the rights of persons receiving assessment and treatment' (s 10(c)) and 'to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity' (s 10(b)). The following mental health principles are also relevant:

- persons receiving mental health services should have their rights, dignity and autonomy respected and promoted (s 11(1)(a))
- services should be provided with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life (s 11(1)(b))
- assessment and treatment should be provided in the least restrictive way possible (s 11(1)(a))
- persons receiving mental health services should have their individual needs (whether as to culture, language, religion, gender, sexuality or other matters) recognised and responded to (s 11(1)(g)).

1.8.1.2 *Charter of Human Rights and Responsibilities Act 2006 (Vic)*

The Charter of Human Rights and Responsibilities Act, with which public mental health services as public authorities must comply, provides that:

- 'every person has the right to liberty and security' (s 21(1))
- a person must not be treated in a 'cruel, inhuman or degrading way' (s 10(b))
- a person has a right 'not to have his or her privacy ... arbitrarily interfered with' (s 13 (a))
- 'all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person' (s 22(1)).

These rights place positive obligations on mental health services to take steps to ensure that people accessing their services are safe, including sexually safe, and that their human rights are upheld.

1.8.1.3 *Optional Protocol to the Convention Against Torture*

Australia's recent ratification of the *Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* further emphasises the responsibility of mental health services to promote and protect the sexual safety of people accessing inpatient treatment. The protocol aims to prevent torture and cruel, inhuman or degrading treatment within closed environments including secure mental health services. By ratifying the protocol, Australia has committed to ensure independent scrutiny of these environments and agrees to allow the United Nations to inspect places of detention.

— This places an additional degree of accountability on mental health services to ensure people do not experience cruel, inhuman or degrading treatment in inpatient settings, including by ensuring all reasonable measures are taken to protect the sexual safety of people who may be at risk from other people accessing inpatient treatment.

1.8.2 STANDARDS

1.8.2.1 *National Standards for Mental Health Services*

Standard 2.1 of the *National Standards for Mental Health Services* (NSMHS) requires mental health services to take steps to ensure sexual safety as part of their responsibility to provide a safe service, requiring services to promote 'the optimal safety and wellbeing of the consumer in all mental health settings' and to ensure that the consumer is 'protected from abuse and exploitation'. In addition, Standard 6.2 of the NSMHS provides that 'consumers have the right to receive services free from abuse, exploitation, discrimination, coercion, harassment and neglect'.

1.8.2.2 *National Safety and Quality Health Service Standards*

To maintain their accreditation, health services are required to meet the criteria set out in the *National Safety and Quality Health Service* (NSQHS) Standards. Standard 1 of the NSQHS Standards requires all health services to have 'integrated systems of governance to actively manage patient safety and quality risks' (ACSQHC 2012a, p. 10). The second edition of the NSQHS Standards, launched in November 2017, specifies that health services are required to provide 'a safe environment for the delivery of care' (ACSQHC 2017a, p. 17). From January 2019, mental health services will be required to demonstrate the safety of their care environment for accreditation under these updated standards.

1.8.3 POLICY, GUIDELINES AND STRATEGIES

1.8.3.1 *Chief Psychiatrist's Guideline*

The Chief Psychiatrist's Guideline provides that mental health services must actively promote the sexual safety of people accessing treatment, including taking action to prevent harm occurring to people in their care. It states that:

... mental health services have a duty of care to protect all consumers from the unwanted behaviours of others, and behaviours of their own that they might not choose to engage in when well. It is generally recognised that sexual activity in a treatment setting is not appropriate and should be actively discouraged.
(Department of Health 2009, p. 8)

The Chief Psychiatrist's Guideline also outlines the importance of identifying patients who are at risk of engaging in 'inappropriate sexual activity' to promote sexual safety and prevent harm (Department of Health 2009, p. 17). It states that these individuals need to be closely monitored and regularly assessed. It sets out elements to consider as part of an assessment and strategies for reducing the risk of harm. In the event of an allegation of sexual assault or harassment, the Chief Psychiatrist's Guideline outlines the procedure for re-establishing safety, responding to the victim, medical examination of the victim, assessment of the person's decision-making capacity, reporting to the Chief Psychiatrist, and when to report an allegation to the police.

1.8.3.2 *Service guideline on gender sensitivity and safety*

This Department of Health (2011a) guideline aims to help mental health services to deliver services that identify and respect the needs, wishes and experiences of people in relation to their gender and sexual identity. The guideline acknowledges the specific challenges posed by mixed-gender acute inpatient units, particularly the exposure of women to sexual, physical or emotional abuse. The guideline, along with advice provided on the department's gender safety in bed-based services webpage (see www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/gender-sensitivity-and-safety/gender-safety-in-bed-based-services), acknowledges the impacts of these experiences and offers suggestions for services to promote women's safety. These suggestions include:

- adopting a policy of no sexual activity
- conducting regular risk assessments
- providing clear guidance to staff about what a sexually safe environment looks like and their responsibility to protect the safety of all patients
- establishing women-only areas and lounges
- installing door locks on bedrooms and bathrooms
- identifying specific staff and creating committees to monitor gender issues and to make recommendations for service improvements.

1.8.3.3 *Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*

Targeting zero (Department of Health and Human Services 2016c) reviewed the department's safety and quality systems and made recommendations about how these might be improved to achieve contemporary best practice, with a view to ensuring improved identification and prevention of avoidable harms occurring during treatment. While the report focuses on the department's responsibilities in providing adequate oversight of safety and quality, the recommendations also have implications for mental health service providers and the governance structures of the health services they belong to (discussed further in section 2.3.3.3.)

Targeting zero specifically noted the concern that people accessing mental health treatment are exposed to particular risks and harms not experienced by people accessing other types of healthcare services, including 'assault (including sexual violence) from other patients (which ... is very rare for general patients)' (Department of Health 2016c, pp. 133–134). The reports points to unacceptable disparities in service provision for people with mental illness.

1.8.3.4 Incident reporting policy and guidelines

The department's VHIMS policy (Department of Health 2011c) and policy guide (Department of Health 2011d) are intended to 'guide health services to establish and support a structured incident management review process that is consistent with best practice and reflective of their clinical governance policy and overarching framework' (Department of Health 2011c, p. 5). These guidelines outline service responsibilities to report and manage incidents occurring in health services (including mental health services).

Issues in applying the VHIMS policy and policy guide in relation to reporting of sexual safety incidents are discussed in section 2.5.6.1.

1.8.3.5 Victoria's 10-year mental health plan

The 10-year mental health plan (Department of Health and Human Services 2015), while it contains no specific reference to sexual safety, has a key focus on human rights, emphasising Victoria's 'strong rights-based framework'. The plan also notes the impact of gender inequality on women, noting the disproportionate rates of domestic violence and sexual abuse experienced by women and the associated impacts on mental health. It prioritises co-production as a means to improve services and promotes the need for services to appreciate that 'a person's life experiences, expectations, culture and beliefs, age, sex, gender, gender identity, sexual orientation and ethnicity, and the relationship between these factors, all influence their understanding and experience of mental health' (Department of Health and Human Services 2015, p. 20).

The 10-year mental health plan also acknowledges the impact of discrimination, marginalisation and disadvantage experienced by some groups, which increases their risk of mental health problems and affects whether they seek help, and notes the need to design and deliver services in a way that ensures safe services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities.

1.8.3.6 Safe and strong: A Victorian gender equality strategy

Safe and strong, Victoria's gender equality strategy (Department of Premier and Cabinet 2016), sets out a framework for action to build the attitudinal and behavioural change required to ensure gender equality as a foundational prevention strategy to prevent violence against women and girls. The strategy identifies four drivers of violence against women:

- rigid gender roles
- condoning of violence against women
- men's control of decision making and limits to women's independence
- male peer relations that emphasise aggression and disrespect towards women.

This last driver is particularly relevant to mental health inpatient services, given women's reports over time of feeling intimidated, threatened and unsafe because of the behaviours of men accessing services.

Mental health services have a key role to play in setting expectations, monitoring and ensuring respectful interactions between people accessing mental health services.

The strategy also notes that the impact of gender inequality is compounded by the way that gendered barriers interact with other forms of disadvantage and discrimination, and that women who face multiple and intersecting forms of discrimination and disadvantage are at even greater risk of violence and encounter greater difficulties in accessing support (Victorian Government 2016, p. 28). Particular considerations for ensuring the sexual safety of diverse groups are set out in this report in section 2.4.3.

Actions to ensure sexual safety within acute mental health inpatient units support the implementation of the gender equality strategy, linking directly to:

- outcome 5 (all Victorians are safe in their homes, communities and workplaces; indicator: decrease in prevalence of reported sexism, sexual harassment and gendered bullying)
- outcome 6 (all Victorians are socially connected and healthy; indicator: increased access to gender-sensitive health services).

— Accordingly, ensuring sexually safe mental health services should be considered a core part of Victoria's endeavour to achieve gender equality and prevent all forms of violence against women. —

1.9 CONCLUSION TO THE OVERVIEW

Issues of sexual safety breaches in acute mental health inpatient units are longstanding, serious and impact disproportionately on women accessing acute mental health inpatient treatment. These issues are still present despite attempts to improve the safety of mental health services. Jurisdictions take different approaches to ensuring sexual safety; however, what is clear is that approaches to ensuring sexual safety must provide a framework for implementing current standards and be grounded in principles of human rights, gender equality and violence prevention.

1.8.3.7 Free from violence: Victoria's strategy to prevent family violence and all forms of violence against women

Free from violence: Victoria's strategy to prevent family violence and all forms of violence against women (Department of Premier and Cabinet 2017) sets out five essential actions, drawn from national frameworks, to address the factors known to drive violence against women:

- challenging the condoning of violence against women
- promoting women's independence and decision making in public life and in relationships
- fostering positive personal identities and challenging gender stereotypes and roles
- strengthening positive, equal and respectful relations between and among women and men, girls and boys
- promoting and normalising gender equality.

Particularly relevant to ensuring sexual safety in mental health acute units is taking action to challenge the condoning of violence against women (including doing so inadvertently by failing to identify or address women's experiences of sexual safety breaches in mental health acute inpatient units) and strengthening respectful interactions between women and men in these environments. Further, the strategy also focuses on the need to prevent exposure to violence and support those affected to reduce its consequences, supporting the need for an overarching strategy to prevent sexual safety breaches in acute mental health inpatient environments and to ensure effective responses to any breaches that do occur.

SECTION 2 DISCUSSION AND RECOMMENDATIONS

2.1 OVERVIEW OF FRAMEWORK

Section 2 of this report discusses the key issues relating to sexual safety identified from the project and outlines the recommendations to the Secretary to the Department of Health and Human Services, the Chief Psychiatrist and mental health service providers to prevent breaches of people's sexual safety in acute mental health inpatient units.

The project identified that the goal of ensuring people's sexual safety in acute mental health inpatient units requires detailed consideration of a number of key areas and practices that affect a person's experience of quality and safety in these environments. These key areas are best understood when considered as part of an overall framework for preventing and responding to breaches of sexual safety in mental health services.

The literature on approaches to preventing violence and abuse commonly refers to the need for strategies to consist of primary, secondary and tertiary interventions. These three levels of intervention provide a useful framework for considering the key issues and actions required to ensure people's sexual safety in mental health services. This report uses a similar framework to *Free from violence: Victoria's strategy to prevent family violence and all forms of violence against women* (Department of Premier and Cabinet 2017) in defining the levels of intervention in the following way:

- Primary interventions are whole-of-population initiatives that address the underlying drivers of sexual safety breaches (in this instance, taking a 'whole of system' approach).
- Secondary interventions aim to identify and respond to individuals who are at high risk of perpetrating or experiencing sexual safety breaches.
- Tertiary interventions support people who have experienced sexual safety breaches, hold perpetrators to account and aim to prevent any recurrence.

This framework has been applied to the discussion of the key issues identified from this project, with associated recommendations included at the end of each discussion section.

2.1.1 PRIMARY INTERVENTIONS: PRIMARY PREVENTION

Primary interventions to prevent breaches of sexual safety include reviewing the role of leadership, governance and service cultures, implementing trauma-informed care, and looking at the impact of infrastructure, design and use of spaces on safety. The issues relating to infrastructure include mixed- versus single-gender mental health units, the use of more flexible areas to accommodate individual needs, and options for addressing the particular safety issues associated with high dependency units/intensive care areas (ICAs).

2.1.2 SECONDARY INTERVENTIONS: TARGETED PREVENTION

Targeted prevention strategies for addressing the risks of sexual safety in acute mental health inpatient units include the need to effectively orient people (in terms of policies and expectations in relation to sexual conduct and people's right to be and to feel safe in the service) and reviewing approaches to risk assessments and risk management. The need for targeted prevention strategies for responding to the diversity of needs of people accessing mental health services was also identified.

2.1.3 TERTIARY INTERVENTIONS: RESPONSES TO INCIDENTS

Tertiary interventions and responses to incidents include applying the principles of trauma-informed care and open disclosure, the need for clear standards and requirements for reporting and investigation, working with Victoria Police, documentation standards, and referral and discharge planning processes.

Many of the issues identified in the approaches to targeted interventions and current responses to incidents relate to underlying issues of leadership, governance, service cultures and practices.

All areas discussed in the following sections require action, leadership and a partnership approach from the department, Chief Psychiatrist and mental health service providers to effect lasting change. Some of the recommendations will be more complex to implement than others, requiring partnerships with external agencies including Victoria Police and the Centres Against Sexual Assault (CASA), or reconsideration of the way treatment and care is provided within services. Some of the recommendations will also interface with the work and initiatives being undertaken by Safer Care Victoria and the Victorian Agency for Health Information.

Because the Mental Health Act does not provide for recommendations to be made directly to these new agencies, the recommendations to the department should be read in a way to include potential referral of relevant aspects to Safer Care Victoria and the Victorian Agency for Health Information. Similarly, some of the recommendations to the department could be referred to the Chief Psychiatrist or Chief Mental Health Nurse to address relevant aspects through their programs of work. It is acknowledged that dedication and focus at all levels and coordinated efforts will be required to achieve the types of changes envisaged by the recommendations in this report. However, a number of recommendations can be implemented more immediately to help provide safer environments and to prevent the significant avoidable harms associated with breaches of people's sexual safety.

Primary interventions

Review the role of leadership, governance and service cultures

Implement trauma-informed care

Consider the impact of infrastructure, design and use of spaces on safety

Secondary interventions

Effectively orient people to the inpatient unit

Review approaches to risk assessments and risk management

Tertiary interventions

Apply the principles of trauma-informed care

Apply the principles of open disclosure

Establish clear standards and requirements for reporting, documentation and investigation

Review protocols for working with Victoria Police to respond to sexual safety breaches

Ensure effective referral and discharge planning processes

2.2 THE NEED FOR A COMPREHENSIVE STRATEGY AND POLICY DIRECTIVE

As indicated in the discussion in Section 1 on the various initiatives and actions that have been taken over time to address issues of sexual safety in acute mental health inpatient units, it is clear that much more needs to be done to ensure people's safety in these environments.

The range of issues identified from complaints and the consultations point to the need for a comprehensive strategy from the department that addresses breaches of sexual safety as a priority to preventing avoidable harm in acute mental health inpatient units.

Each of the recommendations discussed in the sections below are important for addressing the particular issues identified from complaints and the consultations for this project. However, to achieve the goal of ensuring people's sexual safety in these environments, the following overall recommendation is made to the department:

Overall recommendation:

That the department develop a comprehensive sexual safety strategy to plan, coordinate and monitor action to prevent and respond to breaches of sexual safety in acute mental health inpatient units

This comprehensive 'sexual safety' strategy should address the range of recommendations in this report, draw together and build on existing initiatives and include:

- a clear policy directive that outlines minimum requirements for infrastructure, policies, practices, staff training, reporting, self-assessments and audits that is supported by guidelines (as outlined below)
- a clear objective of ensuring sexual safety for people in all acute mental health inpatient units (across all age groups)
- guiding principles that reflect human rights, violence prevention (including how gender, disability, race, culture and age may affect people's experiences of violence) and prioritise working with people with lived experience in developing resources and strategies to ensure sexual safety at both the departmental and service levels
- statements that sexual harassment and sexual assault are unlawful and unacceptable and that sexual activity is not permitted in acute mental health inpatient units to ensure all people's sexual safety
- clear definitions of breaches of sexual safety including sexual activity, sexual harassment and sexual assault
- strategies to address primary, secondary and tertiary levels of prevention and intervention in an integrated way

- mandatory reporting requirements, including to the police, department and Chief Psychiatrist
- revision and expansion of the Chief Psychiatrist's Guideline, with references to the broader service guideline on gender-sensitivity and safety to support services to meet their responsibilities under the abovementioned policy directive
- consideration of how to build capacity in service approaches to ensure sexual safety, including building capacity and capability in providing trauma-informed care
- consideration of how to build on or expand existing peer support approaches to help people to feel, as well as be, safe in acute mental health inpatient units
- an implementation, evaluation and monitoring process
- performance measures for services and the inclusion of sexual safety in quality and safety reports across mental health services
- sexual safety as a key consideration when developing or reviewing policies, programs and capital works.

There are many overlapping initiatives, strategies and systems that the department and the wider Victorian Government have been implementing that, together, can form the foundation of the recommended strategy. The central component of this strategy will rely on elevating the issue of sexual safety from being reliant on guidelines and separate initiatives, to one that is underpinned by a clear policy directive by the department and a shared commitment with services to the goal of ensuring people's sexual safety in all acute mental health inpatient units.

Part 15, Division 5 of the Mental Health Act also provides for the Secretary to create a code of practice to 'provide practical guidance to any person or body exercising powers or performing functions and duties under this Act to promote best practice' (s 366). Given the gravity of the issues associated with breaches of sexual safety in acute mental health inpatient units, consideration could also be given to the potential benefits of such a code for managing sexual safety and responding to incidents. This code of practice could reference the Chief Psychiatrist's Guideline while also setting out clear expectations and obligations of services in respect to notification and reporting arrangements, and arrangements with Victoria Police and other bodies.

2.3 PRIMARY PREVENTION

The critical role of governance and oversight of service provision for preventing avoidable harms was highlighted in the *Targeting zero* report (Department of Health and Human Services 2016c).

2.3.1 THE ROLE OF GOVERNANCE

The types of recommendations made in relation to health service governance and the department's role in monitoring and oversight of service performance are particularly relevant to the need for a comprehensive primary prevention strategy to address sexual safety in mental health inpatient units.

2.3.1.1 Performance assessment and monitoring

The department monitors health service performance largely via performance measures set out in service 'Statements of Priorities'. These documents are annual accountability agreements between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets and funding for the year as well as government service priorities. See the department's website at www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/statement-of-priorities for more information.

The *Targeting zero* report noted that the performance measures in place to measure service performance are not sufficiently broad to provide an accurate measure of performance or indication of quality and safety of care (Department of Health and Human Services 2016c, p. 146). In particular, *Targeting zero* highlighted the issue that measures have commonly focused on quantifying efficiencies and have not included longer term outcomes. For mental health, these measures include targets for rates of 28-day readmission, post-discharge follow-up and seclusion but have not included other measures of avoidable harms.

Given the potentially catastrophic long-term effects of breaches of sexual safety, as well as the immediate effect on the efficacy of treatment (see section 2.3.3), the themes identified by this project point to the need for such avoidable harms to be a high priority for reporting and monitoring performance in mental health services. The gross disparity between the rate at which people with mental illness experience sexual violence while accessing treatment compared with general patients (Department of Health and Human Services 2016c, p. 133) warrants increased oversight of these incidents in mental health services.

One option would be to include sexual safety in Statements of Priorities as a way of ensuring service accountability and transparency for breaches. This would most likely require a change in categorisation of these incidents as a distinct category, with different types and severity ratings such as those used in New South Wales and South Australia, which specify alleged or suspected sexual assaults as category 1 incidents (New South Wales Ministry of Health 2013b; South Australia Health 2015b). Mandatory reporting of alleged or suspected sexual assaults is also a way of ensuring effective oversight and monitoring of prevention strategies. As discussed below, the issues identified in relation to incident reporting first require an immediate focus on ensuring all of these incidents are accurately reported under the current system. There is a critical need to accurately identify the prevalence and nature of sexual safety breaches at each service to inform the development of individualised and sector-wide prevention strategies.

The *Targeting zero* report also sets out a range of strategies for the department to improve its ability to detect and respond to potential risks, including by implementing a system of oversight that:

- analyses safety and quality comprehensively
- focuses attention on the outcomes that are most harmful, preventable and prevalent
- combines this information with a broader assessment of risk in hospitals
- links information on risks with appropriate and timely action through monitoring problems and risks until there is strong evidence that they have been resolved. (Department of Health and Human Services 2016c, p. 85)

This last point raises some particular considerations for the department in its oversight role in relation to sexual safety in acute mental health inpatient units. As acknowledged in Section 1 of this report, significant effort has been expended to address these issues but progress has not been measured. Given the variability and inconsistency in incident reporting (see discussion at sections 2.3.1.2 and 2.5.6), it is difficult to assess the prevalence of sexual safety breaches and the impacts of the various initiatives that have been implemented.

— The information available from complaints, however, highlights that people are still experiencing significant avoidable harms associated with breaches of sexual safety and that these are not consistently being reported or escalated through the current systems. This supports the need for a comprehensive strategy that includes clear policy directives for reporting incidents, as well as departmental monitoring and oversight.

2.3.1.2 Data reporting and analysis

A key foundation of any primary prevention strategy is a robust system of data reporting and analysis of all sources of information relevant to safety and risks. This was highlighted in the *Targeting zero* report, which pointed to the need for the department to 'view and assess the rich range of information collected about risks to patient safety' (Department of Health and Human Services 2016c, p. 108). This requires using data collected in the Victorian Hospital Incident Management System (VHIMS), reports to the Chief Psychiatrist and data from complaints handling bodies including the MHCC.

The analysis of complaints to the MHCC and those reported by services, together with stakeholder consultations, indicates that sexual safety incidents are not consistently being categorised or escalated in the current reporting systems and that issues identified in complaints are not consistently captured in incident reports. Issues relating to the current categorisation and rating system in the VHIMS is discussed in detail in section 2.5.6. In summary, however, the complaint analysis shows that incidents of suspected or alleged sexual assaults are not consistently assessed at an

incident severity rating (ISR) of 2 or above to ensure appropriate escalation, monitoring and oversight. There is also evidence from complaints to the MHCC that some incidents would warrant assessment as an 'other catastrophic' type of sentinel event and categorisation of ISR 1. The current *Victorian health incident management policy* however does not specify alleged sexual assaults as a sentinel event or an ISR 1 (Department of Health 2011c). Such categorisation would ensure external review and oversight of service responses by the department.

The inconsistencies in the reporting of alleged sexual assault in particular, including inconsistency in approaches to incident classification and in reporting to the Chief Psychiatrist, means that the department and Chief Psychiatrist currently lack the information required to identify and respond to trends in sexual safety incidents. Incident reporting systems and reporting requirements to the Chief Psychiatrist are also not currently integrated, creating a further barrier to accurate monitoring and an increased burden on services. The department is currently undertaking work on legislative reform that will enable information sharing between the MHCC and the department, and this is a welcome reform that will improve the department's ability to identify and respond to risks to safety including sexual safety.

— The issues identified in complaints and consultations, however, point to the need to readily identify 'sexual safety incidents' as a distinct incident type.

This will enable different types and levels to be categorised to ensure both appropriate escalation of incidents and monitoring of sexual safety in services. This occurs in other jurisdictions such as South Australia and New South Wales, where sexual safety breaches are categorised as, for example, 'suspected or alleged sexual assaults', 'sexual harassment', 'sexual activity' or 'sexually disinhibited behaviour' (New South Wales Ministry of Health 2013b; South Australia Health 2015b). The New South Wales Ministry of Health's *Sexual safety: responsibilities and minimum requirements for mental health services* policy directive includes processes and requirements for services to accurately record all sexual safety breaches and conduct audits to identify priority actions to increase safety (New South Wales Ministry of Health 2013b, pp. 6–7).

New South Wales and South Australia both have a policy directive that specifies that suspected or alleged sexual assaults are category 1 incidents, which require external reporting within 24 hours. This requirement is also consistent with the requirements of the department's Client Incident Management System (CIMS), which it is implementing for a range of funded and departmental services including mental health community support services (Department of Health and Human Services 2017c). The potential application of some of the features of the CIMS to sexual safety incidents is discussed further in section 2.5.6.

Reporting different levels and types of sexual safety breaches would require leaner processes for capturing incidents that do not necessarily warrant escalation to external bodies, as recommended in the *Targeting zero* report (Department of Health and Human Services 2016c, pp. 111–112). Such processes could address the concerns raised in consultations that sexual harassment by other people accessing treatment is rarely recorded as a complaint or incident despite the significant impact it can have on a person's sense of safety within an acute inpatient environment, and that this was at least in part due to the onerous nature of reporting requirements (see discussion in section 2.5.6). This commentary was not applied to concerns about allegations of sexual harassment by staff, although it is possible that there are other barriers to reporting these allegations, including fear of reprisal or effect on treatment, or lack of trust in the efficacy of reporting these allegations. Streamlined reporting systems that enable trends in relation to sexual harassment and other types of sexual safety breaches to be identified will help to more accurately assess the prevalence of these issues and ensure that adequate attention is directed to developing prevention strategies for mental health services.

2.3.1.3 Health service governance

Complaints to the MHCC have identified a number of instances where hospital boards and service leadership have not been apprised of allegations of sexual assaults occurring within mental health services. However, s 655 (2)(d) of the *Health Services Act 1988* (Vic) requires that hospital boards monitor the health service to ensure:

- effective and accountable systems are in place to monitor and improve the quality and effectiveness of services provided
- any problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner
- the health service continuously strives to improve the quality of the services it provides and to foster innovation.

Breaches of sexual safety, particularly allegations of sexual assault, pose serious questions about service quality and must be escalated for adequate oversight and action.

The apparent gaps in monitoring by hospital boards can be largely attributed to issues in accurately categorising sexual safety breaches in incident reporting systems at a level that prompts escalation and review of these concerns. The complaints analysed for this project also indicate that not all suspected or alleged sexual assaults are reported to the Chief Psychiatrist as required by the Chief Psychiatrist's Guideline. Options for ensuring effective governance and oversight of sexual safety breaches by health services include adding the prevention of sexual safety breaches in services' Statements of Priorities, adopting clear service policies for escalating such incidents and monitoring through service risk registers.

Issues and recommendations in relation to incident reporting are discussed in more detail in section 2.5.6. See also the discussion on 'clarity of service policies and procedures' in section 2.3.2.4.

RECOMMENDATIONS: GOVERNANCE

Establish clear reporting and monitoring mechanisms to ensure accountability for preventing sexual safety breaches.

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- Consider mechanisms for ensuring services are accountable for preventing breaches of sexual safety in acute mental health inpatient units such as policy directives (including prevention of sexual safety breaches in service Statements of Priorities) and reporting and monitoring requirements.
- Develop ways to measure whether interventions intended to support services to prevent breaches of sexual safety are effective in doing so and take remedial action as required.
- Work with the MHCC to understand the trends observed in complaints and how these relate to, or differ from, trends in incident reporting in services to more accurately identify areas for departmental support or intervention.

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- Develop a system for monitoring all sexual safety breaches and include these in service risk registers or an equivalent mechanism for monitoring serious quality and safety issues.
- Review service policies and practices to ensure suspected or alleged sexual assaults are classified under the current incident reporting system as ISR2 level incidents at a minimum and are reported directly to senior management for review and decision making (see also section 2.5.6)

2.3.2 THE ROLE OF LEADERSHIP AND SERVICE CULTURES

Leadership is an essential element of any strategy to prevent the avoidable harms caused by breaches of people's sexual safety in acute mental health inpatient services. The *Targeting zero* report notes the 'extensive literature on quality and safety in healthcare [that] demonstrates that boards and hospital executives must prioritise, pursue and assure high-quality care, setting an example for all staff' (Department of Health and Human Services 2016c, p. 18). While the complexities of providing acute mental health inpatient care are acknowledged, strong leadership and a shared commitment is required from the department, Chief Psychiatrist and mental health services to prioritise preventing breaches of people's sexual safety in acute mental health inpatient units.

2.3.2.1 Challenges for leadership and cultures in mental health services

The *Targeting zero* report (Department of Health and Human Services 2016c, p. 138) drew attention to the significant challenges faced by mental health services, noting that in 2013–14 Victoria had:

- the lowest proportion of the population receiving (public) clinical mental health services (1.1 per cent versus a national average of 1.8 per cent)
- the lowest proportion of new clients to all clients, indicating failure or inability to discharge (36.8 per cent versus 41.7 per cent)
- the highest proportion of patients readmitted within 28 days of discharge (14.7 per cent versus 14.3 per cent).

The report also noted that the issues that were present in 2013–14 have continued, with shorter lengths of stay and people being more unwell on admission and discharge than previously. Anecdotal reports indicate that increased presentations to emergency departments are one driver of the need to increase throughput, resulting in shorter inpatient admissions. This context of mental health service provision needs to be recognised and addressed in implementing strategies to address the particular risks to people's sexual safety in acute mental health inpatient units.

— The pressures faced by services explain, in part, some of the practices observed by stakeholders and identified in complaints, including the placement of men in women-only corridors or gender-safe areas due to high occupancy rates and demand for beds. However, they do not explain the range of issues identified by this report, which are associated with pervasive issues of practice or service culture.

The 2017 report of the review into South Australia's Oakden Older Persons Mental Health Service notes the role of culture as follows:

In every organisation, there are cultural norms, values and practices that distinguish that organisation and that often evolve over time. The culture of an organisation will often consist of a shared set of assumptions, values, principles, beliefs and expectations that will determine for many people within that system how they behave whilst in that organisation. The culture is often a product of the history of that organisation. (Groves et al. 2017, p. 93)

The *Targeting zero* report noted hospital culture as a critical element of patient safety and proposed that the department includes the following cultural risks in assessments of hospital's cultures (Department of Health and Human Services 2016c):

- a potentially poor incident reporting culture, as suggested by a low ratio of incident reports to comparable adverse events apparent in the routine data or as detected by the Health Services Commissioner¹
- a poor patient safety culture, as measured by low rates of agreement with any of the eight patient safety questions in the Victorian public sector 'People Matter Survey' of staff culture or as detected by the Health Services Commissioner (for mental health services, this implies poor patient safety cultures as detected by the MHCC)
- limited interest in consumers and their families, as measured by poor results in the patient experience survey, poor handling of complaints and a poor approach to patient-centred care detected by the Health Services Commissioner (or MHCC, as above).

Some of these risks, particularly people's reported poor experiences in making complaints directly to the service, and low ratios of incident reports to comparable reports to the MHCC are particularly evident in services' approaches to managing sexual safety.

¹ The department's implementation of recommendations of the *Targeting zero* report has interpreted all references to the Health Services Commissioner as also applying to the Mental Health Complaints Commissioner.

2.3.2.2 Service culture and its role in sexual safety

Service culture plays a central role in creating and maintaining environments where people feel safe and supported to speak up about any concerns. Themes from complaints, consultations and the literature note that people reporting sexual safety breaches too often confront a culture that does not acknowledge their concerns or fails to take appropriate action to respond to their concerns, including taking action that may prevent further harm. In complaints to the MHCC, people accessing treatment (and their families) identified cultural change as essential to ensuring that what happened to them does not happen to anyone else. Thematic analysis of the 27 written complaints to the MHCC revealed that in 92.6 per cent ($n = 25$ of 27) of cases, the person was not satisfied with the response of the staff/service when the issues were discussed or disclosed directly to the service. Equally frequent themes, described in 74.1 per cent of cases ($n = 20$ of 27), were that the patient felt unsafe and traumatised by their experience. It is significant that in only 55.6 per cent ($n = 15$ of 27) of these complaints, complaint documentation revealed that an apology was provided by the mental health service, and only 33.3 per cent of these apologies ($n = 5$ of 15) were made before the MHCC became involved in the complaint.

Leadership at all levels is important in establishing and leading cultures that prioritise the sexual safety of people accessing acute mental health inpatient treatment. Some of the key areas for attention in developing service cultures that support and uphold people's right to sexual safety are discussed in the sections that follow.

2.3.2.3 Recognition of sexual risks, harassment or assault

The findings from surveys and research conducted over the past decade with women with lived experience of acute mental health inpatient units have consistently identified concerns about the adequacy of actions taken by services in response to complaints and concerns raised about sexual safety, particularly complaints about sexual harassment (Victorian Women and Mental Health Network 2007; VMIAC 2013; WMHNV 2017). In MHCC project consultations, people who had accessed acute mental health inpatient treatment expressed views that one reason for a lack of response by staff was a reluctance to confront and address the sexual behaviours of others. There were also views expressed in consultations that staff may be unable to adequately identify these behaviours or appreciate their impact, that some staff may be desensitised to issues of sexual harassment and assault, and that staff may be unclear about the actions required in response to allegations of sexual safety breaches.

Sexual harassment and assault against women in particular have been identified as a result of broader societal attitudes (Department of Premier and Cabinet 2016). To address these issues, there is a need to ensure the prevailing service culture is one that recognises and directly addresses issues of gender inequality and violence, and emphasises the responses required as part of the professional responsibilities of staff. Central to this is the ability of staff to accurately recognise, describe and respond to behaviour that can breach sexual safety.

Key statistics from written complaints to the MHCC

92.6%

of cases, the person was not satisfied with the response of the staff/service when the issues were discussed or disclosed directly to the service

74.1%

of cases, the patient felt unsafe and traumatised by their experience

55.6%

of cases, an apology was provided by the mental health service, but the majority of these only occurred after the complaint was made to the MHCC

“

They didn't seem to get it. I didn't even get an apology.” —

Woman who made a complaint to a service about a sexual safety breach

Complaints to the MHCC indicate that the ability of staff to accurately describe and record sexual activity, harassment and assault varies. Terms used to describe observed or reported behaviours can be euphemistic or not factually accurate (see section 2.5.7 for discussion). It is not clear whether staff have accessed adequate training on the range of behaviours that can constitute sexual harassment and assault. For example, sexual harassment can include more commonly recognised behaviours such as requests for sex, leering, staring, brushing up against someone, touching, fondling and hugging, as well as less commonly recognised behaviours including (Victorian Equal Opportunity and Human Rights Commission (VEOHRC) 2016):

- comments about a person's private life or the way they look
- sexually suggestive comments or jokes
- displaying offensive screen savers, photos or objects
- repeated requests to go out.

In addition, themes in complaints and consultations indicate variable understanding and appreciation of the range of behaviours that could constitute a sexual crime. Victoria Police's *Code of practice for the investigation of sexual crime* provides the following summary of behaviours that could be considered a sexual offence under the *Crimes Act 1958*:

Sexual crimes are generally defined as a sexual activity that a person has not consented to, whether or not it involves physical or emotional force. It can refer to a broad range of sexual behaviours that make the victim feel uncomfortable, frightened or threatened and can include: touching, fondling, kissing, being made to look at or pose for pornographic photos, voyeurism, exhibitionism, sexual harassment, verbal harassment/innuendo, rape, incest, intrafamilial child sexual crime and/or stalking. (Victoria Police 2016, p. 3)

— Complaints also indicate a lack of consistency in the ability to recognise the impact of sexual behaviours on other people accessing inpatient treatment and the need to take action in response to these behaviours regardless of whether the behaviour was intended to intimidate or harass.

This is consistent with themes expressed in consumer literature over time, where women have frequently stated that staff responses to sexual harassment are driven by an assessment of the perpetrator's illness rather than the impact on the women affected (Armstrong 2008; WMHNV 2007; 2017). A lack of ability to recognise and name behaviours as sexual harassment or sexual assault, and failure to appreciate the impact of these behaviours on other consumers (including those who may witness such behaviours), is likely to be a significant contributing

factor to inadequate responses to breaches of sexual safety and must be addressed as part of approaches to implement trauma-informed care in mental health services (see discussion in section 2.3.3.5). The New South Wales policy directive, in requiring sexual safety standards to highlight that 'sexual activity is not supported in an acute setting due to the vulnerability of the people involved as well as the vulnerability of the consumers that may witness any such activity' (New South Wales Ministry of Health 2013b, p. 8) [emphasis added] is an example of a document that specifically recognises the broader potential for sexual activity to impact negatively on people accessing treatment.

There was a common concern identified in consultations with stakeholders that some people working in mental health services have become desensitised to sexual harassment and assault due to the frequency with which this occurs in these environments. This view is consistent with a view expressed in consultations for the VEOHRC's *Beyond doubt: The experiences of people with disabilities reporting crime* report that 'there is a built-in tolerance that people with mental illness will experience violence' (VEOHRC 2014, p. 38). Moreover, complaints to the MHCC indicate that the impact of sexual safety breaches may not be well understood by staff, particularly if the person affected does not exhibit external distress at the time. It was also reported in consultations that it can be difficult for staff working in an acute inpatient unit, where their engagement with people accessing inpatient treatment is short-term, to appreciate the long-term impacts of breaches of sexual safety while accessing treatment.

Effective primary prevention strategies therefore need to address the causes of the perceived desensitisation or failure to identify and name issues of sexual safety in acute mental health inpatient services as part of strategies to better prevent and respond to these issues. While this must also be addressed more broadly in strategies to implement trauma-informed care (see sections 2.3.3.5 and 2.3.3.6), there was support in the consultations for developing short videos (using a co-production approach) that highlight people's experiences of not feeling or being sexually safe within acute mental health inpatient units and the impacts of these experiences. This would provide a direct learning opportunity for inpatient mental health staff and help to address concerns about desensitisation. Some resources are already developed, and their wider distribution and use may be beneficial.

“

If you see it [sexual activity], you're worried about the person involved, and you're also worried that you might be targeted next.”

Participant in consultations

Actions that can help to ensure sexual safety

Ensure clear governance and leadership for ensuring sexual safety

Ensure clear leadership responsibility for preventing sexual safety breaches

Engage lived experience in approaches to transforming culture, including further developing approaches to peer support in acute mental health inpatient units

Tie responsibility for ensuring sexual safety to existing safety-focused roles

Create clear and simple staff resources including flow charts, wallet cards and lanyards outlining the steps required to respond to sexual safety breaches

Support people accessing inpatient treatment to understand and exercise their rights including by implementing supported decision making and creating accessible resources that outline rights and responsibilities in relation to sexual safety

2.3.2.4 Clarity of service policies and procedures

It has been observed in complaints to the MHCC and by stakeholders that the quality and utility of local service policies and procedures for responding to alleged or observed sexual safety breaches varies broadly. Complaints to the MHCC have demonstrated that service policies, procedures and practices do not uniformly meet the standards outlined in the current Chief Psychiatrist's Guideline. This report identifies a number of areas of ambiguity in the existing guideline and accordingly recommends developing a clear policy directive outlining the minimum expectations of mental health services in preventing and responding to sexual safety breaches. Developing such a directive will provide mental health services with a clear, effective base from which to develop local policies and pathways.

Where local pathways are unclear or fail to provide advice about the required elements of a response, this will have an inevitable impact on the ability of staff to respond appropriately to sexual safety breaches, and this effect was observed in some complaints to the MHCC. However, good practice was also noted in some services. Some simple measures that were observed were wallet cards or lanyards for staff that outline the steps required to respond to alleged or observed sexual safety breaches, as well as simple flow charts and other tools to help staff quickly and effectively respond to an alleged breach of sexual safety.

If staff are not well trained to use the approaches described in these tools, there is a risk that responses to sexual safety breaches may be 'routinised' or not adequately tailored to individual circumstances. However, when these tools are supported by training and reinforced in supervision and peer learning, and clarify the need to escalate sexual safety breaches internally so individual responses can be guided by senior staff, they can contribute to a culture where staff are more confident to act and, more importantly, create a cultural expectation that these actions will occur. Accordingly, mental health service providers must ensure that the expected responses of staff are clear.

Given some services have started developing supportive tools and resources, the department could play a role in identifying and sharing good practice approaches as part of a broader approach to supporting services to implement an overarching sexual safety strategy. A framework for monitoring and self-auditing (as used to support the policy directive implementation in New South Wales) would also be useful.

2.3.2.5 Commitment to capacity building

Responses to complaints generally indicate that services that have better systems and structures in place to prevent sexual activity, harassment and assault or to ensure adequate responses where breaches occur tend to have a dedicated workforce or system development position within the service. These positions are clearly responsible for driving service approaches to sexual safety and take responsibility for improving systems and practice to better ensure safety. This approach is consistent with recommendations in the department's *Service guideline on gender sensitivity and safety* (Department of Health 2011a), as well as implementation approaches in other jurisdictions including New South Wales. The need for a dedicated focus on women's mental health that is relevant to responding to sexual safety concerns was also noted in consultations and by advocates (WMHNV 2010). Approaches that tie responsibility for sexual safety clearly to existing safety-focused roles (for example, creating safety nurses), as well as ensuring clear leadership responsibility for ensuring sexual safety, may support mental health services to better prevent and respond to sexual safety breaches and should be considered as part of the overarching strategy.

“

I saw some of that training [trauma-informed care, gender sensitivity and safety] on the board where they're offering the nurses to attend or whatever, but not all nurses have the opportunity to attend [that] training.”

Mental health service staff member

Lived experience can play a significant role in transforming approaches and cultures (Sweeney et al. 2016). Considering the role of people with lived experience in contributing to a culture of safety is consistent with the Victorian Government's commitment to expanding and building on co-production approaches (Department of Health and Human Services 2015; 2016a). The consultations provided strong feedback about the sense of support and safety that can be offered by peers in inpatient units, whether through a paid peer workforce or through more informal support derived from consumer/peer groups and meetings operating in inpatient units. There is some evidence that people accessing inpatient treatment often take action to support one another to mitigate the risks of treatment in an acute mental health inpatient unit (Quirk, Lelliott & Seale 2005).

In the consultations, several people with lived experience of inpatient treatment also observed that the mutual support provided by people accessing inpatient treatment can be one of the more therapeutic aspects of inpatient admission. One participant noted that some people may experience considerable barriers in disclosing concerns about sexual safety to staff (perhaps due to previous experiences of disclosure or concern about being placed in a more restrictive environment for their safety) and may be more inclined to raise these concerns with a peer. In considering approaches to improving the capacity of services to ensure sexual safety in acute inpatient units, the department and mental health services should also consider opportunities to further develop approaches to peer support within acute mental health inpatient units. These approaches should be consistent with the priorities outlined in *Victoria's 10-year mental health plan* (Department of Health and Human Services 2015) and the *Mental health workforce strategy* (Department of Health and Human Services 2016b) to further expand and develop the lived experience workforce.

Building the capacity of people accessing inpatient treatment

Understanding rights is a necessary foundation to taking action to exercise them. Currently, complaints indicate that many people are not provided with clear information about their right to sexual safety and the steps they can take if they feel unsafe (see section 2.4.1). However, for many people accessing acute mental health inpatient treatment, there is a broader issue that information provided at admission about rights may be provided in a way that is difficult to understand at a time when they are extremely unwell. A focus on ensuring people accessing inpatient treatment are supported to understand and exercise their rights in relation to sexual safety would consider alternative approaches such as:

- implementing supported decision making to ensure services provide people with the information and support they need to make decisions
- developing clear, simple, accessible resources (for example, video resources and/or posters) that outline people's rights and responsibilities in relation to sexual safety.

2.3.2.6 Understanding the reasons for preventing sexual activity in acute inpatient units

The Chief Psychiatrist's Guideline is clear that even if sexual activity in an acute inpatient unit is perceived as consensual by the participants, it is 'incompatible with the acute treatment environment and is unacceptable' (Department of Health 2009, p. 1). In addition, the Chief Psychiatrist's Guideline states that:

While for the most part people's sexual relationships are their own responsibility and private concern, when a person is admitted to an acute inpatient unit, the primary purpose is treatment ... Any sexual activity in this setting can be damaging for all concerned, irrespective of whether it is perceived to be consensual. Usual concepts of consent cannot be assumed when one or more parties are acutely unwell. Sexual activity is not appropriate to the treatment environment. (Department of Health 2009, p. 3)

The policy of sexual activity not being permitted in acute mental health inpatient environments is already clearly established in the Chief Psychiatrist's Guideline; however, specifically addressing the human rights considerations behind this prohibition may assist in building understanding of the reasons for it. This project has identified significant inconsistencies in understanding and practice. Views were raised in consultations, and by some staff in the course of complaint resolution, that restricting a person's capacity to engage in sexual activity places an undue restriction on their freedom and autonomy and does not respect the principle of the presumption of capacity or represent least restrictive practice.

Restricting a person's capacity to engage in sexual activity may involve a restriction on their rights, dignity and autonomy, and may limit rights under the Charter of Human Rights and Responsibilities Act. However, the Charter provides for the reasonable limitation of human rights where these can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom. This limitation must also take into account the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relationship between the limitation and its purpose and any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve (s 7).

Two of the objectives of the Mental Health Act that are relevant to preventing sexual activity in acute inpatient units are 'to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity' (s 10(b)) and 'to protect the rights of persons receiving assessment and treatment' (s 10(c)). Principles of the Act also require for services to be provided in a way that promote the best possible therapeutic outcomes and recovery, and respond to people's individual needs (see section 1.8.1.1).

Similarly, Standards 1, 6 and 10 of the *National Standards for Mental Health Services* (NSMHS) deal in part with upholding consumer rights, including rights to be treated with respect and dignity, to autonomy, to privacy and to be treated in the least restrictive environment. In addition, Standard 6.2 provides that 'consumers have the right to receive services free from abuse, exploitation, discrimination, coercion, harassment and neglect'. Standard 1 of the *National Safety and Quality Health Service* (NSQHS) Standards also specifically requires services to have 'integrated systems of governance to actively manage patient safety and quality risks' (ACSQHC 2012b, p. 10). The second edition of the NSQHS Standards (launched in November 2017) also specifies that health services are required to provide 'a safe environment for the delivery of care' (ACSQHC 2017a, p. 17).

Further, the Charter provides that 'every person has the right to liberty and security (s 21(1)), a person must not be treated in a 'cruel, inhuman or degrading way (s 10(b)), a person has a right 'not to have his or her privacy ... arbitrarily interfered with' (s 13(a)) and 'all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person' (s 22(1)). All of these rights, standards and obligations must be considered as part of a holistic approach to ensuring sexual safety in the acute mental health inpatient environment.

In this instance, the purpose of the limitation of any right is to prevent the significant trauma that can occur for people accessing acute mental health services when sexual safety is breached. The risks of harm arising from breaches of sexual safety are well established in the literature and are discussed in depth in this report (see section 2.3.3). It is well recognised in other jurisdictions that sexual activity occurring in acute inpatient environments is an inherent breach of sexual safety (New South Wales Ministry of Health 2013b). Reasons for this include the vulnerability of people who may participate in the activity as well as the potential impact on any other people accessing inpatient treatment who may witness the sexual activity (New South Wales Ministry of Health 2013b).

Staff should be aware of the following:

Individuals within the acute inpatient unit are experiencing a disturbance of their mental state for a number of reasons.

The mental state of one or both of the participants in sexual activity could be altered enough to impair capacity to give consent. Either may not understand what they are consenting to, or may have lost the ability to weigh up the consequences of what they are consenting to.

A person's understanding of a situation and their reasoning may seem intact, but their decision making may be at odds with their normal or baseline moral or sexual attitudes, as a result of their mental state at the time. It is possible that with the passage of time and return to everyday functioning the person may see their actions as being undesirable and feel they were not protected from engaging in actions they would later regret.

Mental state changes may make the person more vulnerable to coercion, as a result of lack of judgement, loss of confidence, fear, or a sense of helplessness.

Example of a mental health service's policy that includes explanations for staff on the reasons why no sexual activity is permitted.

The average stay in an adult acute mental health unit in Victoria is approximately nine days (Department of Health and Human Services 2018a), which is a short period for such a restriction to apply. Moreover, preventing sexual activity in acute mental health inpatient units directly prevents the trauma that can be caused by engaging in unwanted or damaging sexual activity while unwell. Taking steps to prevent people from engaging in potentially damaging behaviours that may result in significant trauma (for them or others) forms part of the obligation to promote recovery and to support the rights, humanity and dignity of individuals accessing acute mental health inpatient treatment.

Enforcing a clear policy of no sexual activity also prevents harm to people who may be vulnerable to predatory behaviour while accessing inpatient treatment. Seeking to prevent potentially traumatic experiences for people accessing mental health services is also fundamental to providing trauma-informed care and forms part of the requirement under the NSQHS Standards to actively manage patient safety risks and to provide a safe environment (ACSQHC 2012a; 2017a).

There is therefore clear evidence from the literature, existing policy and regulatory and legislative frameworks that a temporary restriction to the ability to engage in sexual activity is reasonably necessary to ensure sexual safety in acute mental health inpatient units. This project has identified the need for departmental and service leaders to ensure this principle, and the reasons behind it, are well understood by staff working in acute mental health inpatient units.

It must be noted that despite these commonly reported experiences and areas for improvement, it is also clear that many people working in mental health services are deeply distressed by the harm experienced by people who are subject to sexual safety breaches. These staff work to the best of their ability to promote a safe environment and to provide a supportive response where sexual safety breaches occur. However, individual staff need strong leadership and support at all levels to work together to build safe and supportive services.

RECOMMENDATIONS: LEADERSHIP AND SERVICE CULTURES

Build leadership to support best practice in preventing and responding to sexual safety breaches to ensure people are and feel safe in acute mental health inpatient services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

As part of the implementation of the recommended 'sexual safety strategy':

- consider the development of co-produced resources for staff to highlight people's experiences of not feeling or being sexually safe within acute mental health inpatient units, and the impacts of these experiences
- identify and share best practice approaches to ensuring sexual safety, including supportive tools and resources to support staff to identify and respond appropriately to concerns about sexual safety
- ensure sexual safety is a key consideration in mental health workforce development to build staff knowledge and understanding of sexual safety, recognition of sexual harassment and sexual assault, and the reasons why sexual activity in acute inpatient environments should be treated as a breach of people's sexual safety
- consider ways to establish or use dedicated positions to support sexual safety as part of a broader capability-building strategy.

MENTAL HEALTH SERVICE PROVIDERS

- Take steps through training and workforce development to build staff knowledge and understanding of sexual safety, recognition of sexual harassment and sexual assault, and the reasons why sexual activity in acute inpatient environments should be treated as a breach of people's sexual safety.
- Ensure that the guidelines, policies and processes relating to identifying and responding to concerns about sexual safety are clear and easy to follow, and create supportive tools and resources to support staff to fulfil their responsibilities.
- Ensure clear responsibility is allocated within each service for building capability to ensure sexual safety.
- Consider opportunities to expand or refocus the peer support available in acute mental health units to include a focus on sexual safety.

2.3.3 TRAUMA-INFORMED CARE

2.3.3.1 Trauma-informed care as a primary prevention strategy

Trauma-informed care is considered in detail here as a core primary and secondary prevention strategy to ensure people's sexual safety in acute mental health inpatient units. Understanding the impacts and prevalence of trauma among people accessing mental health services is foundational to creating safe and therapeutic environments. Trauma-informed care is also critical to ensuring effective and supportive responses to incidents and allegations of sexual safety breaches (discussed in section 2.5.1).

Trauma may arise from single or repeated adverse events that can interfere with a person's ability to cope or to integrate the experience. It is an experience of real or perceived threat to life, bodily integrity and/or sense of self. The impacts of traumatic experiences can be cumulative across the lifespan.

(Mental Health Coordinating Council 2013, p. 8)

Adverse events do not affect all people in the same way. However, there is clear evidence that experiences of trauma, especially during early life, are significantly associated with developing mental illness or distress in later life (Cutajar et al. 2010; Daskalakis et al. 2013; Heim et al. 2008; Read et al. 2005; Rees et al. 2011; van Os, Kenis & Rutten 2010; Varese et al. 2012).

2.3.3.2 Prevalence of trauma experiences among people accessing mental health services

The prevalence of trauma among people accessing public mental health services is widely acknowledged. The literature review to the *Service guideline on gender sensitivity and safety* (Department of Health 2011a) observes the following:

- Between 49 and 90 per cent of women accessing inpatient mental health treatment have experienced abuse (sexual and/or family violence) at some stage in their lives (Hawthorne, McKenzie & Dawson 1996; Morrow 2002).
- Prevalence rates for interpersonal violence are twice as high for men with a mental illness than for the general population, with one study showing that 40 per cent of men in an inpatient unit had experienced childhood sexual abuse (Read 1997; Read et al. 2005).
- The types of trauma experienced by those accessing mental health services tend to be interpersonal in nature, are intentional, often prolonged and repeated, occur in childhood and adolescence as well as in adult life, and may extend across many years or over a person's life. 'They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional or psychological abuse. They may also include the witnessing of violence, repeated abandonment, and sudden and traumatic losses' (Jennings 2004, p. 6).

Particular demographic groups are also more likely to have experienced trauma. Australia's history of colonisation and the loss of family, language, land, spirituality and culture for Aboriginal people, as well as past practices including forced removal of children, mean that Aboriginal communities have experienced multigenerational trauma that continues to have significant impacts (The Bouverie Centre 2013). Other groups with extremely high prevalence of trauma include people from refugee backgrounds and people who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI). There is evidence worldwide that women with serious mental illness are far more likely than the general population to experience sexual violence (Basile et al. 2016; Goodman et al. 2001; Khalifeh et al. 2015; Latalova, Kamaradova & Prasko 2014; Mcfarlane et al. 2006; Seeman 2002). Women with intellectual disability have been estimated to be 10 times more likely than other women to be sexually assaulted (Frohman 2002, cited in Mental Health Coordinating Council 2013), and this should inform approaches to treating women with dual disability.

Childhood sexual abuse

There is strong evidence that trauma from childhood abuse, and particularly childhood sexual abuse, is a powerful predictor of both the occurrence and severity of mental illness (Molnar, Buka & Kessler 2001; Mullen et al. 1993).

Australian Bureau of Statistics (ABS) data suggests that more than one in 10 Australians aged 18 years or older (13 per cent or 2.5 million) have experienced abuse before the age of 15. This includes an estimated 1.6 million people (8.5 per cent) who experienced physical abuse and 1.4 million (7.7 per cent) who have experienced sexual abuse. Around one in six women and just over one in 10 men experience at least one type of abuse before the age of 15 (ABS 2017).

The literature also identifies childhood sexual abuse as a major risk factor for an increased lifetime risk of experiencing further sexual violence in adulthood (Classen, Palesh & Aggarwal 2005; Maker, Kemmelmeier & Peterson 2001; Widom, Czaja & Dutton 2008). Estimates vary, but international studies suggest that up to two out of three women who are sexually abused as children experience further sexual violence as adults (Brenner & Ben-Amitay 2015; Classen, Palesh & Aggarwal 2005; Van Bruggen, Runtz & Kadlec 2006).

Impact of trauma

There is a clear association between experiences of trauma, particularly childhood trauma, and developing physical and mental health concerns in childhood, adolescence or adulthood (Danese et al. 2009; Dube et al. 2003; Felitti et al. 1998; Reiser et al. 2014; Schilling et al. 2007; Upthegrove et al. 2015; Varese et al. 2012). Increased experiences of trauma also increase the likelihood of developing physical or mental health concerns (Edwards et al. 2003; Scott-Storey 2011).

The recent Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA) identifies that the impacts of childhood sexual abuse can be lifelong, with the complex trauma experienced affecting all aspects of life (2017a, p. 15). The impacts of trauma can arise across key milestones of adolescence, partnering, childbirth, parenting and ageing. Child sexual abuse can affect mental health, interpersonal relationships, physical health, sexual identity, gender identity, sexual behaviour, connection to culture, spirituality, religious involvement, interactions with society and education, employment and economic security (RCIRCSA 2017a, p. 16). However, the most common impact noted was on mental health, with effects including depression, anxiety and post-traumatic stress disorder as well as 'other symptoms of mental distress such as nightmares and sleeping difficulties; and emotional issues such as feelings of shame, guilt and low self-esteem' (RCIRCSA 2017a, p. 16).

Research indicates that people who have been abused as children are likely to experience earlier first admissions to mental health services, have longer and more frequent admissions, and be prescribed larger doses of medication (Read 1998). People who have experienced previous trauma are also more likely to experience instances of seclusion and/or restraint during inpatient treatment (Beck & Van der Kolk 1987; Frueh et al. 2005), potentially resulting in re-traumatisation (Cusack et al. 2003; Frueh et al. 2005; Jennings 2004). For women, lack of safety within mixed-gender inpatient units increases the likelihood of experiencing or witnessing further interpersonal violence (Davidson 1997; Graham 1994; Victorian Women and Mental Health Network 2007; VMIAC 2013).

Given the high prevalence of trauma among people accessing mental health services, implementing trauma-sensitive and trauma-informed care must be a high priority for mental health services. In particular, the notably high prevalence of previous sexual violence against women accessing mental health services, when combined with the risks presented by mixed-gender acute inpatient treatment, indicates the need to consider specific approaches to ensuring safe, trauma-informed responses for women accessing acute inpatient mental health treatment.

2.3.3.3 Trauma-informed care – definitions

Services are generally described as trauma-informed or trauma-specific, although there can be overlap between the two. Trauma-informed services provide services in ways that recognise the prevalence of trauma in general society and are organised to avoid further harm to already traumatised people, acknowledging that complex trauma may not be identified or known by the service. Trauma-specific services are those designed to directly address the effects of trauma, with the goal of health and recovery (Moses et al. 2003).

The department's *Service guideline on gender sensitivity and safety* states that:

Trauma-informed care acknowledges the ongoing impact of trauma on people's health, wellbeing and behaviour, and ensures that the care provided is sensitive to trauma-related issues. In particular, trauma-informed services take care to avoid practices that may exacerbate or retrigger previous experiences of trauma and undertake routine enquiry about people's experiences of abuse. Where disclosure of past or current abuse occurs, services facilitate effective and coordinated responses based on individual preferences.

In recognising that previous experience of abuse renders people vulnerable to further abuse, and given the high incidence of trauma amongst people accessing mental health and [alcohol and other drug] services, a trauma-informed service takes care to ensure the physical, emotional and sexual safety of people accessing the service.

(Department of Health 2011c, p. 7)

Other definitions of trauma-informed care note that trauma-informed services seek to understand the connection between trauma and presenting symptoms or behaviours (Hodas 2006). The literature also describes trauma-informed services as ones that actively evaluate and modify all levels of the organisation, management and service delivery system to reduce harm caused by treatment, and to empower a wide range of people to better engage in treatment. This includes those who may be least likely to engage in or benefit from existing approaches (Australia's National Research Organisation for Women's Safety 2017; Centre for Substance Abuse Treatment 2014; Isobel 2016). Specifically in mental health services, trauma-informed services recognise the harms associated with the spectrum of coercive and restrictive practices permitted by mental health law and endeavour to eliminate their use. Additionally, the literature pinpoints employment of peers and access to advocacy as integral to mental health service systems adopting a trauma-informed approach.

Trauma-informed care has been described as requiring a 'radical shift' in the thinking of doctors, nurses, allied health professionals and services (Isobel 2016) because it requires viewing people's mental distress and behaviours as an adaptation to early traumatising environments. This trauma-informed approach seeks to provide services in ways that understand the prevalence of trauma and its impacts, promote safety, support consumer choice, control and autonomy, ensure cultural competence, share power, integrate care, focus on healing through relationships, and hold hope for recovery (Mental Health Coordinating Council 2013). These principles have implications for service approaches to ensuring sexual safety, and particular considerations for women.

In parallel with the work to develop staff skills and practices, organisations will need consider and respond to trauma experiences within the workforce (Lee et al. 2015) because the significant level of post-trauma among mental health nurses and others poses a barrier to change. Organisations must also acknowledge that discussions about trauma prevalence, and particularly the re-traumatising impact of some mental health practices including the use of restrictive interventions, can feel overwhelming for staff. As acknowledged above, implementing trauma-informed care is a fundamental shift in practice, and a whole-of-organisation approach is required to support change.

The National Health Service's *Transforming psychological trauma: a knowledge and skills framework for the Scottish workforce* (NHS Education for Scotland 2017) provides an alternative framing of trauma-informed approaches to service delivery. This framework emphasises that all elements of the workforce have a role to play in ensuring that services are safe and provide the maximum opportunities to identify and respond to trauma.

This framework outlined four levels of approaches to trauma as follows:

Trauma-informed: defines the baseline skills and knowledge required, and includes recognition of the prevalence of trauma and its impacts, identifying and minimising practices that may cause re-traumatisation while identifying ways to practise that support choice, collaboration, trust, empowerment and safety.

Trauma-skilled: describes the knowledge and skills required by people who have direct contact with people who are likely to have had traumatic experiences, whether or not those experiences are known. The knowledge and skills described include:

- the ability to relate to all people using trauma-informed principles
 - translating trauma-informed principles into trauma-informed systems and procedures
 - recognising and supporting the need for safety
 - supporting people to identify and access appropriate services
 - meaningfully demonstrating hope and optimism.
- Trauma-enhanced:** details the knowledge and skills required by workers who have more regular and intense contact with individuals who are known to be affected by traumatic events (including mental health services). Skills required include:
- recognising how trauma has affected the person's physical and mental wellbeing
 - helping people to identify links between current difficulties and past trauma, including normalising and making sense of current difficulties as adaptive responses to past trauma
 - understanding triggers for the person and advocating for them to ensure systems and procedures do not create re-traumatisation
 - working with the person affected by trauma to evaluate their needs in terms of safety/risk, practical and emotional support, physical and mental healthcare and therapeutic resources
 - working with the person to identify and support referrals to specialist trauma services
 - communicating a willingness and ability to hear a disclosure/discuss trauma and abuse if the individual wishes to disclose

– providing an empathic, non-blaming and trauma-informed response to a planned or spontaneous disclosure of trauma and abuse.

Trauma-specialist: details the knowledge and skills required by staff who, by virtue of their role and practice setting, play a specialist role in directly providing evidence-based interventions, offering consultation to inform the care and treatment of those affected by trauma, managing trauma-specific services, leading the development of trauma-specific services, or coordinating multi-agency service-level responses to trauma. Skills and knowledge required include:

- undertaking a risk assessment that takes into account experiences of previous trauma
- where appropriate, directly intervening psychologically to manage risk to the person or others
- working therapeutically to enable the person to develop trust in the therapeutic/professional relationship
- comprehensively and appropriately assessing the person's current psychological distress and functional difficulties in light of their trauma history, taking into account the person's current context and the purpose of assessment
- identifying the person's current coping, resources and protective factors
- reframing 'symptoms' in a way that marks their original function as a means or attempt to cope with an overwhelming threat and/or harm
- contributing to safe and effective services and systems by providing trauma-informed/trauma-specific supervision that is underpinned by a robust understanding of trauma-informed practice and supervision models.

The framework provides a useful model to consider in any approach to implementing trauma-informed care in mental health services. It is likely that all of the competencies at the trauma-enhanced level, and many of those described at the trauma-specialist level, would be required for mental health services to successfully implement approaches to care that respond to the prevalence and impact of trauma among people accessing mental health services.

2.3.3.4 Implementing trauma-informed care

The literature points to the challenges of finding examples of trauma-informed care successfully implemented in a mental health inpatient environment (Muskett 2014), let alone examples with specific regard to ensuring sexual safety. The Royal Commission into Institutional Responses to Childhood Sexual Abuse (2017a) noted that:

... despite the many skilled and dedicated practitioners providing advocacy, support and therapeutic treatment to victims and survivors of child sexual abuse, the level of knowledge and expertise available in mainstream and community-based service sectors relating to recognition and responses to child sexual abuse and providing trauma-informed care was ad hoc and inconsistent. (RCIRCSA 2017a, p. 126)

Specifically, the report noted that:

- not all mainstream professionals provided trauma-informed practice
- specialist sexual assault and trauma expertise was limited and inconsistent
- services lacked the necessary skills and knowledge to work with the diverse range of population groups.

The report specifically identified the mental health sector as one that 'often did not provide an adequate response' to disclosures of child sexual abuse (RCIRCSA 2017a, p. 128). Specifically, the Royal Commission noted that the focus within mental health services on diagnosis could 'lead to underlying trauma being overlooked, with treatment focusing instead on presenting symptoms' (RCIRCSA 2017a, p. 128).

Existing research on implementing trauma-informed care generally tends to focus on reducing rates of restrictive interventions (restraint and seclusion). In regard to reducing the use of restrictive interventions, there is some evidence that models of change that are based in trauma-informed principles and use strategies including leadership, use of data, skill development and involvement of people with lived experience can have a positive effect on practice (in this case, a reduction of the use of seclusion and restraint) (Azeem et al. 2011).

The implementation of Safewards in Victoria may provide a model that could be adapted or expanded to support services to move closer to a model of trauma-informed, sexually safe care. The Safewards model is being implemented in Victoria with the aim of creating safer mental health services for both staff and patients and to reduce the use of restrictive interventions (Department of Health and Human Services 2018b). This model, which was developed in the UK, focuses on reducing 'conflict and containment' in acute mental health services, where

conflict includes behaviours that pose risks to people accessing inpatient treatment or others and containment includes the practices used by staff to manage those behaviours, including the use of restraint and seclusion (Bowers 2014). Safewards uses a range of strategies that focus on ways to promote more positive interactions between staff and people using services, as well as establishing a regular 'mutual help' meeting with staff and people accessing inpatient treatment. While this model is not specifically aimed at implementing trauma-informed care or ensuring sexual safety, its focus on improving the nature of the relationships between people accessing mental health services and staff is closely aligned with the aims of trauma-informed care. The model encourages staff to take a strengths-based perspective regarding consumer behaviour; that is, assuming the person is coping as best as they can under the circumstances, recognising trauma-related responses and applying psychological understandings compared with merely challenging the behaviour.

Safewards has been evaluated in the UK and in Victoria. In both jurisdictions, it was found that implementing the Safewards interventions led to a reduction in conflict and containment practices (Bowers et al. 2015; Fletcher et al. 2017). In addition, the Victorian evaluation found that consumer consultants viewed mutual help meetings in particular as an extremely positive intervention, suggesting that 'intentionally increasing mutual support could reduce anxiety and fear on the ward' (Hamilton et al. 2016, p. 44). This echoes themes that women in particular expressed in consultations, of finding their greatest support in other women accessing inpatient treatment, and may suggest one strategy for helping people to feel, as well as be, sexually safe while accessing mental health inpatient treatment.

2.3.3.5 Trauma-informed care and sexual safety

A trauma-informed approach to ensuring sexual safety in acute inpatient mental health services requires policy settings and mental health services to recognise and respond to the prevalence and impacts of trauma in people accessing mental health inpatient treatment – at all levels and in all aspects of service delivery. While there is a stated commitment from the department and mental health services to implement trauma-informed care, embedding such approaches into service delivery still requires significant practice changes to ensure that people experience trauma-informed, sexually safe services. Some key principles underlying trauma-informed care and practice, and considerations for their relevance to sexual safety in acute inpatient units, are outlined in Table 1.

Table 1
Key principles of trauma-informed care and practice and their relationship to delivering sexually safe services

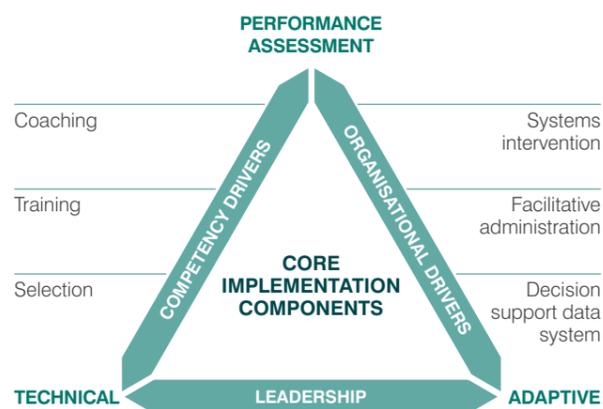
Trauma-informed care principle	Description	Implications for providing sexually safe care and treatment
Recognition	<p>Recognise the prevalence, signs and likely impact of trauma, including that people may not always identify or disclose their experiences of trauma.</p> <p>Recognise the intrinsic traumatising potential of compulsory treatment.</p>	<p>Services assume most people will have previous experience of trauma and ensure this is incorporated into treatment and care planning. The particularly high prevalence of trauma associated with sexual violence against women is recognised and responded to.</p> <p>Services ensure good information transfer to inform service responses to known trauma.</p>
Prevent re-traumatisation	<p>Understand that operational practices, power differentials between staff and people accessing treatment, authoritarian interactional styles, poorly handled trauma disclosures, blaming language and other features of mental health treatment including providing mixed-gender care, experiences of injustice and the use of compulsory treatment or coercive practices can re-traumatise people.</p>	<p>Services take steps to minimise and eliminate coercive practices.</p> <p>Single-gender treatment is prioritised, particularly in ICAs. Services pay particular attention to whether there is a genuine need for a vulnerable person to be placed in an ICA. Services address behaviours of individuals that may re-traumatise others.</p> <p>In assessment and treatment, avoid using language that inadvertently blames the patient for harm done by others. For example, use 'What happened to you?' in preference to 'What is wrong with you?'.</p>
Cultural, historical and gender contexts	<p>Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender-sensitive and appropriate. Recognise the impact of racism, ableism, sexism, homophobia, ageism and poverty. Recognise the impact of intersectionalities of people's various social identities and the potential of relationships and communities to aid recovery.</p>	<p>Services are aware of and sensitive to the extremely high prevalence of sexual trauma in certain demographic groups, notably women and particularly women with intellectual disability and Aboriginal women. Services also recognise the high prevalence of trauma in people who identify as LGBTI and people from migrant and refugee backgrounds. Services recognise that people's experiences of trauma may be compounded by experiences of racism, ableism, sexism, homophobia or ageism.</p>
Trustworthiness and transparency	<p>Services ensure decisions (organisational and individual) are open and transparent, with the objective of building trust. This is critical in building relationships with people with a trauma history who may have experienced secrecy and betrayal.</p>	<p>People are asked about and provided with the supports they need to make their own treatment and recovery decisions so they can maintain agency and are able to exercise choices.</p> <p>Services identify opportunities to make decisions transparently and, where possible, jointly with people accessing services, including undertaking joint sexual safety risk assessments.</p>

Trauma-informed care principle	Description	Implications for providing sexually safe care and treatment
Collaboration and mutuality	<p>Services understand the inherent power imbalance between staff and people accessing services and ensure that relationships are based on mutuality, respect, trust, connection and hope.</p>	<p>Services and the department focus on creating environments where therapeutic relationships between staff and people accessing treatment can be developed.</p> <p>The support offered by peers, both formally and informally, is recognised, supported and built on.</p>
Choice and control – supported decision making	<p>Services adopt strengths-based approaches, with people supported to develop self-advocacy and self-determination. This is important as experiences of trauma are often characterised by a lack of control and disempowerment.</p>	<p>Services provide people with the supports they need to make their own decisions. This includes encouraging and supporting the development and use of advance statements as well as engaging support people, advocates and nominated persons to support an individual to make decisions about their treatment.</p>
Safety	<p>Services must ensure that everyone within a service feels and is emotionally and physically safe. This includes feelings of safety through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, sexually, socially, morally and culturally safe.</p>	<p>People are routinely asked about what would help them to feel safe in an acute inpatient environment. Reports of feeling physically or emotionally unsafe are validated and specific actions are identified and agreed with the person and acted on to support them to feel and to be safe.</p> <p>Providing single-gender acute inpatient treatment is prioritised.</p>
Pathways to trauma-specific care	<p>People with experience of trauma should be supported to access trauma-specific care.</p> <p>Trauma-specific care should be provided by mental health services (among other services) and be well resourced.</p>	<p>Services ensure all acute inpatient staff are able to respond empathically to disclosures of sexual activity, harassment or assault and support the person to access appropriate services. Services also have clear internal protocols to ensure that any follow-up enquiry, treatment or care is undertaken by skilled and experienced individuals who are able to provide trauma-specific care.</p> <p>Services have clear protocols with trauma-specific services to support effective and efficient referrals.</p>

Adapted from Bloom 2006; Elliott et al. 2005; Hodas 2006; Mental Health Coordinating Council 2013; Centre for Substance Abuse Treatment 2014; Sweeney et al. 2016

Implementing trauma-informed care requires attention to the role of governance, leadership, service cultures, infrastructure and design, which are discussed in this report as key components of primary prevention strategies for ensuring sexual safety in acute mental health inpatient units. Implementation science suggests that implementing any significant cultural or systems change requires a multifaceted approach that takes into account leadership, organisational drivers (including systems intervention, administration, use of data) and skill and competency drivers including staff selection, training and coaching (see Figure 1).

Figure 1 Core implementation components for cultural change



Slides presented at implementation master class Dublin 2011, Karen Blase and Dean Fixen, cited in National Health Service Education for Scotland *Transforming psychological trauma: a knowledge and skills framework for the Scottish workforce* (NHS Education for Scotland 2017)

The model presented as Figure 1 provides a useful way of seeing how the recommendations made in relation to leadership and governance connect with other primary prevention strategies to ensure Victoria's mental health services are sexually safe (see section 2.3.2). Many of the recommendations outlined in section 2.3 of this report concern systemic interventions such as reconsideration of mixed-gender acute inpatient care, particularly within ICAs (see 2.3.5), as well as stronger reporting requirements and better use of existing data to understand the extent and nature of people's (particularly women's) experiences of acute inpatient mental health treatment.

Some of the key practice/skill and competency challenges to implementing trauma-informed care are discussed below, including embedding supported decision making in mental health service practice and expanding the availability of peer support approaches.

2.3.3.6 Embedding trauma-informed care in practice regarding sexual safety

Embedding trauma-informed care in service delivery requires a comprehensive approach to workforce planning and development. The department's *Mental health workforce strategy* (Department of Health and Human Services 2016b) lists trauma-informed care as a key principle driving workforce development, noting that the values and attitudes of mental health service staff are equally as important as technical skill in producing positive experiences of care. Trauma-informed care is also a central domain of the department's proposed organisational capability framework, which will 'describe the capabilities and values that mental health service delivery should demonstrate to improve services in a changing service paradigm' (Department of Health and Human Services 2016c, p. 28). The strategy also states that tools and resources will be developed to support organisations, teams and individuals to embed the capabilities described in the framework. Particular considerations for embedding trauma-informed care with regard to sexual safety include the following.

Prevention and screening – issues and concerns

Trauma-informed approaches to preventing sexual safety breaches include many of the approaches outlined elsewhere in this report – including single-gender treatment, understanding and responding to any known previous trauma and the associated link with sexual vulnerability, and ensuring that people's views about what will help them to feel safe are actively sought and incorporated into treatment planning.

Approaches to seeking people's views about previous trauma and what would help them to feel safe vary. As discussed in section 2.4.1, the Chief Psychiatrist's Guideline, while providing detailed advice about the information that should be given to people accessing treatment, does not include the guidance that people should be asked what might help them to feel safe during their admission. Unsurprisingly, the consultations for this project with people who have accessed services, advocates and staff of services indicated that services do not routinely enquire about what they can do to support people to feel safe during their admission. It was frequently observed (primarily by people with experience of accessing services) that asking about what would help a person to feel safe may be more helpful than routinely enquiring about people's experiences of abuse as described above (Department of Health 2011a, p. 20).

Concerns were raised in consultations and complaints about the current guidance for routine enquiries about trauma in an acute inpatient unit environment. These included concerns about:

- whether all staff have the skill, adequate time and privacy available to appropriately take a trauma history
- the appropriateness of screening for trauma at the point of high distress and in the process of compulsory admission to an acute inpatient unit
- the appropriate protection of privacy if a trauma disclosure is shared across the very large team in an inpatient setting
- trauma screening, in that it may induce a false sense of certainty among a care team that a person has *not* experienced trauma given many people will not disclose trauma.

In consultations, people noted in their experience that problem-focused admission assessments tend to enquire what is 'wrong' with a person rather than 'what happened' to them does not support the disclosure of previous trauma and also risks pathologising traumatic experiences. Others noted that communities with an extremely high prevalence of trauma (for example, Aboriginal communities) may have told their trauma history to service providers many times, and asking again at a vulnerable time may be unhelpful.

Given the high prevalence of trauma in people accessing mental health services, it was often suggested that it may be more helpful for services to assume and acknowledge likely trauma and simply ask, 'What will help you to feel safe?' during their inpatient admission. This approach can help to identify triggers and concerns for the individual, as well as strategies that will help to avoid re-traumatisation, without specifically enquiring about trauma. This may be an effective alternative for ensuring trauma-informed care is provided to people accessing mental health services who are reluctant to disclose specific details of past trauma but are prepared to acknowledge that they feel unsafe.

Supported decision making

Supported decision making is fundamental to implementing trauma-informed care. As experiences of trauma are often characterised by a lack of control and disempowerment, supporting people to exercise autonomy and to make choices is a critical trauma-informed care strategy (Mental Health Coordinating Council 2013) that may also help to identify and respond to sexual vulnerability.

The principles of the Mental Health Act require that people have access to the supports they need to make treatment and recovery decisions (s 11(1)(c)). The Act also contains provisions for advance statements, nominated persons and access to a second psychiatric opinion as means of people maintaining autonomy and agency. The establishment of the Independent Mental Health Advocacy (IMHA) service provides an additional way to support people to access independent support to make treatment and recovery decisions.

Advance statements

Advance statements may be particularly useful in avoiding re-traumatisation for people with a history of trauma who may be sexually vulnerable in an acute mental health inpatient environment, and who may be unable to identify or express these concerns at admission. Advance statements could be used to provide an overview of triggers for trauma, suggest preferred support strategies or approaches, and provide advice about what would help the person to feel safe during an admission.

Victoria's mental health services annual report 2016–17 (Department of Health and Human Services 2017e) reported that 2.34 per cent of adults accessing public clinical mental health services had a recorded advance statement and that 2.43 per cent had a recorded nominated person. The proportion of people newly accessing mental health services in 2016–17 was high at 36.6 per cent, reflecting that services have had limited time to engage with these people about using supported decision-making mechanisms. However, over half of all inpatient admissions and 56.9 per cent of adult inpatient admissions in 2016–17 were compulsory (Department of Health and Human Services 2017e). The initiation of compulsory treatment should be a particular prompt to ensure the person has access to supported decision-making mechanisms. However, complaints to the MHCC indicate that even when a person has experienced a traumatic event during inpatient treatment, developing an advance statement to ensure the person's views and preferences are known and respected in treatment planning in any future inpatient admission is rarely considered (see section 2.5.8). While rates of recorded advance statements and nominated persons is a crude measure of the extent to which supported decision making has been implemented in mental health services, the extremely low rate of take-up indicates that this element of supported decision making is not yet well implemented.

Therapeutic relationships

Transparent and supportive therapeutic relationships between staff and people accessing treatment are key to better implementing supported decision making (Healthtalk Australia 2016), as well as being critical to implementing trauma-informed care. Research supports the value of therapeutic relationships built on trust, empathy and mutual respect (Walsh & Boyle 2009; Wood & Alsawy 2016). People accessing mental health services have stressed the need for service staff to be genuine and empathetic in their interactions with service users (Gilbert, Rose & Slade 2008; Gunasekara et al. 2014; Sweeney et al. 2014). Indeed, experiencing positive relationships with staff has been identified as the most important factor in an effective mental health inpatient stay (Wood & Alsawy 2016) and has also been consistently identified by women as a factor that would help them to feel safe during acute inpatient treatment (Victorian Women and Mental Health Network 2007). However, both staff and people with experience of inpatient treatment expressed the view in consultations about the limited time that is available or taken by staff to engage therapeutically with people accessing treatment. While the busy nature of service delivery is acknowledged, some of these concerns can be addressed through taking different approaches to existing tasks as outlined elsewhere in this report.



I think nurses should have to spend at least 10 minutes each shift actually talking to each patient on their contact list, and to document that they've done that. When I've been an inpatient in the past, sometimes my contact nurse hasn't actually spoken to me during their shift.”

Person with lived experience of inpatient treatment

Peer support

Greater consideration of the role of peer support may also help to ensure a sexually safe, trauma-informed environment is provided. People with experience of accessing services reported that they may feel more comfortable raising concerns about sexual safety with a peer worker rather than a nurse, and greater access to peer workers may therefore be beneficial. Blanch, Filson and Penny (2012) have developed a guide and resource specifically designed for engaging women in trauma-informed peer support that could be considered in approaches to expanding peer support. Others noted the significant impact of the support that people offer each other during inpatient admissions to help each other to be and to feel safe; this was also identified in the literature (Rebeiro Gruhl, LaCarte & Calixte 2016). People noted the potential benefits in services identifying ways to build on the mutual support that already exists.

Engaging women in trauma-informed peer support: a guidebook is an example of a resource on approaches to trauma-informed peer support. It is intended as:

... a resource for peer supporters in these or other settings who want to learn how to integrate trauma-informed principles into their relationships with the women they support or into the peer support groups they are members of. The goal is to provide peer supporters – both male and female – with the understanding, tools, and resources needed to engage in culturally responsive, trauma-informed peer support relationships with women trauma survivors.

(Blanch, Filson & Penny 2012, p. 1)

The resource outlines:

basic values and principles of peer support work

cultural, religious and spiritual considerations in relation to trauma

trauma-informed peer support across the lifespan

trauma and peer support relationships

guidance about working in a trauma-informed approach within organisations and systems

self-awareness and self-care

trauma-informed storytelling.



One time when I was an inpatient I saw a predatory guy harassing some of the younger women. I told him to leave them alone and he started really abusing me and threatened me with physical violence. A staff member was watching the whole thing and when it was over he said 'good on you for sticking up for yourself' and I just said 'but you didn't do anything!'. He didn't understand how unsafe it was for me. Afterwards, other women on the unit checked on me and made sure I was OK. I didn't get the help I needed from staff but I looked out for other women and then when I needed it, they looked after me.”

Participant in consultations (person with lived experience of inpatient treatment)

RECOMMENDATIONS:

TRAUMA-INFORMED CARE AS A PRIMARY PREVENTION STRATEGY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

In developing policy directives and guidance for mental health services about ensuring sexual safety:

- articulate the principles of trauma-informed care as underpinning effective primary prevention of, and responses to, breaches of sexual safety
- ensure that information about the prevalence and impact of trauma and likelihood of re-traumatisation of people accessing mental health services is comprehensively addressed within the whole workforce. This should include information about trauma prevalence in particular groups including women, women with disabilities, Aboriginal people, people from migrant and refugee backgrounds, and people who identify as LGBTI, as well as how people's experiences of trauma may be influenced or compounded by their experiences of discrimination. This should also include information about the impact of restrictive interventions in re-traumatising people.

In its role of workforce development and planning:

- ensure that sexual safety, supported decision making and building awareness of the impact of the use of restrictive interventions in re-traumatising people accessing inpatient treatment are considered as a key element of planned workforce development activities in addition to, or as part of, workforce development in relation to trauma-informed care (including existing approaches to learning and development, as well as developing the organisational capability framework)
- work with education and training bodies to ensure that trauma, particularly in relation to sexual safety in acute mental health inpatient units, is addressed in postgraduate training and education programs (across all disciplines)
- consider ways to expand, build on or develop peer support approaches that can support people to feel and be sexually safe while accessing acute mental health inpatient treatment.

CHIEF PSYCHIATRIST

In the review of the Chief Psychiatrist's Guideline, include:

- more information about the prevalence of trauma and its relationship to people experiencing mental health concerns in their lifetime
- a greater focus on the links between previous trauma and sexual vulnerability
- guidance about how trauma-informed care and supported decision making relate to sexual safety in acute inpatient units, including approaches to help people be and feel safe.

MENTAL HEALTH SERVICE PROVIDERS

- Identify opportunities to enhance supported decision making, particularly the development of advance statements with people accessing mental health treatment to identify what would help them to feel and be safe during their admission to an acute inpatient unit.
- Continue to work to minimise and eliminate the use of restrictive interventions, acknowledging their effect in re-traumatising people accessing inpatient treatment.
- Integrate principles of sexual safety, trauma-informed care and supported decision making into supervision models and practice.
- Encourage and support staff to access training in trauma-informed care and principles.

2.3.4 IMPACT OF INFRASTRUCTURE, DESIGN AND USE OF SPACES ON SAFETY

As discussed in section 1.8 people have a right to receive, and services have a responsibility to provide, treatment in an environment that is safe, secure and free from harassment or assault. Section 1.8 also outlined the way in which key standards, guidelines and legislation require services to provide a safe environment for all people accessing mental health treatment. Current work being undertaken to update the *Australasian health facility guidelines* (Australasian Health Infrastructure Alliance 2015) for acute mental health inpatient units is considering specific reference to requirements for design and use of physical environments that will be relevant to sexual safety.² Considerations in working with specific groups are discussed in more detail in section 2.4.3.

2.3.4.1 Overview of themes identified from the literature and complaints

The literature and themes from consultations highlight that women, in particular, experience or fear sexual harassment and assault when accessing inpatient treatment in a mixed-gender environment (Davidson 1997; Graham 1994; Latalova, Kamaradova & Prasko 2014; Stamp 2009; WMHNV 2017). This is not to diminish the fact that men also experience breaches of their sexual safety while accessing inpatient treatment and that strategies are equally required to improve their safety and to prevent them from engaging in behaviours that could potentially harm themselves or others.

Analysis of the literature and of complaints has, however, pointed to the particular issues and risks associated with mixed-gender environments for women. This analysis indicates that most complaints about sexual safety breaches, including sexual harassment or alleged sexual assaults, in acute

inpatient environments were reported by women (80 per cent ($n = 68$ of 83) of complaints where data about the gender of the person making the complaint was available). Men were described as the perpetrators in more than 83 per cent ($n = 49$ of 59) of complaints where data about perpetrator's gender was available, with a further 7 per cent ($n = 4$ of 59) of these complaints involving both male and female perpetrators. The majority of perpetrators were described as other consumers (77 per cent, $n = 65$ of 85), which, as noted earlier, is the focus of this report. This is not to understate in any way the seriousness of complaints relating to staff, which included complaints about the conduct of clinical staff and security personnel, as such alleged conduct represents potential misconduct and/or criminal offences. There are, however, clear requirements and processes for addressing alleged conduct issues of staff; these differ from those required for addressing sexual safety risks posed by other people accessing inpatient treatment.

Most complaints involved male-to-female breaches (72 per cent, $n = 42$ of 58), with male-to-male breaches representing 10 per cent of complaints ($n = 6$ of 58); 5 per cent were described as female-to-male breaches ($n = 3$ of 58) and 3 per cent were described as female to female breaches ($n = 2$ of 58) (the remaining complaints (8 per cent, $n = 5$ of 58) had multiple perpetrators).

A recent survey of women accessing acute mental health inpatient services and staff working in mixed-gender environments conducted by the WMHNV indicates that:

- over two-thirds of respondents (68 per cent) felt unsafe during their inpatient stay
- over half of respondents (55 per cent) experienced harassment, intimidation or assault from another consumer
- nearly two-thirds of respondents (65 per cent) were not offered the option of being accommodated in a women-only corridor

Key statistics about gender in complaints

80%

of complaints, data about the gender of the person making the complaint was available

83%

of complaints, data about the perpetrator's gender was available

83%

of complaints, men were described as the perpetrators

77%

of complaints, perpetrators were described as other consumers

72%

of complaints were male-to-female breaches

10%

of complaints were male-to-male breaches

- over half of the respondents noted that men could access women-only corridors
- over two-thirds (67 per cent) were not able or permitted to lock their bedroom or bathroom doors, and only 32 per cent found working locks on their doors
- 60 per cent of respondents indicated that their inpatient admission was traumatic
- concerns were raised about the impact of a lack of staff presence or responsiveness on people's feelings of safety
- women feel 'a lack of dignity and insecurity' while accessing acute mental health inpatient treatment (WMHNV 2017).

While the sample size of this survey was small (42 women and 27 staff) and was completed in 2016, the survey provides a useful insight into some of the issues experienced by and views of women accessing mixed-gender mental health inpatient treatment. The themes identified in this survey echoed those in earlier surveys conducted by VMIAC (2013) and the Victorian Women and Mental Health Network (2007), as discussed in section 1.5. These types of experience have also been identified in the complaints dealt with by the MHCC, particularly those matters that were subject to investigations.

2.3.4.2 Women-only corridors within mixed-gender units

There was general agreement throughout consultations that, while women-only areas including women-only corridors do not completely prevent sexual harassment, assault and activity, access to these spaces can improve women's safety and experience of care. This is also supported by the limited literature available (Kulkarni et al. 2014). However, there are several issues with the current implementation of women-only areas within a mixed-gender environment.

The literature and relevant guidelines, including the *Australasian health facility guidelines* (Australasian Health Infrastructure Alliance 2015), highlight the way in which the design and infrastructure of inpatient units can play a key role in providing a safe environment for people accessing acute inpatient care. Despite the investment in creating more gender-safe environments and improvements in many services, it is evident that inherent design and infrastructure constraints continue to pose significant challenges to some services in their efforts to ensure sexual safety. The literature points to design features that can help to mitigate the risks associated with acute inpatient treatment and provide a more pleasant and therapeutic environment for people accessing treatment. These include spaces that allow for high staff visibility within the unit, as well as a variety of flexible spaces (for example, enclosed garden areas, quiet areas, sensory rooms and activities and games rooms) (Groves et al. 2017, p. 34). However, not all services have access to this kind of infrastructure.

As many older units have been retrofitted to implement women-only areas, it is not surprising that there are significant variations in design that influence their effectiveness. Consultations and complaints identified concerns about infrastructure in some services with small, corralled areas and multiple corridors that make it difficult for staff to maintain visual observation of much of the unit. There is also variability in the application of women-only corridors where these exist. For example, not all corridors have systems that support access to these areas being restricted to staff and consumers who are allocated to those areas (for example, swipe-band access). Consultations and the literature noted shared bathrooms as a particular risk for women in older inpatient units that do not have ensuite bathrooms (NHS Institution of Innovation and Improvement 2007; WMHNV 2017). Through consultations and complaints, it is also evident that shared bedrooms still exist in some services, despite guidelines for single bedrooms in an acute inpatient mental health service units (Australasian Health Infrastructure Alliance 2015).

Concerns about the maintenance of women-only corridors or gender-safe areas was frequently raised in consultations or evident in complaints in relation to both practice and physical maintenance. The maintenance of the theoretical boundary between women-only corridors or gender-safe areas and the rest of the unit was observed to be eroded by a number of practices. **The practice of most concern was accommodating men within a women-only corridor or areas, most often due to demand for beds.** While this practice was a common concern raised in consultations and complaints, there does not appear to be any systematic monitoring of the frequency of placing men in a women-only corridor or area. In addition, it was reported that where there are high numbers of women accessing treatment, not all can be accommodated on the women-only corridor and must be placed in the mixed area of the unit. These practices can potentially lead to re-traumatisation for women for whom accommodation in a women-only environment is a critical element of providing trauma-informed, appropriate care. It is recognised that, at times, accommodation in a safe space is required for all people accessing treatment, and appropriately balancing the various needs of people accessing inpatient treatment is a complex exercise for services and indicates the need for all units, whether mixed or single-gender, to have access to multiple flexible spaces.

“

Once you put a man in a woman's corridor, it ceases to be a women's corridor.”

Participant in consultations (person with lived experience of inpatient treatment)

² Information provided by Department of Health and Human Services and the Australasian Health Infrastructure Alliance, February 2018.

Other practices that can undermine the effectiveness of women-only corridors or gender-safe areas include only locking the doors to these areas at certain hours of the day (usually overnight), propping doors open for convenience and the failure of or inability for staff to have a clear view of entry points to these areas to prevent opportunistic or inadvertent access by men into these areas. Indeed, in one complaint to the MHCC, a male relative raised concerns that he was able to access the women-only corridor of a service without being advised by staff or signage that this was inappropriate. A number of complaints of sexual safety breaches also included instances where men are alleged to have gained access to an apparently secure women-only corridor due to the door being left unlocked or propped open.

Second, the physical maintenance of women-only corridors and areas appears to be a concern. Staff interviewed for the investigations and for the consultations noted the difficulty in maintaining swipe-band access systems (due to both system faults and wristbands not being returned), difficulties in replacing sensory modulation equipment or soft furnishings in women's lounges, and the impact of general 'wear and tear' in an acute, high-turnover environment.

As a separate concern, complaints, consultations and the literature (WMHNV 2017) identify that people accessing inpatient treatment are not always able to lock their own bedroom doors. This occurs because people are not advised that doors can be locked or because locks are broken. In complaints to the MHCC, people have reported that they have locked their doors overnight to preserve their sense of safety but the doors have subsequently been left unlocked by staff after conducting overnight observations.

“

I woke up and found a man in my room. I had asked the staff to lock my door but it wasn't locked. He had got through the door to the women's corridor and into my room and staff hadn't noticed.”

Woman who made a complaint

The analysis of MHCC and local complaints revealed 22 examples where available infrastructure was not used as intended. The majority of these complaints (13) included concerns where women were not accommodated in women-only areas (in some cases because this area was at capacity), while others related to women sharing a communal bathroom with men or being the only woman in an ICA. Four complaints involved areas of the service not being locked as intended, and a further five complaints involved issues of staff supervision – for example, lack of supervision in a courtyard area, lack of staff presence in an ICA and men being able to access the women-only areas.

“

Until this incident, I had assumed that the women's area was safe. Now I don't.”

Mental health staff member

These issues highlight the need for monitoring and oversight of the adequacy of maintenance and appropriate use of infrastructure that is intended to support sexual safety. An audit of the status of the current infrastructure that is available to support sexual safety across all acute mental health inpatient services (including child and youth mental health services and aged persons mental health services) would enable areas requiring priority support to be identified to ensure minimum infrastructure requirements are in place. A process of self-assessment and reporting by services about the maintenance and appropriate use of such infrastructure should also be established.

2.3.4.3 Practice issues in mixed-gender units

People with lived experience of inpatient treatment and staff both raised a range of practice issues about sexual safety in mixed-gender units. People who had experienced inpatient treatment noted that the physical presence of staff on the unit and staff capacity to engage therapeutically with consumers were critical factors in supporting people to be and feel safe. There were variable views of the extent to which staff are currently available to provide this in busy inpatient environments, with most comments pointing to the challenges for staff in finding the time to engage therapeutically with people.

It was evident in consultations with staff and in complaints to the MHCC that in a mixed-gender environment staff spend significant time and energy in observing markers of sexual risk and other dynamics between consumers, increasing observations in attempts to mitigate risk and intervening to prevent people from developing sexual relationships rather than spending this time establishing a therapeutic relationship with people accessing treatment. It is possible the need for this level and nature of observation could be reduced through providing single-gender units or more options for gender-safe and flexible areas. Such options, along with developing approaches for peer support as discussed earlier in this report (see section 2.3.3.6), were put forward in the consultations as ways of increasing staff capacity for therapeutic engagement with people accessing inpatient treatment.

“

I remember being scared all the time. I was just sleeping and sedated. And a guy came into the room and ... no staff were onto it.”

Woman who made a complaint

2.3.4.4 Considerations for single-gender care and treatment

As discussed in section 1.5, there have been calls over time in Victoria for single-gender care, with a particular focus on the safety of women in acute mental health inpatient units (Armstrong 2008; VMIAC 2013; Victorian Women and Mental Health Network 2007; WMHNV 2017). The most recent survey on this issue by the Women's Mental Health Network Victoria (WMHNV 2017) reported strong support from women accessing services and from staff for implementing single-gender care. There was a slightly higher preference for mixed-gender units with strict minimum requirements for women-only corridors, including bathrooms and lounges, compared with standalone women-only mental health inpatient units (and two responses indicating a preference for mixed-gender units with no further description). It should be noted that the description of mixed-gender units with strict minimum requirements correlates more closely with the UK requirements for providing single-gender care (see section 1.7.3) than the current Victorian experience, given the variability of infrastructure and lack of capacity to ensure gender separation to the required level in most Victorian units.

Consultations with a broad range of stakeholders for this project, as well as feedback from complaints to the MHCC, also revealed a high level of support for considering single-gender acute inpatient unit care as a way of improving the safety of people accessing inpatient treatment, particularly for women and priority population groups. In complaints to the MHCC about sexual safety breaches, the consumers, their families and staff commonly raised women-only units as a possible solution when asked how services can improve women's safety in inpatient units. With respect to priority population groups, single-gender acute inpatient treatment was put forward as offering more appropriate care for Aboriginal people, as well as women from some culturally and linguistically diverse (CALD) backgrounds who may find treatment in a mixed-gender unit traumatising, shameful or incompatible with therapeutic engagement due to cultural considerations.

Providing care that is responsive to cultural needs is also consistent with the mental health principle to recognise and respond to individual needs, including culture (s 11(1)(g) of the Act). It was noted in the consultations that families and carers would likely also welcome a move to single-gender acute inpatient units on the basis that family members, particularly younger women, would likely be safer in a single-gender environment. While there is limited evidence about the effectiveness of single-gender acute inpatient care in ensuring sexual safety, one Australian study (Kulkarni et al. 2014) has identified that establishing women-only areas in mental health inpatient units is effective in improving the safety and experience of care for women.

Single-gender care has, in recent years, been made available in the context of a women-only Prevention and Recovery Care (PARC) services. A recent evaluation of this found that 96 per cent of respondents appreciated being in a women-only environment, with comments including 'Being all female just felt more comfortable', 'I felt intimidated by the men in hospital and it was nice not to feel that way during my recovery' and 'I felt safe and secure' (Dixon et al. 2018, p. 47). The positive impact for trauma survivors of being able to access single-gender care was also noted, with one participant advising that she preferred single-gender care because 'I feel nervous, easily taken advantage of, when around males. Also suffer from PTSD due to domestic violence' (Dixon et al. 2018, p. 47).

“

It's almost impossible to ensure women's safety, but we are starting to have conversations around a women-only ward ... it has so many benefits. It's certainly worth pursuing and giving a trial.”

Mental health service staff member

Many stakeholders also highlighted issues that may affect implementation, particularly in relation to considering standalone single-gender units. Responses that were mixed or uncertain about the model of single-gender units often raised concerns that single-gender acute inpatient care does not reflect the broader world and may reduce the opportunities for services to support appropriate interactions between men and women. These types of concerns can, however, be questioned in light of the purpose of acute inpatient treatment (to safely recover from an acute episode of mental illness, rather than socialisation or rehabilitation), the short duration of acute inpatient admissions (in quarter 2 of 2017–18 this was an average of 8.9 days for adult acute inpatient units excluding long-stay patients staying over 35 days (Department of Health and Human Services 2018a)) and the gravity of the harm that can be experienced by women in mixed-gender units, including re-traumatisation. An additional concern about the potential volatility of men-only units expressed by some stakeholders is also not supported by the available evidence on introducing these units and is not defensible as a reason for not considering single-gender units as a way of addressing known risks for women in mixed-gender care.

The limited evidence available about men-only units in the UK found, contrary to expectation, that interactions within the unit became calmer after gender separation occurred (Hawley et al. 2013). Unexpectedly, there was some evidence that women-only units experienced slightly more verbal and physical aggression between women than in mixed-gender units, but in all other respects single-gender units were found to be as effective or better than mixed-gender units. Consultations with senior staff of the Professor Marie Bashir Centre in New South Wales, which provides single-gender 'high dependency' acute inpatient units, noted the positive outcomes and dramatic reduction of sexual safety breaches after implementing this model of care. Unfortunately, there is limited research or formal evaluation of introducing single-gender units either in Australia or overseas apart from the studies noted above.

Practical considerations raised in consultations included staffing concerns if a model for gender-separated care included a requirement for staff to be of the same gender as people accessing treatment. In principle, same-gender staffing may assist both in providing trauma-informed care and in reducing the risk of sexual harassment or assault being perpetrated by staff members, and has associated benefits for staff

confidence. A review of a single-gender unit in the UK found that men described feeling more confident to work in a men-only environment because it removed their concerns about allegations of sexual abuse from women patients, and women reported being more easily able to discuss 'female issues' in a single-gender environment and to better manage concerns about inappropriate attire or nudity (Hawley et al. 2013). Conversely, this review also found that men would be reluctant to work in a women-only unit due to fear of allegations of abuse or inappropriate behaviour and a (lesser) reluctance of women to work in a men-only unit due to fears of violence or physical vulnerability (Hawley et al. 2013).

Such findings are particularly relevant when considering the fact that women comprise almost 70 per cent of the mental health nursing workforce (Australian Institute of Health and Welfare 2015). Stakeholder consultations also noted the difficulties of engaging psychiatrists, particularly in rural areas, and that additional gender requirements would be extremely difficult to meet. These challenges are acknowledged and require further consideration. These issues and challenges are, however, not unique to the consideration of single-gender care because current guidelines and expectations for gender-sensitive care require services to explore requests for care by staff of a particular gender and accommodate these wherever possible (Department of Health 2011a).

Other concerns raised about the model of single-gender inpatient units included challenges with accommodating people who identify as trans or gender-diverse within a system that has established a binary concept of gender and separation of men and women. At the same time, concerns about the safety for LGBTI people, particularly for trans and gender-diverse people, in current mixed-gender environments were raised in consultations and acknowledged in the literature (Benoit 2015; Lucksted 2004).

The literature and consultations both point to the principle of people being accommodated according to their self-identified preference and to the availability of flexible space to accommodate individual needs and preferences. The consultations also identified some of the challenges experienced by services in creating dedicated spaces within their existing units for people who identify as trans or gender-diverse, as such spaces may not reflect people's preferences. For instance, a transwoman may have a clear preference for being accommodated in a women-only corridor. On balance, the evidence points to the desirability of all units (mixed or single-gender) having areas that can be used flexibly to accommodate the safety and privacy needs of individuals, depending on the needs of the mix of consumers in the unit at any one time.

Complaints to the MHCC demonstrate that, while opportunities for improvement exist, it is very difficult for staff, no matter how diligent, to completely eliminate breaches of sexual safety occurring within a mixed-gender unit. The low and decreasing average length of stay in mental health acute inpatient units (8.9 days for Q2 2017–18), combined with high occupancy rates, brings enormous pressures for services and staff. Services report that the need to use all available beds to accommodate increasing demand and acuity is the direct cause of men being placed in women-only corridors or in there being insufficient beds in the women-only corridor to accommodate all women requiring admission. Such circumstances are identified in turn as being a cause of women feeling and being unsafe in these environments.

“

If I could have it the way I want it, I would have in every mental health service split wards – one female ward and one male ward.”

Woman who made a complaint

Moreover, as noted above, the impact on staff of bearing the onus to observe and frequently intervene where a person is engaging in behaviours that could breach or compromise another person's sexual safety detracts from their capacity to engage therapeutically with people accessing treatment (see sections 2.3.3.6 and 2.3.4.3). Monitoring sexual safety can be an onerous task, with nursing staff often expending significant time and energy on monitoring sexual risk. It is also a strategy that can be ineffective, with some activity being covert and therefore remaining undetected. In addition, as will be discussed in section 2.4.1.1, some staff report that intervening to prevent possible sexual safety breaches can be difficult, posing challenges to maintaining a therapeutic relationship with people accessing inpatient treatment. While it is acknowledged that separating genders will not prevent all incidences of sexual harassment, activity or assault (Hales et al. 2006), it may enhance the capacity of nursing staff to prioritise therapeutic engagement with people over monitoring or observations. In general, women have reported experiencing women-only wards as safer and more attuned and responsive to their needs (Department of Health 2002).

Over recent years, the UK's experience with moving to implement single-gender acute mental health inpatient treatment (Bowers et al. 2014) provides some limited evidence that single-gender units can be effective in reducing (although not preventing) breaches of sexual safety. It found that of 522 individuals, 75 per cent (391) were accommodated on mixed-gender wards, 10 per cent (54) on women-only wards and the remaining 15 per cent (77) on men-only wards. The study defined 'sexual incident' as including consensual sexual touching, non-consensual sexual touching, exposure and public masturbation. During the study period, there were 102 sexual incidents on the mixed-gender ward and 45 incidents on the same-gender wards. The authors concluded that while sexual incidents occur on single-gender wards, they were fewer in number and lesser in severity and their impact was considered less significant compared with the incidents on mixed-gender wards (Bowers et al. 2014).

Some literature suggests that having a choice to access single- or mixed-gender mental health treatment may be the most important factor in improving women's experiences of acute inpatient treatment (Armstrong 2008; Department of Health 2002; Garling 2008; Henderson & Revely 1996). This view was largely supported by the broad range of stakeholders consulted for this project. This choice may be particularly important for women with trauma histories, women with disabilities and women from a CALD background where treatment in a mixed-gender environment is unacceptable on cultural or religious grounds (Seeman 2002).

However, the literature and the reports from the Royal Commission into Institutional Responses to Child Sexual Abuse also point to the under-reporting and barriers that men face in reporting issues of sexual safety, particularly alleged sexual assaults (RCIRCSA 2017b, p. 23). It is therefore noteworthy that 20 per cent of the sexual safety complaints made to the MHCC and services were made by men and that the safety of vulnerable men in both mixed-gender and men-only unit units were raised in project consultations. The need to provide flexible spaces in any mental health unit, whether mixed or single-gender, is acknowledged throughout the report, and the needs of vulnerable men would require consideration in any implementation of single-gender care.

Overall, the literature, and Victorian experiences to date, demonstrate that ensuring the sexual safety of all people in acute inpatient environments requires more than the separation of men and women within the same unit (Bowers et al. 2014); different models of care require further research to establish their efficacy in delivering sexually safe and gender-sensitive mental healthcare.

RECOMMENDATIONS: INFRASTRUCTURE AND DESIGN

Ensure unit planning, design and maintenance supports sexual safety, with a particular focus on responding to the needs of women and vulnerable consumers.

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- Explore opportunities to create and pilot single-gender inpatient units within mental health services, with a priority on piloting women-only units.
- Evaluate the effectiveness of multiple approaches to improving sexual safety, including the use of flexible areas to meet individual needs, taking into account models implemented in other states and countries to inform future infrastructure planning.
- Audit existing service infrastructure across all acute inpatient services (including adult, child and youth, aged and specialist inpatient services including forensic services) against a set of criteria of minimum requirements for sexual safety, including lockable bedroom doors, women-only or gender-safe areas, physical systems such as swipe cards to prevent unauthorised access, avoiding communal bathrooms or shared bedrooms, and developing a plan to address identified risks with services.
- Establish a process for services to self-assess, monitor and report about using infrastructure to support sexual safety.
- Consider ways in which all inpatient units, new and existing, can be designed or adapted to provide flexible areas to meet the needs of varying inpatient populations, including people who identify as trans or gender-diverse.
- Include minimum requirements related to sexual safety in revisions made to the *Adult acute inpatient design guidelines*.

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- Ensure that:
- systems are in place to ensure infrastructure that supports sexual safety (including access to women-only corridors and bedroom door locks) is prioritised, including prioritised for repair when necessary
 - bedroom doors in all acute inpatient units can be locked by people accessing inpatient treatment, and that policies and procedures are in place to advise people of this possibility and to ensure that staff re-lock doors on exit
 - systems are in place to prevent unauthorised access to women-only or gender-safe corridors, including both deliberate and inadvertent access
 - there are systems for assessing and monitoring the appropriate use and maintenance of infrastructure to support sexual safety, and for reporting on breaches and the extent to which these areas are not used as intended.

2.3.5 AMENITY AND USE OF HIGH DEPENDENCY UNITS AND INTENSIVE CARE AREAS

Intensive care areas (ICAs), also known as high dependency units (HDUs), are separate areas within an acute inpatient unit that are able to be locked (Department of Human Services 2002). These areas are referred to as ICAs in this report, as this is becoming a more commonly used term in services. While some of the issues related to the use and design of these areas overlap with the broader infrastructure and design issues discussed in section 2.3.4, there are distinct issues that have been identified from complaints, consultations and the literature on sexual safety.

The Chief Psychiatrist's *High dependency unit guidelines* note that ICAs 'usually' have an increased staff-to-patient ratio and facilitate a 'more intensive level of observation of patients and staff on the unit' (Department of Human Services 2002, p. 1). The reasons for admitting a person to an ICA include significant risk to others, significant risk of harm to self, significant risk of the person leaving the open unit, significant disruption to the environment of the open unit or a patient request where appropriate (Department of Human Services 2002). The existing guidelines, which require updating, were under review at the time of writing this report.

Anecdotally, staff and people with lived experience of inpatient treatment have noted a belief that women tend to be placed in ICAs because they have been assessed as at high risk of harm to themselves or others or as at high risk of inappropriate sexual behaviour (or due to challenging behaviours) while on the open unit. It is therefore not surprising that a strong theme emerged in the consultations of women feeling particularly unsafe in these environments. Providing care to men assessed as at high risk of inappropriate sexual behaviour alongside highly vulnerable women also increases the risks of sexual safety breaches. This is supported by complaints data, with 40 per cent ($n = 19$ of 47) of the complaints analysed for this project where data about location of the alleged sexual safety breach was available occurring in an ICA, despite higher staffing ratios and lower numbers of people accommodated in these areas. Examples of sexual safety breaches identified in complaints about ICAs included men entering women's bedrooms, men sleeping on couches outside women's bedrooms, men entering a bathroom while a woman was inside, sexual harassment and alleged sexual assault. Investigation of the association (in written complaints to the MHCC) between the type of the complaint and the site of the alleged sexual safety breach indicated that a high proportion of alleged sexual assaults occurred in an ICA. These complaints commonly highlighted the significant level of fear, trauma and harm associated with experiences within the ICA environment.



I start saying things like: Do you think it's appropriate to have a woman by herself with two other males? What's the supervision like? Do you think she's safe? What's your duty of care? I said please make sure she's safe."

Family member who made a complaint about a woman's experience in an ICA

Themes in complaints indicate that, prior to admitting a highly vulnerable woman to an ICA, services are not consistently considering and documenting (1) the potential risks of this approach; (2) why on balance an ICA admission is favoured; and (3) how they plan to manage the risk. Instead, the focus appears to be on ensuring that highly vulnerable females are subject to higher frequency monitoring, which in turn justifies the ICA admission.

Most ICAs have physical limitations that mean services are unable to provide a separate safe area for vulnerable consumers (other than bedrooms), including women and people who identify as gender-diverse. While some services have instituted strategies in ICAs to separate men and women, such as prioritising the bedrooms closest to the nurses' station as women-only, the allocation of women to these bedrooms appears to be flexible depending on the gender mix in the ICA at the time. In any event, the effectiveness of this strategy will be limited by the physical environment of an ICA, which is often confined.

In recent years, the Chief Psychiatrist issued a direction for services that at least one clinical staff member must be physically present on the floor where more than one patient is accommodated in a locked area of a unit (Victorian Chief Psychiatrist 2016). While this directive aims to address safety issues within these units, it is evident from complaints to the MHCC that there are instances where staff are not physically present in the ICA. Moreover, it is possible for sexual safety breaches to occur despite the physical presence of staff within an ICA; for example, where multiple staff are required to attend to one person, others may be left without a direct staff presence. Given these clear risks to sexual safety, and women's sexual safety in particular, there is a strong argument to consider ways in which gender separation within ICA environments can be achieved across the service system. It is acknowledged that infrastructure-based solutions may be challenging in some ICAs and that approaches to ensuring safety will need to be considered on an individual service basis and include practice-based solutions.

Staffing practices and approaches appear to differ across services. For example, one service advised that their ICA usually provided one-to-one care ('specialling'), which helped to prevent breaches of sexual safety in that environment despite the acuity of patients and mixing of genders (which is much higher than staffing ratios in most ICAs). Some stakeholders observed that expected staffing ratios were not always met and that there were variable approaches to care in ICAs across services, including access to allied health support in these environments.

A common theme in the consultations was that a fear of being transferred to an ICA is a direct barrier to women raising concerns about sexual safety with staff. The extent to which such transfers currently occur is unclear. The consultations, however, indicated that this appears to be an active fear for many women accessing services. There was also evidence in some complaints to the MHCC that a transfer to an ICA had occurred in response to sexual safety breaches or concerns, with the vulnerable party (generally a woman), rather than the alleged or potential perpetrator, being moved to an ICA to ensure physical separation. In these instances there was little evidence that either the woman's preferences, or the potentially traumatic nature of the alleged breach or the move to an ICA, was taken into account in decision making. The Chief Psychiatrist's Guideline currently advises that where a person discloses sexual assault or activity to staff, they should be placed in a safe area with appropriate staff support. To support people to have greater confidence in disclosing sexual harassment, activity or assault to staff, it would be helpful to clarify that placement in an ICA following such a disclosure or raising other concerns about sexual safety will generally be inappropriate.

“

I was stuck basically. I couldn't call anyone. No one would believe me and the men that did that to me were in there with me.”

Person who made a complaint about a sexual safety breach in ICA

Where fear about sexual safety in an ICA is expressed, or where a vulnerable person expresses concerns about their sexual safety when already within an ICA, there is a strong question as to whether therapeutic treatment can be provided to that person within that environment. In these circumstances, services should consider whether there is a basis to transfer a vulnerable person out of the ICA or to avoid such placement altogether. Options for providing care could include transfer to another ICA if the service has more than one and this is assessed as a lower risk environment or is able to be used as a women-only ICA for a period of time. Another option is to support the vulnerable person in the open unit with one-to-one nursing support ('specialling') if this can be safely done.

It is also critical that services engage directly with the person to develop strategies that enable that person to both be and feel safe in the unit. Based on complaints and direct feedback from people with lived experience of inpatient treatment, increased frequency of observation of the person expressing feelings of being unsafe will generally be inadequate to support a person to feel safer (and may also be inadequate to ensure actual safety). Strategies must include actions to directly address the behaviours of other people placed in ICAs to prevent breaches to another person's sexual safety. Such actions could result in increased restrictions for the person who is unable to manage their sexually disinhibited behaviours due to illness. Any plan to place a vulnerable person in an ICA should therefore consider alternative options that can ensure that person's safety and appropriately balance the rights of all people accessing inpatient treatment.

RECOMMENDATIONS: ICA/HDU ENVIRONMENTS

Develop a plan to improve the safety of ICAs and develop alternative strategies for supporting people who are vulnerable and at risk in these environments.

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- Develop a capital improvement plan for existing ICAs that addresses issues of sexual safety, along with guidelines for designing new ICAs that can designate flexible spaces to accommodate the needs of vulnerable consumers, in particular women or trans and gender-diverse people.
- Consider the purpose, design and staffing of ICAs in pilots of single-gender units, and evaluate the frequency of and reasons for placement in this environment.
- Consider ways for services to support a person who is assessed as being at risk in an ICA environment in the open unit and to use 'specialling' of nurses if additional supervision is required.

CHIEF PSYCHIATRIST

That the Chief Psychiatrist, as part of the review of the Chief Psychiatrist's Guideline:

- clarifies that placing a person in an ICA after a disclosure of a breach or concern about their sexual safety is generally inappropriate and potentially re-traumatising and that all other options should be explored
- includes advice about actions to address a person's concerns about sexual safety if it is assessed that there is no option but to place such an individual in an ICA.

That the Chief Psychiatrist, as part of the review of the ICA guidelines, acknowledges the challenges that the ICA environment presents to ensuring sexual safety, and considers approaches that can mitigate the challenges of providing care in these small spaces.

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- Consider options for using existing resources flexibly to ensure sexual safety in ICA environments (for example, where more than one ICA is available, consider designating one as a women-only ICA at times).
- Review policies and procedures to ensure that if there is no alternative but to place a vulnerable person in an ICA, that a plan is developed with direct input from the person to ensure their safety.
- Review policies and procedures to ensure sexual safety is a key consideration in the decision to place a person in an ICA environment, and that where a person is assessed as vulnerable, all other alternatives are explored first.
- Implement strategies and monitoring systems to ensure that risks of breaches of sexual safety are actively managed in ICA environments.

2.4. TARGETED PREVENTION

2.4.1 ORIENTATING PEOPLE TO MENTAL HEALTH INPATIENT UNITS

Effective orientation processes are critical targeted prevention strategies when people are first admitted to an acute mental health inpatient unit. The Chief Psychiatrist's Guideline states that orientating a person to an acute unit should encompass a written and verbal explanation that includes the right to a safe and therapeutic environment, including sexual safety, an explanation that sexual activity on the unit is inappropriate and not permitted, and that intimate behaviour or sexualised contact with other patients or staff is not acceptable (Department of Health and Human Services 2009).

The themes identified in complaints to the MHCC and in consultations highlighted a number of issues and challenges in implementing the approaches outlined in the Chief Psychiatrist's Guideline.

2.4.1.1 Advising that sexual activity is not permitted

Despite the clear guidance in the Chief Psychiatrist's Guideline, feedback through complaints and consultations suggest that clear verbal explanations that sexual activity is not permitted within an acute inpatient unit are not routinely provided. Rather, people are sometimes advised that they are not allowed in others' bedrooms, or cautioned against forming friendships or relationships during inpatient treatment. These statements do not clarify that one reason for these prohibitions is to prevent sexual activity. For example, prohibiting entry to another person's bedroom could be interpreted as being for privacy reasons. Sexual activity can also occur in many areas of an inpatient unit, not just a bedroom. Only one-third of the sexual safety-related breaches contained in the analysis of MHCC and local complaints occurred in a bedroom area, with the remainder occurring in other areas of an acute inpatient unit.

For these reasons, verbal explanations must specifically identify that sexual activity is not permitted in the inpatient unit and clearly outline expected standards of behaviour (see Practice example p. 67). These discussions, whether occurring at orientation or repeated during the course of an admission, should also be clearly and specifically documented in the clinical record (see also discussion about documentation standards in section 2.5.7).

Complaint themes and consultations suggest that it can be challenging for staff to convey the message that sexual activity is not permitted, and that some staff feel this message can create challenges in establishing and maintaining a therapeutic relationship. It may be particularly difficult to have these conversations with younger people, who may have generationally different attitudes to sexual activity and feel that it is not reasonable for limitations to be placed on their capacity to engage in sexual activity. There is a clear need for the message about sexual activity to be communicated in a way that focuses on the need to uphold everyone's right to be safe while accessing treatment, and that prohibiting any sexual activity between people in acute mental health inpatient units is necessary to ensure this.

Staff also expressed views that specifically mentioning sexual activity may be alarming for some people. Resources to assist staff to have these conversations with people accessing treatment in a supportive and clear way that accounts for the different approaches that may be required with different groups would therefore be beneficial.

“

There should be more information about what the rules of the ward [are] ... sometimes I think that if we bring up sexual topics, that could trigger a reaction to them.”

Mental health service staff member

Practice example:

The New South Wales *Sexual safety of mental health consumers guidelines* (New South Wales Ministry of Health 2013a, p. 58) provides an example of sexual safety standards of behaviour for an acute inpatient mental health service, which all people accessing treatment are asked to adhere to:

Standard 1: I respect myself.

Standard 2: I treat others with respect, dignity and courtesy.

Standard 3: I do not engage in any sexual activity with another person while on the grounds of the service.

Standard 4: I do not try to talk someone else into engaging in sexual activity, or harass another person sexually.

Standard 5: I try to be aware of how my behaviour makes others feel, and will change my behaviour if someone tells me it makes them uncomfortable, or I will ask for help with this if I need to.

Standard 6: I respect the rights of others to space and privacy to fulfil their sexual needs through masturbation.

Standard 7: I understand that fulfilling my own sexual needs through masturbation must be conducted privately and discreetly.

Standard 8: I speak up if I have been hurt, harassed or assaulted either physically or sexually.

Standard 9: I speak up if I see or hear about someone else being hurt, harassed or assaulted either physically or sexually.

2.4.1.2 Mode and timing of orientation

People accessing mental health inpatient treatment will have varying capacity to interpret written information, particularly at the time of admission. Factors including distress, mental state, the impact of medication, low levels of English proficiency, poor literacy and experiencing a first admission may affect a person's ability to review and respond to written information. Verbal explanations, while they do not replace the need to provide information in writing or to have additional information aids such as posters, are therefore particularly important in ensuring people understand they have a right to be and feel safe, how and where to seek help if they feel unsafe at any time during their admission, and to clarify that sexual activity is not permitted in the inpatient unit. Verbal explanations about sexual safety also offer an opportunity for staff to engage with a person about what would help them to feel safe during their admission, and to put measures in place to support this from the start of the admission.

These types of discussions should occur at orientation or as soon after orientation as possible. Full orientation may not be possible for some people when they are first admitted because they may be too unwell to engage fully in an orientation process. However, if this is the case, services should consider what can be discussed, and a plan to conduct a full orientation should be made. The responsibility for conducting this orientation should also be clearly indicated (for example, as part of handover until the orientation is completed). In any case, these messages should be repeated as required during an admission as part of an ongoing discussion about safety and rights.

The consultations identified a range of strategies to support comprehensive orientation such as the benefits of having video resources that outline the rights of people accessing inpatient treatment (including the right to sexual safety). While this does not replace the responsibility of staff to ensure adequate orientation, simple, accessible videos that explain what people have a right to expect while accessing mental health treatment, and how and to whom they can raise concerns (including to external agencies such as IMHA, Community Visitors and the MHCC if they are not satisfied with the initial service response), may provide an additional way for services to ensure people are aware of their rights.

Practice example:

Some mental health services have adopted proactive and clear processes to ensure people are aware that sexual activity in an acute inpatient unit is not permitted. This includes clearly advising people at orientation about expected standards of behaviour, the existence and expectations about women-only spaces in the unit, advising how to report sexual safety concerns, providing written as well as verbal information, and clearly advising that sexual activity is unacceptable/inappropriate in the hospital environment where people are unwell and will result in a report to police.

“

I had assumed that the nurses were telling consumers that sexual activity wasn't permitted, but I found out that they weren't and that they found it hard to bring up.”

Mental health service staff member

2.4.1.3 Preventing sexual harassment and promoting respectful interactions

There was a clear theme in the consultations and in some complaints to the MHCC that women experience various types of sexual harassment in acute mental health inpatient units and do not feel that this is satisfactorily addressed by staff when reported (see discussion in section 2.3.2.2).

Complaints to the MHCC also identified that staff, both medical and nursing, may not correctly identify and document behaviours as sexual harassment and instead refer to people being 'overfamiliar', 'close', 'intrusive' or having 'boundary issues', which fails to distinguish the impact of behaviours from an assessment of intent and makes it difficult to accurately assess and manage risk. It is also not clear that services routinely enquire about how inpatients feel about certain behaviours from others, giving rise to the risk that staff will make assumptions about the conduct being welcome and, therefore, not inappropriate or identified as sexual harassment. Effective orientation therefore requires a clear understanding and knowledge among staff of the definitions and impacts of sexual harassment from a rights-based perspective.

— The right of people to access treatment free from sexual harassment, as well as other potential breaches of sexual safety, should be explicitly addressed in orientation. Assurances should be given that staff will take action to prevent and respond to any reported or observed sexual safety breaches.

**RECOMMENDATIONS:
ORIENTATION**

Ensure orientation clearly outlines that sexual activity is not permitted in the inpatient unit and that behaviour that may breach the safety of others, including sexual harassment, will be addressed by staff. Ensure orientation also includes working with the person to identify what will help them feel safe, how they can seek support from staff, and the response that can be expected when concerns are raised about sexual safety.

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Support the development of a suite of co-produced resources to:

- support staff to have clear conversations with people accessing inpatient treatment about their right to sexual safety, how to seek help if they do not feel safe, and to clearly explain that sexual activity is not permitted in the inpatient unit

- support people accessing mental health services to understand their right to sexual safety, and steps they can take and responses they can expect if they report concerns about sexual safety, including how to make a complaint if they are not satisfied with the response.

CHIEF PSYCHIATRIST

- Review the Chief Psychiatrist's Guideline to include a requirement that orientation includes an expectation that mental health services will support respectful interactions between all people. This should specify that people accessing inpatient treatment and staff have a right to be free from sexual harassment, and staff must take action to prevent and respond to reported or observed sexual harassment.

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- Have systems in place to ensure that a verbal and written explanation is routinely provided at orientation to people accessing mental health treatment that clearly states that sexual activity is not permitted (where this explanation cannot be provided at admission for any reason, services must ensure that this is completed as soon as practicable and repeated as necessary).
- Ensure that orientation includes a discussion that the unit supports respectful interactions between all people and that staff will take action to prevent and respond to all reported or observed breaches of people's sexual safety including sexual harassment and suspected or alleged sexual assaults.
- Ensure that safety plans are developed for and in conjunction with all people accessing inpatient treatment.

2.4.2 RISK ASSESSMENT AND MANAGEMENT

2.4.2.1 Assessment of sexual risks

Understanding the factors that increase the likelihood of sexual activity, harassment or assault is a crucial step towards preventing these avoidable harms in acute mental health inpatient units. Services commonly rely on structured risk assessments to identify and manage risks. While these assessments have largely been derived from clinical research and practice, these assessments are also relied upon to meet services' obligations under NSQHS Standards 'to actively manage risks' and 'to provide a safe environment' (Standard 1, ACSQHC 2012, updated 2017). Effective assessment and management of risks is also required to provide a safe environment and ensure people accessing inpatient treatment are free from 'abuse, exploitation, discrimination, coercion, harassment and neglect' in accordance with Standard 6.2 of the NSMHS and to uphold a person's right under the *Charter of Human Rights and Responsibilities Act 2016* (Vic).

Structured risk assessment instruments are increasingly used in mental health inpatient settings to ensure a more accurate prediction of risk. However, a recent review suggests that the accuracy of an individual-based approach to risk assessment remains questionable, in that rates of violence also depend on local factors including staff attributes and the physical environment (Singh et al. 2014). In addition, structured sexual risk assessment instruments have largely been developed on different population types or focus on a narrow subset of incidents and cannot be applied to predict the risk of breaches of sexual safety in an inpatient unit.

Given the difficulties in predicting sexual risk based on perpetrator factors alone, the literature and themes from MHCC complaints point to the need for sexual safety strategies to be informed by a combination of perpetrator risk assessment, assessment of individual vulnerability and other factors associated with the milieu and dynamics of the inpatient unit. The Chief Psychiatrist's Guideline identifies risks associated with individual vulnerability and includes consideration of risk factors such as violent behaviour and previous sexual offending but could be expanded to address the interaction of individual and environmental factors in assessing sexual risk (Department of Health 2009). Complaints to the MHCC indicate that services commonly rely on 'tick box' approaches to risk assessment, which do not facilitate clear and detailed identification of risk and plans for risk management. These approaches sometimes focus on perpetrator risks without considering broader environmental factors or identifying individuals who may be vulnerable to risks posed by others. Further, inconsistencies in how staff interpreted terms such as 'risk of inappropriate sexual behaviour' meant that sexual vulnerability was not always reflected in risk assessments.

Themes from complaints made to the MHCC and services also indicate that, where risk is identified, adequate management of risk is compromised by a number of factors including:

- the physical structure and maintenance of inpatient units (for example, availability of women-only or gender-safe areas, capacity for doors to be locked by people accessing inpatient treatment, functionality of swipe-card systems to restrict access to women-only or gender-safe areas, risks presented by communal bathrooms)
- high occupancy rates and low average lengths of stay in acute mental health inpatient units, which leads to men being placed in women-only or gender-safe areas
- lack of capacity for gender separation within ICA environments and a lack of flexible options to care for people who are assessed to be highly vulnerable
- lack of staff supervision in some instances, including in ICAs or courtyard areas
- deficiencies in recording and handover processes in some instances.

2.4.2.2 Risk factors

Perpetrator risk factors

While there have been several studies examining the risk factors for perpetrating violence and aggression (Papadopoulos et al. 2012) by people accessing mental health inpatient treatment, risk factors for perpetrating sexual violence against other people accessing treatment have not been examined to the same extent. However, research has identified several specific risk factors including being a male with high levels of aggression, sexual disinhibition and dependency needs, along with efforts to compensate for feelings of inferiority, and responses to auditory hallucinations (Modestin 1981).

In complaints to the MHCC and services, the perpetrator of sexual safety breaches was described as male in 83 per cent ($n = 49$ of 59) of complaints, with a further 7 per cent of complaints ($n = 4$ of 59) involving both male and female perpetrators. Data about other perpetrator risk factors was not able to be extracted from complaints given the limited information available about the alleged perpetrator in most instances.

Appendix 1 of the Chief Psychiatrist's Guideline (sexual safety assessment tool) lists a number of other factors to include in risk assessments such as stated intent to have sexual relations, minimal insight into consequences of sexual activity, history of sexual offending and history of violent behaviour, abusive language, threats and intimidation (Department of Health 2009). Themes from complaints to the MHCC suggest that, while many of these factors are recognised and considered by services in assessing sexual risk, the risks associated with generalised violence and aggression is not always well recognised or responded to as a risk factor for sexual violence.

Assessment of vulnerability

The literature identifies a range of factors that may contribute to the risk of people experiencing a breach of sexual safety while an inpatient. These include the following:

- **Personal characteristics:** An assessment of vulnerability should be informed by any personal characteristics that may increase vulnerability to sexual harassment, activity or assault. While both men and women accessing inpatient treatment may be vulnerable to breaches of sexual safety (Scobie et al. 2006), women may be more likely to experience sexual assault while accessing treatment (Latalova, Kamaradova & Prasko 2014). The analysis of MHCC and local complaints demonstrated that women (80 per cent, $n = 68$ of 83) were significantly more likely than men (20 per cent, $n = 17$ of 83) to report a breach of sexual safety. There is limited evidence about vulnerability of people with other characteristics to breaches of sexual safety in an acute mental health inpatient environment. However, these characteristics should also be considered on the basis of what is known about the vulnerabilities of these groups in other environments or based on more general experiences of acute mental health inpatient environments. These characteristics include being from a CALD background, identifying as LGBTI (Luckstead 2004), being an older (Bardell, Lau & Fedoroff 2011; Fisher & Regan 2006) or younger person (Brown et al. 2010; Lipschitz et al. 1999; Seth et al. 2012), or having a disability (Benedet & Grant 2014; Chenoweth 1996; Sobsey & Doe 1991). Because of the nature of the complaints data, no or minimal information was available about factors such as sexual/gender identity, disability, age or racial or religious background in complaints to the MHCC and services.
- **Trauma history:** Rates of trauma, including sexual trauma, are extremely high among people accessing acute mental health inpatient treatment (Department of Health 2011c; Mental Health Coordinating Council 2013). This requires addressing in providing trauma-informed care more broadly (see discussion in section 2.3.3) and must be considered in undertaking risk assessments. People who have experienced previous sexual trauma, including childhood sexual abuse, may be less comfortable with their sexuality and their sexual behaviours; they may perceive themselves to be more unattractive and have more difficulty managing sexual thoughts, feelings and interactions. This low sexual self-esteem has been associated with increased vulnerability to later sexual assault. A sense of powerlessness resulting from previous abuse has also been hypothesised to contribute to an increased risk of experiencing further sexual trauma (Van Bruggen, Runtz & Kadlec 2006).

Complaints to the MHCC have revealed little evidence of service responses being informed by knowledge and recognition of a person's trauma history. In addition, even when one part of a service is aware of previous

trauma, this information is not always available to or sought by inpatient staff and is therefore not considered in the assessment of sexual risk. Analysis of complaints to the MHCC and services where data about previous trauma was available indicates that, in many instances (94 per cent, $n = 16$ of 17), people who experienced a breach of sexual safety within an acute inpatient unit had a previous experience of trauma, including three people reporting instances of previous sexual assault within an acute inpatient environment.

- **Distress and social isolation:** People can experience considerable distress during mental health inpatient treatment. Social isolation is a common experience, with people becoming detached from their home, family, friends and community (Wood & Alsawy 2016). Distress can arise for some people who perceive their stay in hospital to be detrimental to their existing relationships, possibly due to stigma or added pressure on carers (Wood & Alsawy 2016). The literature highlights the ways in which social isolation, loneliness and distress can result in seeking the comfort of people during inpatient admissions, which can be exploited by others (Scobie et al. 2006). Some stakeholder consultations, as well as themes from complaints to the MHCC, suggest that risk factors related to being withdrawn or lonely or to general emotional vulnerability are not consistently understood or identified by services as a sexual risk factor.
- **Vulnerability associated with the mental illness:** The way in which some symptoms of mental illness can increase impulsivity, participation in risky behaviours and involve sexual disinhibition is highlighted in guidelines developed to address sexual safety in mental health services (see Department of Health 2009; New South Wales Ministry of Health 2013b; Queensland Health 2016). People experiencing conditions that affect neurocognitive functioning (for example, acute psychosis and delirium) can also experience increased confusion and disorientation, diminished attention and awareness, and deficits in perception, memory, language and visuospatial ability (American Psychiatric Association 2013). These symptoms can compromise decision making, capacity to consent and capacity to respond, potentially resulting in vulnerability to predatory behaviour. Women receiving inpatient treatment for conditions that involve these symptoms are particularly vulnerable in a mixed-gender inpatient environment.

Complaints to the MHCC, along with concerns raised in stakeholder consultations, indicate that while sexual disinhibition is commonly recognised as a sexual risk factor, confusion and disorientation is not consistently identified or responded to as part of a sexual safety risk assessment. This is particularly relevant in considering a person's risk in the context of the broader relational environment of the inpatient unit including vulnerability to the actions of others.

– **Sedation:** People accessing acute mental health inpatient treatment are frequently prescribed sedating medication to control symptoms and respond to distress. Sedation can compromise psychomotor and cognitive performance, impair judgement and cause disorientation (Bourin & Briley 2004). Sedation is highlighted in the literature as being a potentially dangerous factor (Bourin & Briley 2004) that increases sexual risk. Complaints to the MHCC and to services reflected this, with sedation a factor in 12 complaints where people reported a breach of sexual safety. Sedation was also a factor in people's ability to recall and report specific details of the breaches. As stated above, risk associated with sedation should be considered in the context of the broader milieu of the inpatient unit.

“

I'd woken up and I feel his arms around me and he started touching me ... [I thought] do I have to fight off someone else? I just didn't have the energy.”

Woman who made a complaint

“

I hadn't been on medication for a while. I was confused and disoriented.”

Woman who made a complaint

Physical inpatient environment

Historically, inadequate unit design has presented challenges to ensuring sexual safety. Literature suggests that mixed-gender inpatient treatment environments can be experienced by people accessing inpatient treatment as emotionally and physically unsafe, potentially re-traumatising them, and can present challenges to providing therapeutic inpatient treatment and care (Muskett 2014). Over recent years, increasing attention has been paid to the role of the physical environment in establishing a safe and therapeutic atmosphere (Gilburt, Rose & Slade 2008) including significant investment in creating gender-specific areas in Victorian acute mental health inpatient units (see discussion in section 2.3.4). However, complaints to the MHCC demonstrate that even where these improvements have been made, changes to the physical environment alone, including the creation of women-only or gender-safe corridors, do not prevent sexual activity, harassment and assault.

Relational environment

Themes from complaints to the MHCC indicate that risk assessments do not always consider the relational environment of the unit, such as the way in which the milieu or dynamics of the unit may pose a risk to vulnerable individuals. For example, in some complaints to the MHCC, sexual safety risk ratings largely depended on whether an individual was sexually disinhibited or posed a risk to others. Where an individual did not pose a risk to others, they were rated as a low sexual risk. However, in the circumstances of these complaints, the risks that needed to be assessed were the risks posed to an individual by other people accessing treatment. This is particularly relevant in the ICA environment. Other factors that are relevant in an assessment of the overall environment include the level of staff supervision in a particular unit (or area of a unit), visitors to the unit, and the general acuity of the unit (Queensland Health 2016).

2.4.2.3 Approaches to risk assessment

Complaints to the MHCC suggest that many services assess risk by rating various potential risks as low, medium or high to reach an overall assessment (a 'tick box' approach). This approach does not provide sufficient prompts or information to staff about the reasons for an overall assessment and therefore what strategies may be necessary to ensure safety.

The lack of a requirement to record reasons for a particular assessment may also lead to inconsistent assessments within the same service if staff place different weight on various risk factors and are not required to record detailed reasons for their assessment. In some complaints to the MHCC, this lack of recording has also resulted in critical information not being provided to oncoming staff at handover, meaning that staff did not have all of the information that should have been available to them to assist them in preserving people's safety.

Other sectors have implemented common risk assessment frameworks and tools to support more consistent practice in identifying and responding to risk. For example, the *Family violence risk assessment and risk management framework and practice guides* (Department of Human Services 2012), developed for the family violence sector, provide a common evidence-based framework to identify, assess and manage family violence risk. Importantly, this framework includes the individual's own assessment of risk as one of the three key elements of risk assessment (with the other two being evidence-based risk factors and professional judgement). There is evidence that people accessing mental health inpatient treatment routinely take an active role in creating a safe inpatient environment (Quirk, Lelliott & Seale 2005) by using strategies including avoiding risky situations, de-escalating risky situations, seeking protection from staff, and protective involvement with other people

accessing inpatient treatment. To improve the accuracy and effectiveness of risk assessments and management strategies, services should therefore work in direct partnership with people accessing inpatient treatment to build on people's self-knowledge and preferred strategies for preserving safety.

This framework also identifies key principles and acknowledges the broader factors that contribute to family violence, including the unacceptability of family violence, the need to be aware of how gender inequality can manifest itself in family violence, and the need to prevent violence in the future. This principles-based approach and framework could also be applied to assessing risk in the context of sexual safety in acute mental health inpatient units. A focus on these kinds of principles may help influence staff perceptions and approaches when conducting risk assessments, and encourage more proactive and supportive responses to people accessing acute inpatient treatment.

While risk assessment cannot predict or prevent every breach of sexual safety, developing a common risk assessment and management framework to use across all clinical mental health services may help to improve consistency and rigour in identifying and managing sexual risk.

2.4.2.4 Approaches to risk management

A number of issues appear to affect the ability of services to adequately manage identified sexual risk. Some of these relate to infrastructure, funding and demand issues and require a joint approach between the department and services to address. These are addressed in detail elsewhere in this report (see section 2.3.4) and include:

- units that do not yet have capacity for gender separation
- high occupancy rates leading to men being placed in women-only or gender-safe areas
- insufficient beds in women-only or gender-safe corridors
- lack of capacity for gender separation in ICA areas (see section 2.3.5)
- difficulty maintaining service infrastructure including door locks, swipe cards or bracelet systems for restricting access to women-only or gender-safe corridors.

However, there are also practice issues that present opportunities for service improvement. Staff approaches to care can modify how people accessing inpatient treatment and the physical inpatient environment interact (Bowers 2014). For example, increasing the frequency of nursing observations can compensate for some issues in unit design (Bowers 2014). However, as sexual safety breaches can occur within a very short timeframe, increased observations cannot be relied on to address all risk issues.

Key stakeholder consultations highlighted therapeutic engagement between staff and people accessing treatment as being one of the most important strategies to managing sexual safety risks in acute inpatient environments. It was also clear in the literature, complaints and consultations that the presence of staff, and opportunities to build a therapeutic alliance, is highly desired by people accessing treatment and would contribute to people both being and feeling safer (see section 2.3.3).

The busy nature of public mental health services, reflected in high bed occupancy rates and extremely short (and decreasing) average length of stay, along with the accompanying increased acuity of people accessing public mental health inpatient treatment, certainly poses challenges for staff. These are real challenges for staff and services and are discussed elsewhere in this report (see, for example, discussion in section 2.3.2.1).

However, despite the pressures on mental health services, there are opportunities to increase engagement with people accessing inpatient treatment through different approaches to existing activities and requirements. For example, undertaking risk assessments jointly with people accessing treatment (or seeking information from advance statements, families, carers or nominated persons if the person is unable to participate at a particular point) may help in more accurately and transparently identifying and discussing risks and their management. This may particularly assist in identifying and responding to risks related to vulnerability and provide people accessing treatment with a routine opportunity to raise any concerns about their sexual safety with staff, which may lead to improved responses to these concerns.

Themes from complaints to the MHCC have also identified that, where risk is identified, management plans have not always adequately addressed the identified risk, or information required to adequately manage risks has not been provided at handover between staff. Mental health services must ensure that risk assessments and plans for managing identified risk are discussed at handover so that risks are actively managed and all staff have the information they require to ensure people's safety.

Finally, in 22 complaints identified as part of the complaints analysis it was evident that existing infrastructure is not being used to its full effect in managing sexual risk. For example, staff and people accessing inpatient treatment do not always appear to be aware that doors can be locked by the person occupying the room, or staff were not aware that locked doors should be re-locked if opened to conduct observations. In addition, many complaints demonstrated that women-only or gender-safe areas were not maintained as such, often because doors were propped open or left unlocked for convenience. These are relatively simple matters for services to address as part of regular risk management that would have immediate effects on perceived and actual safety.

RECOMMENDATIONS: RISK ASSESSMENT AND MANAGEMENT

Create a common framework to ensure risk assessments consistently identify and respond to environmental, perpetrator and vulnerability factors, and work jointly with people accessing inpatient treatment to identify and manage risk.

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- Prescribe the core components of a sexual safety risk assessment framework that encompasses perpetrator risk factors, risk factors related to vulnerability and factors related to the physical and dynamic/relational environment of mental health inpatient units to help in assessing the sexual risk of people accessing treatment.
- Develop guidance, using a co-production approach, on ways in which mental health services can undertake sexual safety risk assessments jointly with people accessing treatment.

CHIEF PSYCHIATRIST

- That the Chief Psychiatrist, as part of the review of the Chief Psychiatrist's Guideline:
- includes greater emphasis on holistic risk assessment including the need to assess factors that may cause vulnerability, non-sexual violence and aggression and the physical and relational environment of the inpatient unit when assessing the sexual risk of people accessing treatment
 - specifies the requirement for risk assessments (including the reasons for an assessment) and plans to manage identified risk to be clearly identified at handover.

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- Ensure that sexual safety risk assessments encompass potential perpetrator risk factors, risk factors related to vulnerability and factors related to the physical and dynamic/relational environment of the inpatient unit.
- Review processes to ensure that risk assessments and associated reasons for the assessment and plans are clearly identified at handover points and that staff are aware of these requirements.
- Consider, using a co-production approach, ways to undertake sexual safety risk assessments jointly with people accessing treatment.
- Use existing systems to identify and respond to known perpetrator risks.

2.4.3 RECOGNISING AND RESPONDING TO DIVERSITY

Mental health services are required to recognise and respond to the individual needs of people receiving mental health services, including needs related to culture, language, age, disability, religion, gender and sexuality, when providing mental health services (s 11(1)(g) of the Mental Health Act). This includes recognising and responding to needs in the context of sexual safety. *Victoria's 10-year mental health plan* also specifies the need to design and deliver services that promote 'equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities' (Department of Health and Human Services 2015, pp. 21–22).

Targeted intervention strategies therefore need to be informed by knowledge and understanding of the diversity of needs and the particular risks and challenges that are associated with people's gender, sexuality, culture, disabilities, age and backgrounds. This section discusses some specific considerations for particular groups of people accessing mental health services.

2.4.3.1 Recognising the impact of gender

Women

The issues related to the impact of gender on women's experience of violence, including the range of breaches of sexual safety experienced within acute mental health inpatient units, are highlighted and discussed throughout this report. As an overarching consideration, the literature on violence (including sexual violence) against women perpetrated by men identifies violence against women as being a major public health problem that arises from broader sociocultural contexts of culturally legitimated, gendered power and status differentials between sexes (Welsh 1999) – in short, it is an issue of gender inequality. As discussed in section 1.8, this has been recognised in *Victoria's Safe and strong* (Department of Premier and Cabinet 2016) and *Free from violence* (Department of Premier and Cabinet 2017) strategies for gender equality and prevention of all forms of violence against women. Recent Australian statistics estimate more than one in five women aged 18 years or older has experienced sexual violence (Australian Bureau of Statistics 2013). More specific nationally representative data (Rees et al. 2011) identifies that 15 per cent of Australian women have been sexually assaulted and 8 per cent have been raped. However, for many women the impact of gender is compounded by the way that gendered barriers interact with other forms of disadvantage and discrimination (Victorian Government 2016) such as those associated with age, cultural background and disability, as discussed in the sections that follow.

Older women

There is limited evidence specifically addressing the sexual safety of older women accessing mental health inpatient treatment. However, the literature indicates that older women may be more vulnerable and/or uninhibited due to age-related cognitive impairment or dementia (Bardell, Lau & Fedoroff 2011), are more vulnerable to stressors, and are at heightened risk for serious adverse general health outcomes (Fisher & Regan 2006) resulting from breaches of sexual safety. There is some evidence that older women are equally at risk of experiencing threats, harassment and abuse (compared with women accessing adult mental health services) and that, of people accessing older persons mental health services expressing fear and distress, 74 per cent are women (Groves et al. 2017).

Younger women

There is also little research into the sexual safety of younger women, particularly adolescents, accessing acute inpatient mental health treatment. However, a number of risk factors indicate the need to be aware of the particular risks for younger women. Research shows that young women receiving mental health treatment are more likely to engage in high-risk sexual behaviours and test positive for a sexually transmissible infection than young men (Brown et al. 2010; Seth et al. 2012). Gender-based inequalities in sexual relationships, high levels of psychological distress, low self-esteem, increased rates of mania and comorbid disorders and previous trauma are all associated with the high-risk sexual behaviour of female adolescents with mental illness (Seth et al. 2012).

Prevalence of previous trauma is extremely high in young people admitted to acute inpatient units, with some reports indicating that 93 per cent of adolescents accessing inpatient treatment report exposure to at least one type of previous traumatic event and 76 per cent experiencing two types of trauma, with the majority of incidents being childhood sexual abuse (Lipschitz et al. 1999). These extremely common risk factors may result in particular vulnerability to breaches of sexual safety where younger women are accommodated in mixed-gender inpatient units.

Men

While the evidence is clear that the overwhelming majority of victims of sexual assaults are women, men also experience sexual assault including during acute mental health inpatient admissions. It is clear that some of the risk factors that apply for women (including childhood sexual abuse) are also relevant for many men, with evidence in one study that 40 per cent of men in an inpatient unit had experienced childhood sexual abuse (Read et al. 2005). The findings of the Royal Commission into Institutional Responses to Childhood Sexual Abuse also highlighted barriers to disclosure for male victims of childhood sexual abuse (RCIRCSA 2017).

It is well accepted that men can be sexually abused in custodial settings including prisons and correctional facilities (Crome 2006). While it is not clear that these themes translate to a mental health setting, factors that are associated with risk of sexual assault in custodial settings include higher risk for men who have sex with men or men who have a history of childhood sexual abuse. The presence of interracial violence can also escalate risk (Crome 2006).

Men are more likely to experience sexual violence perpetrated by other men than by women (Crome 2006). While the sample size of men reporting concerns about sexual safety in the analysis of MHCC and local complaints was very small, men reported experiencing sexual violence from other men at double the rate ($n = 6$ of 58) of reported sexual violence perpetrated by women ($n = 3$ of 58). It is highly likely that breaches of men's sexual safety in acute mental health inpatient units are under-reported due to the issues of shame and stigma identified in the literature (Crome 2006). Mental health services therefore need to be alert to preventing and responding to sexual safety breaches experienced by men in acute mental health inpatient units and consider targeted intervention strategies and messages that support men to speak up about their concerns.

2.4.3.2 Aboriginal and Torres Strait Islander peoples

The literature review for the *Gender sensitivity and safety guideline* (Department of Health 2011a) highlights that Aboriginal and Torres Strait Islander people (hereafter referred to as Aboriginal people):

... conceptualise mental health as social, spiritual and emotional wellbeing; not only relating to the individual person but to the whole community. Fostering connection to community, land and family is critical to a holistic approach to care for Aboriginal people, as many suffer from loss, grief and trauma and associated mental health issues as well as social, spiritual and emotional wellbeing issues. Aboriginal people experience higher rates of disadvantage than other population groups in Australia and experience a range of social disadvantages, including poverty, inadequate housing, and physical health problems. Aboriginal people are often reluctant to access mainstream services due to a lack of cultural awareness of service providers, experiences of discrimination, racism and past practices of institutionalisation and forced removal. (Department of Health 2011a, p. 10)

The experience of admission to an acute mental health inpatient unit therefore may be particularly distressing for Aboriginal people in general if the services are not provided in a culturally competent and safe way. The need to address the poor mental health outcomes and experiences of services for Aboriginal Victorians is identified as a priority in *Victoria's 10-year mental health plan* (Department of Health and Human Services 2015) and the recently launched *Aboriginal social and emotional wellbeing framework* (Department of Health and Human Services 2017f).

It is also important to recognise that Aboriginal women experience sexual violence at a rate of between two and five times higher than is experienced by non-Aboriginal women (Mouzos & Makkai 2004; Willis 2011). It is estimated that up to 90 per cent of sexual violence against Aboriginal women is not reported (Willis 2011). While non-disclosure of sexual violence is also common in the broader Australian community, Aboriginal people are likely to face additional barriers to reporting including shame, stigma and lack of trust in the justice system and in government services more broadly due to historical experiences of discrimination, racism and the past practices of institutionalisation and forced removal (Aboriginal Child Sexual Assault Taskforce 2006; Willis 2011). Services must be aware of and responsive to these factors in providing care and treatment for Aboriginal people, and the implications for providing a sexually safe environment. A number of consultations noted that single-gender treatment and care may be more culturally appropriate for Aboriginal people, including that women and men may be more likely to raise or discuss concerns about their sexual safety with someone of their own gender, and feel more comfortable in a single-gender care environment.

2.4.3.3 LGBTI people

It is well established that LGBTI people tend to experience poorer health (including mental health) due to issues including discrimination, abuse, access to services and stigma (National LGBTI Health Alliance 2016). There is evidence that inpatient settings can be unsafe environments for LGBTI people (Benoit 2015), with people reporting harassment or threatening behaviour from other people accessing inpatient treatment (Lucksted 2004). Services therefore need to take a proactive approach to ensuring that acute inpatient units are safe and affirming environments for LGBTI people.

The LGBTI community makes up between 10 and 15 per cent of the Australian population and is as diverse as the rest of the community (Department of Health 2011a), indicating a need for services to take tailored approaches in ensuring sexual safety for each individual. There is significant evidence that trans and gender-diverse people in particular are likely to experience discrimination when accessing health care (Department of Health 2014). Trans and gender-diverse people accessing mental health services in Australia report more negative experiences with mental health professionals including counsellors, psychologists and psychiatrists than positive experiences (although of this group people were more likely to report better experiences with psychiatrists) (Riggs & Due 2013). Negative experiences included 'being misgendered, having to educate the practitioner, paternalism and feeling pathologised', while positive experiences were characterised by 'caring, knowledgeable and responsive engagements where respondents felt heard and affirmed' (Department of Health 2014, p. 26).

The above themes were echoed in consultations with Transgender Victoria, who noted that hospitals are still learning when it comes to working with trans and gender-diverse people. Some services have created separate spaces for trans and gender-diverse people and are actively considering how to ensure a safe and supportive environment. However, trans and gender-diverse people accessing mental health services still experience a range of issues including misgendering through use of inaccurate pronouns or first names, and privacy issues including invasive and inappropriate curiosity about a person's body as well as disclosure about the person's gender identity without the person's consent (for example, by publicly identifying the person as trans or gender-diverse).

Particular consideration of the needs of trans and gender-diverse people as they relate to providing single-gender care is discussed in section 2.3.4.4.

2.4.3.4 People with disabilities

The risk of abuse and prevalence of violence experienced by people with disabilities has been well documented in the literature, and has been the subject of a number of recent reports and inquiries (Coulson Barr 2012; Parliament of Victoria 2016; Sobsey & Doe 1991; VEOHRC 2014).

It is generally accepted that women with disabilities experience violence, abuse and assault at a disproportionately high rate (Benedet & Grant 2014; Chenoweth 1996; Sobsey & Doe 1991) and are subject to such violence for a longer time and by a greater number of perpetrators (Plummer & Findley 2012) than women without disabilities. Women with an intellectual disability are more likely than women with other disabilities to be subject to sexual violence (Healey 2013), with some studies estimating that 90 per cent of women with intellectual disability have been sexually abused (Salthouse & Frohmader 2004). This requires specific consideration in a mental health service context, as women with intellectual disability may be particularly vulnerable to the predatory behaviours of others.

Sexual violence against women with disabilities is significantly under-reported (Healey 2013). Historically, even when a sexual assault has been disclosed, services have been inaccessible or inappropriate in meeting the specific needs of women with disabilities (Sobsey & Doe 1991; VEOHRC 2014). While there is limited coverage in the literature about the experiences of women with disabilities in acute mental health inpatient units, these factors all support the need for services to take a proactive approach to recognising and responding to the safety needs of women with disabilities, for whom these environments may pose significant risks.

2.4.3.5 People from culturally and linguistically diverse backgrounds

The literature review to the *Service guideline on gender sensitivity and safety* notes that:

Victoria is home to people from more than 200 countries, who speak at least 200 different languages and dialects ... More than 850,000 people (17.9 per cent of the Victorian population) were born in a country where English was not their first language. Moreover 20.4 per cent of the population (or more than one million people) spoke a language other than English at home in 2006.

(Department of Health 2011b, p. 11)

Given the high rates of people who speak a language other than English at home, the need for access to interpreters during acute inpatient admission could reasonably be expected to be common. However, themes from consultations indicate that many people from CALD backgrounds are not able to access interpreters during inpatient treatment, particularly during short admissions. Access to interpreters was perceived to be poorer in acute inpatient units than in other parts of the mental health service system, and one perspective was put forward in consultations that services consider people accessing inpatient treatment to be 'too unwell to be dealing with culture'. The lack of access to interpreters is of significant concern and contrary to any principles of trauma-informed care or supported decision making. While logistical difficulties are acknowledged, strategies to ensure access to interpreters during inpatient treatment must be prioritised to ensure that people's rights under the Act and the Charter are upheld. This is of particular concern where people are compulsory patients. Access to an interpreter is critical to ensure people are able to make or participate in decisions about their treatment and care, and to enable clinicians to make accurate assessments of whether the criteria for compulsory treatment apply to the person. This must include sensitivity to the role of culture in the person's beliefs and experiences about mental illness.

Consultations also noted the particular sensitivities that may exist for individuals and families from particular cultural backgrounds in relation to sexual activity, harassment and assault in acute mental health inpatient units, as well as variable practices in services' capacity to recognise and respond to those sensitivities. The Chief Psychiatrist's Guideline draws attention to the need for services to take into account the cultural sensitivities that may exist in relation to sexual activity and assault, particularly that cultural background may influence the impact and disclosure of any sexual behaviour (Department of Health and Human Services 2009).

Along with the themes raised in consultations, issues identified in some complaints to the MHCC point to the need for targeted prevention strategies and responses to breaches of sexual safety that recognise and respond to the specific needs related to the cultural and religious background and beliefs of the person and their family.

2.4.3.6 People from refugee backgrounds

People from refugee or asylum seeker backgrounds may experience specific mental health impacts. The *Service guideline on gender sensitivity and safety* notes that:

... those who have spent time in detention centres are likely to experience additional psychological and mental health impacts from such an experience. Trauma and loss experienced prior to leaving one's own country contributes to the development of mental health problems. Experiences after resettlement and arriving in Australia also constitute a risk factor for the development of mental health problems ... Children and young people from families who had to seek asylum in Australia due to war or intolerable situations in their country of origin are also at risk of developing mental health problems and mental illness associated with their own experience (of torture or trauma) and/or witnessing their parents being exposed to such trauma. (Department of Health 2011a, p. 11)

In consultations, it was expressed that services do not need to enquire about the presence of trauma in a person of refugee background; the presence can be assumed and responses to the person should be planned accordingly. This is consistent with the broader discussion of trauma-informed care in section 2.3.3.

Themes in consultations also indicated that people from CALD backgrounds in general, and refugee backgrounds in particular, are likely to have a fear of authority and be unwilling to complain or raise concerns for fear of delaying discharge. While services must actively ensure the safety of all people accessing inpatient mental health services, this raises the need for services to be particularly proactive in working with people from refugee backgrounds to support them to speak up about safety or other concerns about their treatment.

Recommendations: recognising and responding to diversity

Recommendations on responding to the diverse needs of people accessing inpatient treatment are included within the recommendations for the different areas/sections.

2.5 TERTIARY INTERVENTIONS: RESPONSES TO SEXUAL SAFETY BREACHES

2.5.1 TRAUMA-INFORMED CARE: RESPONSES

Themes from complaints and consultations suggest that trauma-informed care is not yet consistently implemented, even in the specific circumstance of responding to incidents or allegations of sexual safety breaches.

Common general themes from complaints and consultations indicated that:

- the prevalence of trauma in people accessing acute mental health inpatient treatment, and the impacts of that trauma, are not widely understood
- not all services appreciate that admission to an acute mental health inpatient unit can itself be traumatic, particularly when admission is compulsory
- staff access to training about the principles and application of trauma-informed care has generally been limited, either in training curricula or at the service level
- approaches of services to their role in responding to incidents or disclosures of sexual activity, harassment or assault and responses to sexual safety breaches vary widely.

The genuine dedication and hard work of mental health service staff to providing quality care and treatment is acknowledged, as well as the challenges posed by the demanding and busy nature of mental health service delivery. However, despite these challenges, there are a number of actions that can be taken to provide more trauma-informed, sexually safe services.

2.5.1.1 Understanding and identifying trauma

Complaints to the MHCC and services indicated that people whose sexual safety was breached while an inpatient were highly likely to have a trauma history (94 per cent, $n = 16$ of 17) (where information about previous trauma was available). However, themes from complaints and consultations also indicate that people's experiences of previous trauma are often not identified or responded to in treatment plans. Factors that were observed to influence a lack of identification or response to trauma included:

- inadequate transfer of information between parts of the service leading to inpatient staff being unaware of a person's previous experiences of trauma
- difficulties in implementing routine enquiries about people's trauma histories because people may not be ready or able to engage in such discussions at admission, or because of staff reluctance due to perceived inexperience or concern that they will re-traumatise the person

- people choosing not to disclose previous trauma
- lack of routine enquiry about what would support a person to both be and feel safe during their admission (which may assist in identifying trauma-informed care strategies where a person's trauma history is unknown).

The Chief Psychiatrist's Guideline acknowledges the prevalence of trauma and the need for specific responses where it is known that a person has a history of trauma. However, relying on known histories is problematic for various reasons as previously described. Trauma-informed services, in recognising the prevalence of trauma, would ensure that trauma is a key consideration in providing care to all people accessing the service. The shift lies in assuming that people will have experiences of trauma in their background rather than expecting this to be an exception. It is therefore suggested that the guideline provide direction to services about proactive steps that can be taken to ensure *all* people *feel* safe and *are* safe regardless of whether their trauma history is known. In addition to the prevention strategies noted in section 2.3.3, this includes:

- implementing routine enquiries about what will help a person to feel safe, both on orientation and in response to any concerns raised about safety
- listening and responding to concerns about not feeling safe – this must go beyond reassuring the person that they are safe and include an acknowledgement of or enquiry into the reasons a person feels unsafe and working directly with the person on a plan to help the person feel as well as be safe (this should not be bound by staff assessment of whether or not the concerns are based in reality but should acknowledge the feelings of the person at the time and the supports they need to feel safe)
- recognising the impact of sexualised behaviours occurring as a result of illness on other people accessing treatment and addressing these behaviours as required
- taking steps to promote a sexually safe environment.

2.5.1.2 Trauma-informed responses to sexual safety breaches

Trauma-informed responses to sexual safety breaches require all mental health staff to be able to respond to a disclosure of sexual activity, harassment or assault with empathy and without disbelief, criticism or blame, and to enquire about what immediate help or support the person may need (adapted from NHS Education for Scotland 2017). The Chief Psychiatrist's Guideline (Department of Health 2009) outlines the responsibilities of staff as:

- believing disclosures of sexual assault or abuse
- offering referral to CASA or another relevant service
- discussing with the person whether they would like to make a report to police
- consideration of vulnerability during the admission and strategies to maintain safety.

Scottish guidelines (NHS Education for Scotland 2017) provide an additional emphasis on the importance of support strategies being developed *jointly* with the person rather than being based on professional assessment alone. The desire for such a focus was also reflected in feedback gained through complaints and consultations. People commonly reported that they were *not* asked what would support them to feel safe following a breach of sexual safety, nor were their views about what they needed to feel safe *integrated into their treatment plan*. While actions had often been taken to attempt to ensure actual safety, these were not always made clear to the person or were not found by the person to be helpful. For example, some common examples of strategies that people reported finding unhelpful in supporting feelings of safety were for staff to place them on increased observations or the offering of reassurance that the person was safe. It would therefore be beneficial for the Chief Psychiatrist's Guideline to more specifically and consistently outline the requirement for services to work with the person in developing individual safety or support strategies. One example of a simple safety strategy that, according to the WMHNV's 2017 report still does not appear to be routinely implemented, is advising and showing people that they can lock their bedroom door, and ensuring that doors locked by people accessing inpatient treatment are re-locked by staff, if staff need to unlock the door at any point (for example, to do overnight observations).

In complaints and consultations, people reported that many of the expectations of the current Chief Psychiatrist's Guideline are not consistently being met. Specifically, some people reported that their disclosures of trauma, whether historical or current, were not believed or not seen as relevant to the current admission. People reported experiencing service responses that ignored their disclosure or blamed or shamed the person rather than responding to the disclosure and offering support.

As discussed in section 2.3.3, all mental health staff should be able to hear a disclosure of a sexual safety breach with empathy and take action to ensure immediate safety. This must be a minimum expectation for responses.

However, more complex work, including working with the person to develop safety strategies, identify trauma triggers and avoid re-traumatisation, requires correspondingly advanced skill and capability. This does not appear to be acknowledged in current service responses to sexual safety breaches. For example, the MHCC's investigations of complaints found that medical staff were often expected to lead a trauma-informed response to sexual safety breaches and medical reviews despite being less likely to have accessed trauma-informed care training than other staff. This indicates a twofold need – the need for workforce development activities to be inclusive of all disciplines and the need for services to develop more sophisticated approaches to responding to sexual safety breaches and alleged breaches. The initial responses to these breaches and allegations should be led by a person who has the appropriate skills in trauma-informed care to manage the response without causing further trauma.

In addition, the MHCC's investigations found that medical reviews were sought from hospital medical officers in response to some allegations or incidents of sexual assault. While these officers were noted to be diligent in discharging their responsibilities to the best of their ability in the matters investigated, hospital medical officers are generally inexperienced, generalist clinicians. Accordingly, they are unlikely to be suitably experienced in conducting such a review, unlikely to be trained in trauma-informed care and unlikely to be familiar with the relevant guidelines and requirements of the mental health service. It would be preferable for reviews to be conducted by senior clinical mental health staff who are able to provide trauma-informed care (including on-call staff if sexual safety breaches or allegations of such breaches occur overnight or on weekends).

To support services to identify and implement consistent responses to sexual safety breaches, it would be helpful for the department's proposed capability framework and/or the Chief Psychiatrist's Guideline to outline the minimum capabilities expected of all mental health staff (similar to those outlined in current guidelines), as well as the more specialist approaches that may be required to respond to a disclosure of previous sexual assault or a suspected or alleged sexual assault occurring during an acute inpatient admission. This includes approaches to working sensitively and proactively with the person to develop treatment and discharge plans following a sexual safety breach.

While recruiting to and shaping workforce change around organisational capabilities is a useful strategy for creating long-term cultural change within mental health services, the variation in practice noted through complaints and consultations indicates an immediate need for mental health service staff to access specific information and training about trauma-informed care, particularly as it relates to:

- the prevalence and impacts of trauma, including the impacts on a person's presentation and behaviours
- links between trauma history and sexual vulnerability in an acute inpatient environment
- the importance of supportive staff responses to sexual safety breaches including allegations or disclosures of such breaches to avoid compounding the person's trauma by not believing the disclosure or by failing to provide support
- the minimum expectations and responsibilities of various mental health service staff in responding to sexual safety breaches including allegations or disclosures of such breaches.

Any training should be able to be flexibly accessed and be informed by the experiences of people who have accessed acute mental health inpatient units. Strategies to support better implementation of trauma-informed care as it relates to sexual safety must also be supported and reinforced by other strategies including supervision and coaching.

Other specific issues identified through complaints and consultations relating to how incidents or allegations of breaches of sexual safety were responded to included:

- instances where vulnerable people were transferred to an ICA following an incident or allegation of sexual activity, harassment or assault (while the rationale for these decisions has generally been to ensure the person's safety, moving the person to a more restrictive environment may in fact cause re-traumatisation, either because the greater degree of restriction and lack of choice/control may itself be traumatising, or because the person may be at greater risk of further interpersonal violence in an ICA – see section 2.3.4)
- lack of specificity about requirements to contact on-call staff (medical, nursing, management) in response to an incident or allegation of sexual activity or sexual assault
- lack of specificity about the required actions and decisions of on-call staff in services' local policies and procedures, including assessing capacity and consent to contact police or family
- failures to adequately document advice and decisions made by on-call staff following a notification of a possible or confirmed sexual safety breach (see section 2.5.7).

The Chief Psychiatrist's Guideline should clearly provide guidance on the responsibilities of on-call staff in respect of assessment and decision making in response to reports of sexual activity or allegations of sexual assault, as well as emphasising the requirement that these be adequately documented.

2.5.1.3 Referral to trauma-specific services

Themes from complaints and consultations indicate that service approaches to working with trauma-specialist services vary considerably. In complaints made to the MHCC and services, little information was provided about whether people were offered debriefing support or referral to CASA following sexual safety breaches, despite the MHCC's additional request for this information. Out of the 90 complaints in the MHCC's sample, information about the consumer being provided with a debriefing was only available for 31 cases. While the majority of these cases (90.3 per cent of people) were reported to have been offered counselling as part of debriefing of the breach, there is only evidence that 31.1 per cent of all people who reported concerns about sexual safety were offered counselling. It is also important to note that of the complaints that were categorised as alleged sexual assaults in the data analysis, only 11.4 per cent resulted in a referral to CASA.

In addition, there is presently no requirement under the Chief Psychiatrist's Guideline to offer psychological or counselling support to people following sexual activity that is described by the parties involved as consensual. However, the offer of such support would likely be valuable for these individuals, particularly given the difficulties associated with assessing consent in an acute inpatient context and the shame or regret that may follow an event of sexual activity in this environment.

Themes from consultations indicated that relationships between CASA and mental health services vary considerably, with some services supporting and facilitating CASA access to inpatient units and other services having limited connections. People with experience of accessing mental health services noted people may be unable to access CASA while an inpatient either because CASA have not been permitted to see the person or because the person is not able to access leave from the unit to attend a CASA service. To ensure access to these services, services may need to develop or enhance local partnerships and approaches, and mental health services should prioritise this.

The way in which support is offered can significantly affect whether a person who alleges sexual assault accepts the referral. For example, asking, 'Would you like to have a chat with a counsellor?' and outlining what supports CASA can offer is more likely to gain agreement for CASA contact than asking, 'Would you like to speak to CASA?'. There was also some evidence in complaints that a lack of clarity about the role and independence of CASA may also be a cause of people declining the offer of a referral. CASA's independence should be clearly explained in any offer of referral, and it would be helpful for services to be aware of the tailored supports that CASA may be able to provide through approaches developed for people with disabilities.

Some people may not wish to seek immediate support from CASA or other counselling services. For this reason, it is important that the need for further support and referral be included in discharge planning processes and that information be transferred to community teams to enable them to facilitate referrals as needed (see section 2.5.8). Following an incident or allegation of sexual activity or assault, people may also require testing for sexually transmissible infections and pregnancy. These tests should be undertaken while the person is an inpatient if possible. However, if this is unable to occur, a plan to ensure this occurs must be included as part of discharge planning (see section 2.5.8).

RECOMMENDATIONS: TRAUMA-INFORMED CARE RESPONSES

Develop tiered approaches to implementing trauma-informed care to ensure mental health service staff with the appropriate skills and capabilities lead responses to sexual safety breaches, and ensure pathways to trauma-specific care are clear and available.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Ensure the minimum skills and capabilities expected of all mental health service staff in responding to disclosures and breaches of sexual safety, as well as the skills and capabilities required to lead a trauma-informed approach to treatment following sexual safety disclosures, are defined in the planned organisational capability framework.
- Consider developing a co-produced statewide training resource for services on trauma-informed care as it relates to sexual safety.

CHIEF PSYCHIATRIST

That the Chief Psychiatrist, in the review of the Chief Psychiatrist's Guideline:

- includes a requirement that consumers who have engaged in sexual activity, as well as consumers involved in other breaches of sexual safety, be offered the opportunity for counselling or psychological support
- outlines the responsibilities and decisions required by the authorised psychiatrist or delegate in responding to an incident or allegation of sexual activity or assault.

MENTAL HEALTH SERVICE PROVIDERS

- Develop approaches to ensure that initial responses to breaches of sexual safety, particularly sexual activity, alleged sexual harassment and sexual assault, are led by a person or persons with the appropriate skills and capabilities to provide a trauma-informed response.
- Have systems in place to ensure that any trauma history is transferred from community teams to inpatient staff when a person is admitted, and that information about trauma experienced during an inpatient admission, including any required follow-up by community teams, is efficiently and effectively transferred.
- Ensure systems and processes are in place to enable medical reviews to be conducted by senior clinical mental health staff, including on-call staff if necessary.
- Develop or enhance protocols with trauma-specific services (including CASA) to improve consumers' access to these services following an alleged or suspected assault. This may require the development or further enhancement of partnerships with relevant services.

2.5.2 OPEN DISCLOSURE

2.5.2.1 Requirements for open disclosure processes

Open disclosure is 'the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers' (ACSQHC 2013, p. 11). It is critical that open disclosure is undertaken routinely and effectively in public mental health services given the vulnerability of many people accessing treatment, the human rights affected by compulsory treatment and detention, and the risks of closed environments. The *Targeting zero* report noted that people accessing mental health treatment experience particular risks not experienced by people accessing other types of healthcare services, including 'assault (including sexual violence) from other patients (which ... is very rare for general patients)' (Department of Health and Human Services 2016c, pp. 133–134).

The elements of open disclosure include (ACSQHC 2013):

- an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
- a factual explanation of what happened
- an opportunity for the patient, their family and carers to relate their experience
- a discussion of the potential consequences of the adverse event
- an explanation of the steps being taken to manage the adverse event and prevent recurrence.

Mental health services are also required to consider how the mental health principles apply to providing open disclosure. Relevant principles include the following:

- People receiving mental health services should be provided services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- People receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make or participate in those decisions. Their views and preferences should be respected.
- People receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- Carers should be involved in decisions about assessment, treatment and recovery whenever this is possible.
- Carers should have their role recognised, respected and supported.

Delaying, or failing to provide, open disclosure can cause significant distress to the person affected and their family or carer, as well as damaging ongoing relationships that may affect a service's ability to provide therapeutic treatment and care to the person affected. Taking into account all of the above factors, open disclosure following sexual activity or sexual assault is critical to ensure that people accessing mental health treatment and their families and carers receive full information about what happened, receive support as required and can provide input to and be informed about steps that the service will take to investigate or review the breach and to prevent like occurrences in the future. Open disclosure also benefits services by ensuring better detection and awareness of risk, enabling services to make improvements to prevent further breaches of sexual safety and ensuring services meet the requirements of the Mental Health Act.

In addition to the elements of open disclosure previously outlined, open disclosure processes also require services to ensure that:

- staff proactively identify the need for open disclosure
- staff conducting open disclosure processes are adequately senior, trained, supported and prepared to undertake open disclosure
- multiple open disclosure meetings are conducted where this is required to respond adequately in the circumstances
- support for individuals, families and carers is available during the open disclosure process as required. This may include the involvement of social workers, pastoral care or trained patient advocates. In a mental health context, and where these staff are appropriately trained, it may be appropriate for consumer and carer consultants or peer workers to be involved in supporting an individual and their family or carers. Where a sexual safety breach involving sexual activity or alleged sexual assault involves an Aboriginal person, the involvement of an Aboriginal Mental Health Liaison Officer or Aboriginal Hospital Liaison Officer should be considered to ensure open disclosure is managed in a culturally appropriate way. It was suggested in consultations that services should also consult with the individual and their family to identify an Elder or senior community member who may offer support during an open disclosure process.

The MHCC has found significant shortcomings in services' approaches to open disclosure when responding to sexual activity or alleged sexual assault. The shortcomings identified in complaints to the MHCC have included the following:

Timeliness

This refers to undue delays in informing family and/or carers of sexual activity or alleged sexual assault.

The complexity of situations where a person has capacity and has refused consent, or where consent for the service to provide this information to their family fluctuates, is acknowledged. However, in some instances, even when a person had provided unequivocal consent to this information being shared with their family, there were significant delays in contacting family or carers.

Preparation

This refers to failure to plan open disclosure in a way that responded to the needs of the individual and their family or carers.

There were also issues of inadequate preparation for open disclosure, which in some instances was linked to a perception by families and carers of a lack of transparency in explaining what had occurred, and the steps to be taken to prevent a recurrence. It is acknowledged that in many circumstances some level of open disclosure needs to be engaged in immediately, and this will naturally limit the level of preparation and explanation that can be provided by the service at an initial meeting. Perceptions of a lack of transparency can be avoided or minimised by openly sharing known facts, clarifying what is unknown, outlining next steps and conducting follow-up meetings with individuals, families and carers where required. In some instances reviewed by the MHCC, families received neither adequate information nor a clear understanding of the steps that would be undertaken to investigate or review the incident and to advise the family of the outcome.

Workforce support

This refers to inadequately skilled staff leading open disclosure and/or inadequate support for staff leading an open disclosure process.

In many instances reviewed by the MHCC, open disclosure was led by junior medical staff. While these staff members made genuine and conscientious efforts to respond to individuals' and families' concerns to the best of their ability, support from more experienced staff would have been beneficial for individuals, families and the staff involved.

Support for individuals and families

This refers to inadequate support offered for individuals, families and carers when undertaking open disclosure.

This is particularly pertinent for disclosure of a sensitive matter like sexual activity or alleged sexual assault, where it can be anticipated that most families or carers will experience and express significant distress. This should be particularly considered where a person accessing treatment and their family or carers is from a cultural or religious background that has particular cultural norms regarding sexual matters (for example, a culture where there are significant taboos or stigma relating to pre-marital or casual sex). Increased support for individuals and families may also help to diffuse distress and assist staff to complete open disclosure processes.

Focus on individual and family input to quality improvement

This refers to lack of implementation of the two-way nature of open disclosure.

The complaints to the MHCC indicate the need for services to understand open disclosure as being a 'discussion between two parties and an exchange of information' (ACSQHC 2013, p. 11) and that the views of the person accessing treatment and their support people should be actively sought by the service to inform the process and, in particular, to inform any improvements to the service to prevent further like incidents.

The Chief Psychiatrist's Guideline, while acknowledging the importance of and encouraging clear and open communication between clinicians, patients and families and carers, does not specifically address the need for open disclosure in relation to sexual activity or sexual assault occurring within an acute inpatient service. Rather, it focuses on the possibility of family members being perpetrators of past or current trauma. It is critical that services are alert to the possibility of family members being a source of trauma and that information is not disclosed in these circumstances. However, it is apparent from complaints to the MHCC that services require guidance about how to apply the principles of open disclosure in the context of breaches of sexual safety occurring within the acute inpatient unit, including disclosure to families and carers where this disclosure is appropriate.

2.5.2.2 Proposed statutory duty of candour

The *Targeting zero* report recommended that ‘a statutory duty of candour be introduced that requires all hospitals to ensure that any person harmed while receiving care is informed of this fact and apologised to by an appropriately trained professional in a manner consistent with the national Open Disclosure Framework’ (Department of Health and Human Services 2016c, recommendation 5.3). The proposed duty is intended to establish an enforceable mechanism for ensuring open disclosure occurs in defined circumstances (Department of Health and Human Services 2017a).

Consultations about the proposed duty, including the circumstances in which the duty will apply, are currently underway, so the scope of the duty is therefore not yet clear. However, some types of adverse events, including allegations of sexual assault, should be subject to the duty of candour on the basis that it can be assumed that people will experience significant harm and trauma associated with these events. Having sound open disclosure processes in place, including appropriate training and support for staff, will help services to prepare for the future implementation of the statutory duty of candour as well as ensuring that current accreditation requirements are met.

The recommended guidance on open disclosure (see recommendations on p. 87) will require further review as part of the implementation of the statutory duty of candour.

“

A culture of candour is a culture of safety, and vice versa.”

Sir David Dalton and Professor Norman Williams
(Department of Health and Human Services 2017a, p. 4)

“

They must have known we’d come in asking ‘why this and that’ but it was just so guarded ... not much empathy there ... It wasn’t trying to help us understand ... I was amazed how clinical it was when it wasn’t really a clinical thing.”

Complaint from a family member about an open disclosure process

RECOMMENDATIONS: OPEN DISCLOSURE

Develop specific guidance and approaches for managing open disclosure in relation to sexual safety breaches, ensuring that cultural, religious, communication and other needs are responded to, and that staff are supported in conducting open disclosure.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Develop guidance for mental health services in open disclosure processes that includes specific considerations and guidance for responses to breaches of sexual safety, in particular suspected and alleged sexual assaults. When the scope of the proposed duty of candour is clear, guidance about its application in mental health services should also be provided.

CHIEF PSYCHIATRIST

That the Chief Psychiatrist, in the review of the Chief Psychiatrist’s Guideline includes:

- guidance and expectations of services in conducting open disclosure processes in response to breaches of sexual safety, consistent with the ACSQHC’s *Open disclosure framework* and including the areas of concern noted in this report. In particular, this

should include consideration of the likely response of families and/or carers to the disclosure of sexual activity or sexual assault of their family member while an inpatient, as well as the cultural, religious, communication and other support needs of the person at the centre of the event and their family or carer.

MENTAL HEALTH SERVICE PROVIDERS

That mental health service providers review their open disclosure policies and practices to consider the matters outlined in this report. Particular consideration should be given to:

- reviewing the service culture as it relates to open disclosure, including reviewing the training provided to staff regarding open disclosure to ensure this includes a focus on the underlying principles that open disclosure is a right of people accessing mental health treatment, as well as representing good clinical practice and being of benefit to the mental health service
- ensuring adequate supports are available for staff participating in open disclosure, including support from a staff member trained and experienced in conducting open disclosure processes
- reviewing the support mechanisms available for individuals, families and carers participating in an open disclosure process to ensure that the support a service proactively offers is responsive to cultural, religious, communication or other support needs
- ensuring that individuals who experience breaches of sexual safety within an acute inpatient unit, and their family or carers, have the opportunity to express their views about the breach including views about what would prevent future breaches
- ensuring that the service has mechanisms to ensure the views of individuals, families and carers are considered thematically in quality improvement activities as well as in relation to individual sexual safety breaches. The opportunity to express these views as part of an open disclosure process should be in addition to the opportunity to be part of any investigation or review process following the breach.

2.5.3 REPORTING SUSPECTED AND ALLEGED SEXUAL ASSAULTS TO VICTORIA POLICE

A key issue identified in complaints in relation to responses to suspected and alleged sexual assaults occurring in acute mental health inpatient units was that these do not appear to be routinely reported to Victoria Police. In complaints to the MHCC and to services, there was evidence that allegations of sexual assault had been reported to police in less than 40 per cent of these complaints (39 per cent (17) reported, 9 per cent not reported (four), 4 per cent (two) declined by consumer, 47 per cent with information about reporting unavailable (21)).

2.5.3.1 Identifying and responding to potential crimes

Themes in the literature, complaints and consultations indicate that allegations of sexual assault in mental health services are likely to be under-reported to police for various reasons. It is important to clarify the respective roles of mental health services and Victoria Police in responding to allegations of sexual assault. Mental health services do not have a role in determining whether a crime has occurred. They are required to uphold a person's right to communicate lawfully with any person, including the police under s 15 of the Mental Health Act, and also have responsibilities to report allegations of sexual assault to police in most circumstances (see discussion below).

However, the VEOHRC report, *Beyond doubt: the experiences of people with disabilities reporting crime*, raised the concern that services may treat potential crimes as 'incidents' and not view some of these as sufficiently serious to prompt a police report (VEOHRC 2014, p. 23). The Victorian Ombudsman noted, in a submission to *Beyond doubt*, that 'incorrect classification of incidents has been the greatest hindrance to the reporting of possible crimes against people who lack the capacity to act on their own behalf' (VEOHRC 2014, p. 23). Incident reporting is addressed in section 2.5.6 of this report, but this comment can apply equally to reports to police.

Beyond doubt also noted that violence and actions that would not be tolerated in one setting can become normalised in other settings. 'Client-on-client violence' was noted as a particular concern, with the seriousness of this violence 'seen to be mitigated by the perpetrator's disability' (VEOHRC 2014, p. 23), which may also affect reporting. This observation is consistent with themes reported by women accessing mental health services (WMHNV 2017).

The purpose of identifying and responding to potentially criminal behaviour by people accessing mental health services is not to deny that a person may have been acutely unwell at the time of the events in question. Rather, the potentially criminal nature of unwelcome sexual behaviour forms a key reason why mental health services must take decisive action to prevent sexual activity, harassment and assault within their acute inpatient units for the wellbeing of all people accessing these services, including people who may be behaving in sexually inappropriate ways.

2.5.3.2 The role of consent in reporting to Victoria Police

The Chief Psychiatrist's Guideline is currently ambiguous about a service's responsibility to report allegations of sexual assault to Victoria Police. It states that 'all allegations of sexual assault should be reported to police where *an assault is known or suspected to have occurred*' [emphasis added] (Department of Health 2009, p. 25).

The guideline further provides that for compulsory patients assessed as not having capacity, the authorised psychiatrist has a duty of care to report an allegation of sexual assault to the police. However, this requirement to report an alleged assault to police is qualified by a number of scenarios and statements. Where a patient does not wish to involve police, the guideline provides that 'while the patient's choice should be uppermost, the authorised psychiatrist has a duty of care to consider and act in the person's best interests' (p. 26). The guideline further provides that the wishes of an 'involuntary' patient assessed as having capacity 'must be respected' (Department of Health 2009, pp. 10–11). This represents potential inconsistency in the guidance provided and may contribute to the confusion experienced by services in considering their responsibilities to report a potential crime and protect other potential victims. This must be clarified to help services to understand and carry out their responsibilities in reporting allegations of sexual assault to police. In contrast, a South Australian policy directive (South Australia Health 2015b) requires all cases of suspected or alleged sexual assaults to be reported to the police, regardless of whether the alleged victim wishes to be involved in the police process. This policy distinguishes the service's responsibility to report a potential crime to police and the person's views and decision making on police involvement.

The *Interagency guideline for addressing violence, neglect and abuse* (IGUANA) (Office of the Public Advocate 2013) should be considered in providing further clarification for mental health services on their reporting obligations. IGUANA was developed to identify what action should be taken if a situation involving violence, neglect or abuse is reported to, witnessed by or suspected by a staff member or volunteer of a mental health or disability service provider. It provides that where a person wishes

not to report the matter to police and has capacity to make this decision, the wish should be respected except where (Office of the Public Advocate 2013):

- there is evidence aside from the victim's testimony of a crime having been committed
- the victim suffered serious harm
- the victim's decision was made under duress
- the victim or other service users are still at risk of violence or abuse.

These principles must also be applied by services to which the Client Incident Management System (CIMS) relates (Department of Health and Human Services 2017c), including mental health community support services. CIMS does not apply to clinical mental health services, leading to inequitable responses across sectors and less rigorous safeguards for people accessing inpatient mental health services. This is particularly disturbing given the weight of evidence of the vulnerability of people accessing these services (see section 2.1.2), and the known frequency at which people accessing mental health treatment experience sexual assault (Department of Health and Human Services 2017c).

In many of the complaints examined in detail by the MHCC where a person had not provided consent to contact police, at least some of the elements that would enable reporting without consent were present, yet a report was not made based on the lack of consent to reporting.

It is important to note that there is a distinction between fulfilling a duty to report a potential crime to police, and by doing so protect other potential victims, and respecting an individual's wish to not participate in a police investigation. Both of these objectives can be achieved if a person does not subsequently wish to pursue a police investigation. Services need clear guidance to ensure appropriate reporting and to help them navigate these situations.

“

She just wanted to get out of hospital. She told me, 'Don't rock the boat. Don't say anything. I want to get out'”

Family member on why consent to report to police was not given

——— To remove doubt for staff, some services have implemented policies where people are advised at orientation that sexual activity and sexual assault will be reported to police, and provided clear directives for staff that staff are not responsible for determining the truth of any allegations made. Rather, all allegations of sexual activity or sexual assault must be reported to police. ———

Concerns about privacy are also raised in the context of reporting allegations of sexual assault to police without consent. Disclosure of an alleged assault is subject to the *Privacy and Data Protection Act 2014* and does not relate to 'health information' for the purposes of the *Health Records Act 2001* or s 346 of the Mental Health Act. Accordingly, a disclosure could be made to police without the consumer's consent pursuant to the Information Privacy Principle (IPP) 2.1(e) where the service has 'reason to suspect that unlawful activity has been, is being or may be engaged in' or pursuant to IPP 2.2(g) where reasonably necessary for a relevant law enforcement activity. Any disclosure must be lawful and not arbitrary in accordance with the right to privacy.

2.5.3.3 Sexual activity not specifically characterised as sexual assault

Where it is unclear whether a sexual assault has occurred (for example, where activity is described by individuals involved or assessed by clinicians to be consensual), it is arguable that a report to police should still be considered. It is not uncommon that an assessment is made at the time that sexual activity was consensual and police are not involved but at a subsequent time the consumer identifies that the activity was non-consensual and wishes to involve police.

There are some clear problems that arise with decisions about reporting to police being contingent on an assessment of whether the activity was consensual:

- First, it is inconsistent with the principle that sexual activity is always inappropriate in the acute setting.
- Second, the assessment of consent in any event is a difficult exercise. As stated in the Chief Psychiatrist's Guideline, 'in some instances, there may be the appearance of consent with neither party showing any distress or harm' (Department of Health and Human Services 2009, p. 14). In addition, a person may be reluctant to disclose to staff that the sexual activity was not consensual for many reasons. For example, the individual may not have trust or rapport with the first responding clinician or, more broadly, the mental health service. They may also remain fearful, be concerned that they will not be believed or be worried that disclosure will delay their discharge.
- Third, a person may not feel comfortable or capable of disclosing a sexual assault initially but later do so, by which time it may be too late to take certain steps such as preserving evidence.

A failure to initially notify police may also prejudice any subsequent investigation, as well as potentially affect any claim by the consumer for victims of crime compensation, which requires the crime to have been reported to police within a reasonable time.

Accordingly, and subject to privacy issues, there may still be a basis to report sexual activity to police as part of a mental health service's duty of care to the consumer, regardless of whether there has been a specific allegation of sexual assault or an assessment that the consumer has capacity to make an informed decision not to report the incident to police. This is on the basis that the report acts as a safeguard for the potential victim/survivor, who may later describe the sexual activity as non-consensual and wish to involve police and be eligible to make a claim for victims of crime compensation. The report need not progress if the person does not wish to pursue the matter with the police.

The consultations identified some examples where services had implemented a policy to report all sexual activity to the police and were developing local working arrangements with police. Given the variability of arrangements and outcomes reported, implementing this approach as a policy directive would require further consideration between Victoria Police and the department, and the development of options and protocols for reporting sexual activity or suspected sexual assaults in the circumstances as described above.

The complexities of gaining consent to report to police in either circumstance are acknowledged, as is the preference for any reports to be made with consent. The benefits of making a report to police must form a key consideration in any decision about reporting, and these should be sensitively discussed and explained to the alleged/potential victim if they are assessed to have capacity to make a decision about reporting to police. These discussions must be led by experienced staff who have the appropriate skills to persuasively outline the benefits of reporting and to gain engagement in the process.

2.5.3.4 Concerns about a person's mental state and plausibility of allegations

Beyond doubt clearly highlighted that a barrier to people with disabilities reporting concerns to police was a fear that they will not be believed or will not be seen as credible (VEOHRC 2014). These concerns can also apply to people's experiences with reporting allegations of sexual assault to mental health services.

The Chief Psychiatrist's Guideline includes as an example of where clinical judgement is required as 'where an allegation appears related to a person's mental state or condition' (Department of Health 2009, p. 25). In these circumstances, the authorised psychiatrist is responsible for determining the threshold for reporting to police where the available information does not support the allegation or where in fact there is evidence to contradict the allegation. Supporting information is often not available in cases of sexual assault, and care needs to be exercised in assessing such allegations to ensure these are not minimised. The guideline also recommends that follow-up and referral be made for the person including a referral to CASA (Department of Health 2009).

There are clear issues in a response to an allegation of sexual assault that is dependent on an assessment of the consumer's mental state or an assessment of whether allegations appear plausible to staff, and these issues were present in some complaints made to the MHCC. The literature raises the issue that disclosures of sexual violence by people with mental illness are often not coherent or made in plausible terms. However, this has no bearing on the validity of the allegation (Ashmore, Spangaro & McNamara 2015), which may be based on fact despite some details or observations appearing unusual or incoherent. Given this, the threshold for excluding the possibility of a sexual assault occurring is high. For instance, there would need to be clear evidence that the alleged perpetrator could not have had access to the individual alleging assault, for instance, because they were not admitted to the inpatient unit at the relevant time. However, it should be noted that this does not exclude the possibility of the sexual assault occurring at a different time. Due to the effects of illness or medication, a person may be confused about the timing or location of a sexual safety breach. Given the difficulty of assessing whether events were or were not able to occur, the danger of an approach that assesses plausibility is that allegations by people who are acutely unwell will not be adequately investigated or responded to, which has the potential to seriously jeopardise the safety of people accessing inpatient treatment.

This approach is inconsistent with the mental health principle that the rights of people receiving mental health services should be protected and promoted (s 11(1)(e) of the Act). It also may represent discrimination under the *Equal Opportunity Act 2010 (Vic)* and is inconsistent with the requirement under s 8 of the Charter to recognise the rights of people with mental illness to equal protection under the law. All allegations should therefore be thoroughly considered and support provided to the person to contact police if they wish to do so.

RECOMMENDATIONS: REPORTING SUSPECTED AND ALLEGED SEXUAL ASSAULTS TO VICTORIA POLICE

Develop clear guidance about services' duty to report a suspected or alleged sexual assault to Victoria Police, consistent with other service settings.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Develop a policy directive for reporting suspected and alleged sexual assaults occurring within mental health services that addresses services' duty to report a potential crime to police and is consistent with requirements in other service settings.
- Work with Victoria Police to clarify policies and protocols in relation to reporting suspected and alleged sexual assaults in circumstances where the victim does not wish to be involved or report the matter, including processes for reporting sexual activity occurring within mental health services.

CHIEF PSYCHIATRIST

That the Chief Psychiatrist, as part of the review of the Chief Psychiatrist's Guideline:

- reflects the reporting requirements determined through the above process.

MENTAL HEALTH SERVICE PROVIDERS

- Ensure that local policies and procedures are updated to reflect any updated guidance provided about reporting obligations.
- Review policies and procedures immediately to ensure people are assisted and supported to make informed decisions about contacting police following a suspected or alleged sexual assault.

2.5.4 WORKING WITH VICTORIA POLICE TO RESPOND TO SUSPECTED AND ALLEGED SEXUAL ASSAULTS

Themes in complaints to the MHCC and in stakeholder consultations have identified a number of issues in current practices between services and Victoria Police when responding to suspected and alleged sexual assault within services. These matters are not included in any detail in the overarching *Protocol for mental health operating between Victoria Police and the Department of Health and Human Services (2016a)*. While many of these issues are noted in the Chief Psychiatrist's Guideline, adding these matters to the statewide protocol between mental health services and Victoria Police would better support the development of standard operating procedures between services and police, as well as supporting discussions at the local level including at Emergency Services Liaison Committee meetings to provide consistency in responses. It would also be consistent with the recommendations of *Beyond doubt* that standard operating procedures be enhanced to provide for stronger minimum standards regarding response times and communication on progress and the status of matters under investigation (VEOHRC 2014). Areas for particular consideration include:

- preservation of evidence
- documentation standards
- the level and nature of information provided to Victoria Police to inform the assessment of whether a person is fit for interview
- the use of Independent Third Persons (ITPs) for police interviews (both for victim/survivors and alleged perpetrators)
- standard operating procedures and processes for consultation and review.

2.5.4.1 Preservation of evidence

Regardless of whether an allegation is reported to Victoria Police, mental health services must take steps to preserve evidence of both sexual assault and sexual activity. The reasons for preserving evidence of possible sexual assaults are clear. The failure of a service to take appropriate steps to preserve such evidence constitutes a failure to uphold a victim's right to access justice. Evidence of sexual activity should also be preserved on the basis that consent to sexual activity is difficult to assess in the context of an acute inpatient unit and an inaccurate assessment may therefore be made. For example, at the time the activity is discovered, a person may feel unable to disclose that they did not consent to the sexual activity. They may also, on becoming more well, reflect and consider that they were not able to consent to the sexual activity at the time it occurred regardless of any views they may have expressed at the time.

Complaints to the MHCC have demonstrated that physical evidence is not always preserved nor are actions taken to adequately document evidence. The Chief Psychiatrist's Guideline notes the importance of preserving physical evidence and suggests that mental health services seek advice from local police or refer to Victoria Police's (2016) *Code of practice for the investigation of sexual crime* for guidance, as well as providing high-level advice about preserving the state of the room in which an alleged assault occurred and discouraging the victim/survivor from showering or changing clothes. It also notes the need to record in the medical record what evidence was preserved and where and how it was stored (Department of Health 2009).

In some complaints to the MHCC, even these basic steps to preserve evidence were not taken. Individual services must review their local policies and procedures to ensure the responsibilities of staff are clear and understood by all staff, including the consequences of not taking steps to preserve such evidence. However, more detailed and updated guidance should also be provided to services to ensure these matters are thoroughly and consistently applied when developing local policies, procedures and protocols. This may include investigating the availability of a medical examination to preserve forensic evidence without the necessity for a police report (for example, several stakeholders noted the availability of 'Just in case' forensic kits for sexual assaults, which are available from some metropolitan health services³).

³ 'Just in case' is a forensic examination kit whereby evidence is collected and stored safely for 12 months to allow the person time to make a decision to pursue the matter with police.

2.5.4.2 Written records

As noted in section 2.5.6, documentation standards in relation to sexual safety breaches are highly variable. Preserving clear records of staff observations of any suspected or alleged assault, or of reports made to staff, is critical in assisting Victoria Police in any future investigation. Services should ensure clear records are maintained of:

- who made the report, and to whom it was made
- the alleged victim's demeanour
- the date, the time, the location and a description of the alleged assault, so far as these can be immediately ascertained from observations, reports or other available information.

The requirement to record these details should be included in protocols and local standard operating procedures to ensure clarity about the level and nature of information that should be recorded and provided to Victoria Police to assist in any investigation of the allegation.

Where a staff member has observed a sexual safety breach, their observations should be recorded in detail and in objective language. MHCC complaints have identified a number of incidents where this has not occurred. Staff should avoid recording judgements about whether or not they perceive alleged events to have occurred where these judgements are not based on fact. Staff should particularly avoid drawing inferences in the clinical record that are based on an assessment of the person's presentation following sexual activity or alleged sexual assault, as responses to sexual assault can vary widely (Department of Health and Human Services 2009; Klippenstine & Schuller 2012). However, even inferences drawn from available facts should be made with caution, given the considerations noted earlier in this section about issues with responding based on a perception of the plausibility of any allegations. The Chief Psychiatrist's Guideline currently advises that 'staff perceptions' should be included in the clinical record, and this requires further clarification about the circumstances in which these perceptions may, or may not, be appropriate.

2.5.4.3 Statements from victims and alleged offenders – access to Independent Third Persons

A contemporaneous statement from the person alleging assault, as well as any person alleged to have committed sexual assault, is of critical importance. Where a person accessing acute inpatient mental health services makes an allegation of or is alleged to have committed sexual assault, they will generally require the support of an ITP for any police interview that may occur.⁴

ITPs assist people who have a cognitive impairment, including mental illness, when they are interviewed. They help the person to understand questions posed to them by police and assist police to understand replies to their questions. ITPs are available to support victims, alleged perpetrators and witnesses through police interview processes. ITPs are provided by a network of trained volunteers coordinated by the Office of the Public Advocate. ITPs can be contacted by police to support an interview process, and the request for an ITP should be made by service providers when requesting police attendance.

It is not acceptable for any person who is mentally unwell to be interviewed without the support of an ITP; however, this has occurred in some complaints made to the MHCC. Despite the preference for a contemporaneous statement to be taken, interviews may be delayed until the person is better able to participate without the support of an ITP if necessary.

When requesting an ITP, staff should not provide information to police about the person's mental state apart from whether they have impaired mental functioning that may require the support of an ITP. This is implied, but not clear, in the current Chief Psychiatrist's Guideline. The MHCC has dealt with complaints where descriptive information about a person's mental state has been provided by staff to police, which may have influenced police perceptions of the person's account and affected the person's right to recognition and equality before the law in accordance with the Charter of Human Rights and Responsibilities Act.

⁴ The ITP program is operated by the Office of the Public Advocate. See www.publicadvocate.vic.gov.au/our-services/volunteer-programs.

2.5.4.4 Standard operating procedures and consultation/review processes

Other matters not currently covered in detail in existing guidance include the method for contacting police, the point of engagement within Victoria Police for allegations of sexual assault, consultation processes, and methods for mental health services to seek a review of police action if they are not satisfied with the initial police response. Themes from complaints and consultations indicate that approaches to engaging with police about allegations of sexual assault vary widely across areas, with some areas usually engaging a uniform response, while others more frequently request and gain access to a Sexual Offences and Child Abuse Investigation Team (SOCIT).

SOCITs comprise specialist detectives who are specifically trained to investigate sexual offences and are usually best placed to provide advice about allegations of sexual assault. SOCIT assistance can be sought by contacting local police and requesting a SOCIT response. The *Code of practice for the investigation of sexual crime* (Victoria Police 2016) advises that if partner agencies are not satisfied with the responses of police, these should be escalated at the local level initially (for example, to the station sergeant). The code of practice outlines that if concerns are unable to be addressed at this level they should be escalated to an Emergency Services Liaison Committee for review.

Consultation with Victoria Police for this project also indicated variable approaches from mental health services in providing assistance to police to identify people accessing inpatient treatment who may have been involved in potentially criminal activity, with some services reportedly willing to provide this information and other services requiring police to obtain a subpoena. It would be useful for any revised protocol or guideline to address this issue to ensure consistent practice.

While preservation of evidence and adequate documentation are discussed to an extent in the existing Chief Psychiatrist's Guideline, and dispute resolution is discussed in the department's protocol with Victoria Police regarding mental health (Department of Health and Human Services 2016a), all areas discussed above would benefit from revision and expansion.

Beyond doubt (VEOHRC 2014) included recommendations to the then Department of Health on developing protocols and standard operating procedures for police responses to sexual safety breaches within mental health services, including that the department:

- issues comprehensive practice guidelines on when and how to report to police, how to effectively and proactively engage with police, navigating the criminal justice system, services and referral pathways, empowering victims to make choices about the process, appeal and review options, and minimum standards for conducting service investigations
- delivers training for departmental and funded services staff on preventing, recognising, responding to and reporting violence, abuse and family violence, including focused efforts to strengthen supervision and recruitment processes
- promotes prevention, rights awareness and improved response by continuing to support peer-led education, advocacy and self-advocacy.

These recommendations were accepted by Victoria Police and the then Department of Health and the Department of Human Services (now the Department of Health and Human Services).

In response to this recommendation in relation to disability services, the department has recently published *Responding to allegations of abuse involving people with disabilities: guidelines for disability service providers and Victoria Police* (Department of Health and Human Services 2017d), which provides an indication of the detailed level of guidance that should be applied in an equivalent guideline for mental health services. These guidelines cover the required steps and processes to respond to an allegation of abuse including:

- identification of abuse and the immediate response required, including ensuring the safety of the victim, reporting to police, preserving evidence and considerations where the alleged perpetrator is a person with disability
- police investigation, including considerations in taking a report from a person with disability, interviewing or taking a statement from a person with disability, and investigating alleged crimes involving a person with disability
- outcomes of the investigation process, including the respective roles of Victoria Police and disability service providers, escalation processes and the right to complain.

In contrast, while the department has taken action in relation to the latter two elements of VEOHRC's recommendations, including by funding the WMHNV to provide gender-safety and -sensitivity training for mental health services, more detailed guidance for mental health services in responding to allegations of abuse has not yet been provided. As indicated throughout this report, existing guidance is fragmented and insufficiently detailed to support mental health services to provide consistent and thorough responses to these kinds of allegations.

RECOMMENDATIONS: WORKING WITH VICTORIA POLICE TO RESPOND TO SUSPECTED AND ALLEGED SEXUAL ASSAULTS

Develop clear guidance for mental health services and Victoria Police about responding to sexual safety breaches, including preservation of evidence, documentation, reporting and review mechanisms.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

That the department either expands its current protocol for mental health with Victoria Police or considers alternate means to provide clearer guidance for services, staff and police on matters including:

- service responsibilities to identify and preserve available evidence including physical evidence and clear, contemporaneous notes of what was observed by staff or reported to them
- service responsibilities in documenting suspected and alleged sexual assaults

- advice about pathways to report to Victoria Police and to seek a review of police actions or decisions
- processes for requesting and supporting the attendance of ITPs at police interviews
- addressing the recommendations arising from the *Beyond doubt* report.

MENTAL HEALTH SERVICE PROVIDERS

- Immediately review policies and procedures to ensure that staff are aware of their responsibilities in preserving evidence, documenting accounts or observations of suspected or alleged sexual assaults, and requesting or responding to queries from police about the need for ITPs.

- Continue working with Victoria Police through Emergency Services Liaison Committees to clarify roles and responsibilities as they apply locally.
- Work to develop local pathways and protocols to respond to the revised guidance, when available.

2.5.5 INVESTIGATION STANDARDS AND PROCESSES

Complaints to the MHCC identify the need for improved guidance and clear standards for clinical mental health services that set out the thresholds and requirements for conducting reviews or investigations into serious allegations and adverse events within mental health services. While the existing Victorian Health Incident Management System (VHIMS) policy (Department of Health 2011b) includes some guidance about what methodology is required to assess incidents classified at particular levels (see discussion in section 2.5.6), it provides no guidance about the requirements associated with each methodology. As identified in *Targeting zero*, the VHIMS system fails to provide centralised oversight and monitoring of investigations into many high-impact, high-risk incidents, which arguably includes serious sexual assaults.

Complaints to the MHCC have identified serious deficiencies in approaches to investigating allegations of sexual activity or assault. Inconsistencies or areas for improvement include the following:

- There can be a lack of escalation of serious complaints to senior management for immediate review and action due to initial inaccurate classification in the VHIMS (see section 2.5.6), leading to inadequate investigation of serious allegations.
- Where matters are escalated to senior management for review, variable methodologies are used to investigate the concerns without a clear rationale for the methodology used. For example, the reasons for differentiating between the need for a formal investigation compared with other methodologies is often unclear. The requirements of the methodologies used were also sometimes unclear. For example, in instances where the information provided in the clinical record was unclear or incomplete, no steps were taken to supplement this information by interviewing staff who were on duty at the time of the sexual safety breach.

- There can be a lack of independence in conducting a review or investigation. This includes instances where serious allegations have been investigated by staff belonging to the unit in which the allegations occurred. It is important that an adequately equipped staff member who is external to the unit conducts the review to preserve the actual and perceived independence of any investigation, particularly where allegations involve actions or lack of actions taken by staff. Independence is also important to ensure that staff undertaking the review are not overly influenced by their perception of an alleged victim's mental state, which may be difficult for staff who are involved in the person's treatment and care.
- There can be a lack of rigour in the investigation process, including failure to interview and review the records of co-consumers who are the subject of the allegation of sexual assault, failure to interview staff on duty at the time of the allegations, not dating reports and not recording which staff were involved in the investigation or review.
- There can be variability in approaches to ensuring the perspective of people accessing treatment and their carers, family or support people is considered in any investigation. In some complaints made to the MHCC, the person at the centre of the complaint had not been given an opportunity to contribute their perspective to a review or investigation. The perspective of the person at the centre of the complaint, and their family or carer, should be central to any investigation or review of breaches of sexual safety, both to ensure that their concerns and views are heard and understood and so that these concerns and views can influence actions the service may take to prevent further occurrences of harm. Including the person at the centre of the complaint in any review or investigation process is also required by Standard 1 (Clinical Governance) of the *National Safety and Quality Health Service Standards* (ACSQHC 2012, standard 1.11c), that 'the health service organisation involves the workforce and consumers in the review of incidents'. To support compliance with this standard, services should also consider involving consumer and carer consultants in review activities, particularly if the person at the centre of the complaint is unable to provide their views for any reason.

The department has recently begun implementing a CIMS that was developed to assist a range of services (excluding clinical mental health services) to improve the way incidents are managed within these services. CIMS focuses on the impact of an incident on a person using a service and on learning from trends to inform service improvement. In contrast with the existing VHIMS policy (Department of Health 2011b), the *Client incident management system guide* (Department of Health and Human Services 2017c):

- clearly sets out steps and requirements for identifying, responding to, reporting, investigating and reviewing incidents
- requires allegations of sexual abuse to be reported as 'major impact incidents', with all major impact incidents to be reported to divisional offices of the department
- sets out requirements for preserving evidence and notifying police, as well as specific guidance for responding to allegations of physical and sexual assault
- requires all allegations of sexual abuse to be screened for investigation, as well as providing clear thresholds for when an investigation is warranted, minimum standards for an investigation, guidelines for when an external investigation is warranted (for example, where there are allegations of abuse by staff) and requirements that investigation reports are submitted to divisional offices for quality assurance (the CIMS also provides for timeframes for the recommendation to conduct an investigation and for the completion of an investigation)
- provides that if the investigation of a major impact incident is not deemed to be warranted, a case review or a root cause analysis must be undertaken; it also sets out guidance for what these must include and provides for departmental involvement where there is a demonstrated lack of capability of the service provider to adequately conduct these processes.

The differences between clinical mental health services and the services governed by CIMS, including differences in governance arrangements and reporting relationships, are recognised. However, the variance observed by the MHCC in responses to and investigations of complaints involving issues of alleged sexual assault suggests that developing standard guidance for clinical mental health services on conducting investigations into serious allegations is required. Currently, the clearer guidelines that apply to the services governed by CIMS provide a stronger response to reports of sexual violence than is provided in many clinical mental health services. There is no rationale for providing people accessing mental health services with a less comprehensive response to allegations of sexual violence than people accessing other support services. Indeed, given the known risk factors for sexual activity, harassment and assault within acute mental health inpatient units and the known impacts of these events, the need for a comprehensive framework that ensures thorough approaches to investigating these serious safeguarding concerns is clear.

RECOMMENDATIONS: INVESTIGATION STANDARDS

Develop clear policy and guidance outlining the thresholds and requirements for investigations and other review processes, as well as considering external oversight of decision making about the necessary level of review of suspected or alleged sexual assaults that is consistent with the requirements of other service settings.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Develop guidance for clinical mental health services that outlines thresholds and requirements for conducting formal investigations and other review methodologies (this guidance should be consistent, as far as practicable, with the guidance contained in CIMS and should provide for consumer/carer involvement).
- Review the external oversight of investigations and reviews for suspected or alleged sexual assaults occurring within mental health services, compared with the equivalent requirements set out in the CIMS in other service settings.

MENTAL HEALTH SERVICE PROVIDERS

Review investigation processes to ensure that incidents and alleged breaches of sexual safety:

- are investigated by appropriately qualified staff external to the unit in which the alleged breach occurred
- include advice from Victoria Police on the scope and timing of the service's investigation
- include a review of the records of any co-consumers alleged to be involved in an sexual safety breach, as well as staff on duty at the time of the breach, particularly where records are incomplete or otherwise unclear.

Ensure that any investigation into incidents and alleged breaches of sexual safety includes the account and perspective provided by the alleged victim/person at the centre of the concerns, as well as the account and perspective provided by the person raising the concerns (if not the same person).

Consider opportunities for involving the consumer and carer workforce in activities related to the investigation.

2.5.6 REPORTING OF INCIDENTS

2.5.6.1 Incident reporting systems and requirements

The *Victorian health incident management policy* (VHIMS policy) guides health services to 'establish and support a structured incident review process that is consistent with best practice' (Department of Health 2011c, p. 5). The policy, and the accompanying *Victorian health incident management policy guide* (Department of Health 2011d) aim, among other things, to 'provide a system that enables the identification, reporting, review, monitoring and evaluation of all incidents in a timely and effective manner (Department of Health 2011c, p. 7). The VHIMS policy guide sets out descriptors to assist services in classifying incidents and their impacts by graded levels of harm/impact to reach an overall incident classification, which then guides the local response. The responses required by each classification level are set out below:

- **ISR1:** requires a review to determine causation and areas for system improvement. If processes are identified as contributing to the incident, a root cause analysis (RCA) must be undertaken and notification to the department's Sentinel Event Program is required, with a final de-identified summary report to be provided to the department within 60 days of notification. Recommendations arising from the RCA should be linked to the health service's risk register.
- **ISR2:** detailed investigation required, preferably using the in-depth case review methodology. Recommendations should be linked to the health service's clinical governance policies and procedures.
- **ISR3 and ISR4:** require investigation at the local level only but should be reported and analysed on an aggregated basis.

As noted in section 2.3.1.2, the current *Victorian health incident management policy* does not include alleged sexual assaults as a sentinel event or specify an ISR 1 categorisation (Department of Health 2011c, pp. 15–16).

2.5.6.2 Issues in categorising and escalating incidents

Complaints to the MHCC demonstrate inconsistency in the way mental health services classify sexual safety breaches, which in turn can lead to inadequate initial escalation of these breaches. For example, some alleged sexual assaults were recorded in the VHIMS with an ISR3 severity rating, meaning that these breaches were not escalated to senior management for review and response. This has resulted in the absence of or delay in conducting an in-depth internal review and in identifying the steps required to address the particular needs in each case to prevent a reoccurrence. *Targeting zero* found that incorrect classification of incidents is common due in part to the cumbersome nature of the VHIMS system (Department of Health and Human Services 2016c).

Inconsistency in classifying sexual safety breaches in mental health services may be caused, at least in part, by the poor applicability of the ISR rating system to a mental health context and a lack of guidance about how this could appropriately be applied.

———— Guidance provided about incident severity ratings in the VHIMS policy guide (Department of Health and Human Services 2011d) has little or no specific regard to trauma factors, which is likely to influence lower ratings in the VHIMS than is justified by the concerns raised. —————

This poses a significant issue for mental health services given the prevalence of pre-existing trauma in people accessing mental health inpatient treatment, the increased vulnerability to re-traumatisation (discussed in section 2.3.3.2) and the fact that people accessing inpatient mental health services are far more likely than general patients to experience sexual assault while receiving treatment (Department of Health and Human Services 2016c).

For example, the MHCC has seen examples of 'treatment required' following sexual activity or sexual assault being categorised as minor because the immediate treatment interventions may have been limited to sexually transmissible infection and pregnancy testing. However, this fails to take into account ongoing severe psychological harm that can be caused, which may require complex and long-lasting psychological treatment and support. Assessment of the level of care required following a sexual safety breach may also be misleading given the aim of services would generally be to address the risk presented by the perpetrator, perhaps by transferring them to a higher level of care, rather than transferring the victim.

Factors such as these may lead to a lower incident classification than warranted by the severity of the breach and by the potential for sexual safety breaches to cause lasting trauma that may severely affect a person's day-to-day functioning and wellbeing. Given the level of trauma that can result from sexual assault, particularly in the presence of pre-existing trauma, there is an argument that reports of sexual assault in mental health services should be classified as ISR1 – 'other catastrophic' type of sentinel event – given their potential impact (see www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/sentinel-event-program).

By contrast, CIMS requires services to categorise incidents by incident type, as well as categorising these as major or minor impact incidents. Major impacts include unanticipated death, as well as 'severe physical, emotional or psychological injury or suffering which is likely to cause ongoing trauma' (Department of Health and Human Services 2017c, p. 17). Incidents involving sexual abuse, defined as 'actual or attempted unwanted sexual actions (or allegations of such actions) that result in major impact harm to the client or which are otherwise forced upon a client against their will or without their consent, through the use of physical force, intimidation, and/or coercion' (Department of Health and Human Services 2017c, p. 61), are required to be reported as major impact incidents. This approach to classification better responds to the potentially catastrophic impact of sexual assault and leads to more rigorous monitoring and oversight.

It was also suggested through consultations that lower severity breaches that are nonetheless unlawful and experienced by people accessing treatment as threatening (particularly sexual harassment) are not commonly reported in the VHIMS. Some participants in consultations noted their belief that the lack of reporting is in part due to the burden associated with reporting. The findings of *Targeting zero* support the view that reporting in the VHIMS is cumbersome and time-consuming, and that the system should support detailed reporting and monitoring of the most serious events while streamlining and enabling greater flexibility in the reporting of less serious events.

——— As discussed in section 2.3.1.2 on approaches to data analysis and reporting, introducing more streamlined processes that would enable swift capturing of concerns about sexual harassment or other types of sexual safety breaches would enable services to better understand the experiences of people receiving treatment, to review themes arising in particular areas of their service, and to consider actions that would support a safer environment. —————

As well as identifying patterns that may indicate a need for quality improvement activities, capturing incidents of sexual harassment or other types of sexual safety breaches also has the potential to indicate where repeated breaches may have significant impact on an individual, despite the lower impact of each individual event. CIMS reporting requirements demonstrate an approach to reporting that has the potential to better recognise and respond to the trauma that may be associated with repeated sexual safety breaches. CIMS provides that where patterns of incidents have a major impact on the person accessing services as described above, these must be reported as major impact incidents, even where the individual incidents are non-major impact incidents (Department of Health and Human Services 2017c). In a mental health service context, it is possible that an equivalent requirement would require reports of repeated sexual harassment in mental health acute inpatient units to be reported as major impact incidents given the potential for re-traumatisation that this represents.

2.5.6.3 Reporting to the Chief Psychiatrist

The Chief Psychiatrist's Guideline requires the authorised psychiatrist of a service to report 'any occurrence of sexual assault in an acute inpatient unit' (Department of Health 2009, p. 31). Where there is doubt about whether to report, the guideline states that the authorised psychiatrist should seek the Chief Psychiatrist's advice. Analysis of complaints made to the MHCC and reported to the MHCC by services indicate some failures to comply with existing reporting requirements in relation to alleged sexual assault. Despite the challenges of the dataset used for this analysis (see section 1.2.2), it was clear that reporting to the Chief Psychiatrist was variable at best. Of the eight complaints characterised as alleged sexual assault where information about reporting was provided to the MHCC (not the full dataset), none were reported to the Chief Psychiatrist. This is a subset of all complaints about alleged sexual assault and does not include those complaints where no information was available, or able to be ascertained, about whether the complaint was reported to the Chief Psychiatrist. Regardless, the fact that eight possible sexual assaults were not reported as required indicates that current reporting systems are not working well and supports the need for improved reporting as well as increased data sharing between the MHCC and the department as discussed in section 2.3.1.

The reasons for this lack of reporting may include confusion about the role of consent in reporting to the Chief Psychiatrist. Some complaints have indicated that where the person who has alleged to have been sexually assaulted is assessed to have capacity and does not wish to make a report to police or disclose to family, this has sometimes guided other responses and actions by the service including reporting to the Chief Psychiatrist. While the role of consent in considering reporting alleged sexual assaults to police may be a more complex decision (see section 2.5.3), reporting to the Chief Psychiatrist is never contingent on an assessment of consent but forms part of each service's reporting obligations. Further, the Mental Health Act expressly permits services to provide information to the Chief Psychiatrist without consent where 'disclosure is reasonably required' in connection with the Chief Psychiatrist's duties and powers (s 346(2)(l) of the Act).

Another possible factor that may influence under-reporting is the wording in the Chief Psychiatrist's Guideline that 'any occurrence of sexual assault' must be reported (Department of Health 2009, p. 31). The language of 'occurrence' arguably requires an assessment by services as to whether an allegation was or was not based in fact. As discussed in section 2.5.3.4, there are significant concerns associated with requiring mental health services to assess the plausibility of an allegation of sexual assault. For this reason, and to ensure adequate oversight and monitoring of these serious allegations, the guideline should refer to and require reporting of *allegations* of sexual assault, rather than occurrences.

The current lack of accurate reporting significantly limits the Chief Psychiatrist's ability to: review and assess the adequacy of responses to incidents and allegations of sexual assault; support individual services to improve their approaches to these matters; or identify themes and areas for service improvement across the sector. However, the administrative challenges services face must be acknowledged. The requirement to report to the Chief Psychiatrist is in addition to, but is not linked to, services' incident reporting obligations, creating an unnecessary administrative burden and duplication. One of the key issues with existing reporting systems identified in *Targeting zero* is the focus on, and time associated with, detailed reporting that may have little impact on system improvement rather than 'prioritising reporting of incidents that had or risked having severe impact on patients ... and focusing efforts on investigation and remediation of risks' (Department of Health and Human Services 2016c, p. 113, Recommendation 3.6.2).

The Chief Psychiatrist is currently undertaking work to inform an improved approach to reporting. This includes the development of a new reporting checklist for mental health services that requires mental health services to report all incidents of sexual activity, harassment and assault on acute mental health inpatient units. This will operate for a three-month pilot, and will then be evaluated and refined. Important considerations for this work include:

- clarification of the purpose of reporting allegations of sexual assault in the VHIMS and to the Chief Psychiatrist, including ensuring appropriate oversight of investigations into allegations of sexual assault, and of the actions and areas for improvement identified by these processes
- consideration of how these processes will identify areas for service improvement both within individual services and sector-wide, and how to share and apply any lessons learnt with mental health service providers
- how to ensure consistent responses in clinical mental health services to those expected in other sectors by referring to and considering the requirements of the CIMS guidelines
- avoiding additional administrative burden and duplication for mental health services by integrating reporting processes with existing reporting requirements.

2.5.6.4 Reporting sexual activity and other breaches of sexual safety

There is currently no requirement for services to report sexual activity to the Chief Psychiatrist. Analysis of local complaints identified only two complaints that were described by services as being about sexual activity (as opposed to alleged sexual assault) within an acute inpatient environment. However, there were a number of complaints about alleged sexual assaults that appeared to have been treated as sexual activity by services, which, in the MHCC's view, should have been reported to the Chief Psychiatrist.

As outlined in section 1.8, there are a range of policies, standards and guidelines that make it clear that services have a responsibility to provide a sexually safe environment. It is also clear that the risks of sexual activity occurring in acute mental health inpatient units are considerable, particularly given the difficulties in accurately assessing consent to engage in sexual activity when people are acutely unwell, and the harms that can occur where a person later believes that they were not able to consent to the activity.

——— To enable greater monitoring and oversight of all sexual activity, and to enable more informed and targeted support to services to prevent the occurrence of sexual activity and assault and ensure more informed, consistent responses where such activity occurs, it is therefore recommended that sexual activity, as well as sexual assault, be reported to the Chief Psychiatrist. ———

The value of reporting all instances of sexual activity has already been recognised in work being undertaken by the Chief Psychiatrist on piloting an expanded reporting framework that will include sexual activity.

Consistent with the approach outlined above, introducing more stringent reporting requirements should ideally be integrated with existing incident reporting requirements in the VHIMS to avoid creating an additional administrative burden for mental health services and to broaden the information available to the Chief Psychiatrist for monitoring and reviewing sexual safety breaches.

RECOMMENDATIONS: REPORTING OF INCIDENTS

Ensure reporting mechanisms and requirements are consistent with standards required in other service settings, including that breaches of sexual safety are escalated for review and oversight of responses.

Ensure reporting requirements are integrated and can consider ways to review patterns in reported incidents to identify the need for quality improvement.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Review and revises reporting requirements for suspected or alleged sexual assaults to ensure consistency with the standards of reporting required in other sectors by the Client Incident Management System.
- Consider ways of integrating incident reporting with reporting requirements to the Chief Psychiatrist.
- Require that alleged breaches of sexual safety in mental health services be categorised under the current VHIMS system with a minimum rating of ISR2 (with guidance on ISR 1 ratings for incidents assessed as an 'other catastrophic' event) to ensure escalation to senior management for review and response, as well as oversight and monitoring of these incidents.
- As part of the review and redevelopment of reporting systems, consider the ways in which different levels and types of sexual safety breaches can be reported to help identify patterns that may indicate the need for quality improvement, escalation and different approaches to ensuring sexual safety.

CHIEF PSYCHIATRIST

- Review the Chief Psychiatrist's Guideline to require reporting of all suspected and alleged sexual assaults, rather than 'occurrences'.
- Consider options for reviewing sexual activity between consumers, either through increased reporting requirements or through access to incident reports.

MENTAL HEALTH SERVICE PROVIDERS

- Review policies, procedures and training to ensure that all staff are aware of the reporting requirements to the Chief Psychiatrist.

2.5.7 DOCUMENTATION STANDARDS

Complaints to the MHCC indicate a range of issues in documenting treatment and care, including failure to document critical discussions and decision making. Adequate documentation practice is a basic skill and requirement for the mental health workforce and is best addressed within services. Issues and gaps in documentation can significantly affect the effectiveness of investigation and review processes, including processes undertaken by the service and safeguarding or oversight bodies and the service's capacity to respond to legal claims. In the case of alleged sexual assault, poor documentation can also negatively affect reporting to and evidence available to Victoria Police. Lack of documentation affects services' capacity to clearly identify areas requiring improvement and the specific actions that may be required to improve service provision. In this sense, poor documentation practices present a risk to a service's ability to identify and take action to prevent avoidable harms.

The Chief Psychiatrist's Guideline includes advice to staff about what should be documented in a suspected or alleged sexual assault in the medical record, including:

- a factual account of events as known, including staff perceptions and, where possible, verbatim accounts from the parties involved
- avoidance of terms that may be open to interpretation (for example, clinical terminology such as psychotic, deluded and thought disordered should be substituted with actual descriptions of the beliefs, behaviours or speech of those involved)

- particular attention to the comprehensive and accurate recording of:
 - the time, the date, the place and a description of the alleged incident based on available and reported information
 - any clinical assessments and interventions taken following the alleged incident
 - details of steps taken to preserve evidence
 - all discussions with the victim about referral and follow-up
 - the name of the alleged offender and any witnesses
 - the notification of the authorised psychiatrist, nurse unit manager and mental health service management
 - completion of adverse incident forms and reports. (Department of Health 2009, updated 2012, pp. 29–30)

The review of complaints made to the MHCC has shown that records of sexual activity or assault, or records of interventions in relation to other sexual safety breaches, at times do not meet these standards. Some examples include:

- unclear and varying language used to describe alleged sexual assault (including, for example, varying use of the terms 'sexual activity', 'sexual assault', 'sexual intercourse', 'sexual relationship', 'sexual encounter', 'sex', 'incident' and 'casual sex' to describe an allegation of sexual assault)
- unclear differentiation between events that have been reported to or observed by staff, and staff perception or interpretation of events (clear, contemporaneous recording of objective observations is critical to any report to police where a sexual assault may have occurred or other investigations into alleged breaches of sexual safety – see sections 2.5.3 and 2.5.5)
- failure to document notifications to senior on-call staff of an alleged or suspected sexual assault, including failure to document advice provided and decisions made by these staff following an allegation of sexual assault

- using language such as 'overfamiliar', 'obtrusive' or 'boundary issues' to describe consumers' behaviour, without specifying what had been observed (for example, 'touching')
- not referring to behaviour as sexual harassment when warranted
- recording that 'psychoeducation' has been provided without stating what this comprised – for example, whether people were advised that sexual activity is not permitted while an inpatient
- noting that staff 'provided reassurance' in response to concerns about sexual safety without recording the steps taken to discuss and address concerns. (This is unclear language from a recording perspective and is also unlikely to reflect a supportive response for the person raising these concerns. Merely providing 'reassurance' without examining and responding to factors that are causing a consumer to seek assistance from staff – for example, concerns about comments or behaviour from another person that is making the person raising these concerns feel unsafe or uncomfortable – is unlikely to be helpful and is more likely to be experienced as minimisation of these concerns.)

—— While acknowledging the distress experienced by staff in responding to allegations of sexual assault and the need for staff to manage multiple responsibilities in responding to these sexual safety breaches, clear documentation is an important safeguard for any victim who may later wish to make a police complaint or victims of crime compensation claim. As noted, clear documentation is also required to enable the service, or an external review agency, to conduct an investigation that will be able to accurately determine what occurred and make informed recommendations to improve practice and ensure safety.

The issues observed in documenting complaints involving sexual activity, harassment and assault indicate a broader issue in the lack of ability to recognise and name the nature of behaviours observed or reported (for example, 'sexual harassment' or 'alleged sexual assault') and the potential consequences for both parties involved in failing to adequately identify and respond to these behaviours. The use of appropriately objective, factual and consistent terminology is critical to ensuring all staff involved in the care of a consumer have an appreciation for the characteristics of any sexual safety breach that a person has experienced. While the Chief Psychiatrist's Guideline defines these terms, they do not appear to be consistently or appropriately used by services.

In addition, in one complaint to the MHCC, several instances were noted where observation times were pre-recorded and subsequently signed. This practice is not acceptable and presents serious issues when attempting to verify the accuracy of records and chronology of events. If pre-recorded times are not corrected to reflect actual observation times, the resulting records are also noncompliant with the requirements of the *Health Records Act 2001*⁵ and the standards issued under the *Public Records Act 1973*.⁶

⁵ The Health Privacy Principle 3 on Data Quality requires that an organisation must 'take steps that are reasonable in the circumstances to make sure that, having regard to the purpose for which the information is to be used, the health information it collects, uses, holds or discloses is accurate, complete, up to date and relevant to its functions or activities'.

⁶ Public Records Office Standard 10/10 FS2 provides as follows: 'To comply with mandatory requirements, all public sector employees must create full and accurate records of all their work-related decisions and activities'. Additionally, the *Code of conduct for Victorian public sector employees*, June 2015 (clause 5.4), also requires that employees 'maintain accurate and reliable records as required by relevant legislation, policies and procedures'.

RECOMMENDATIONS: DOCUMENTATION STANDARDS

Ensure observations or reports are clearly, accurately and contemporaneously recorded using factually accurate terms to describe the nature of any sexual safety breaches.

CHIEF PSYCHIATRIST

- The review of the Chief Psychiatrist's Guideline should:
- review definitions and use of terms to remove references to 'inappropriate sexual activity'
 - provide guidance on terms that should be used in verbal communication and written documentation
- include examples of vague terms and inappropriate language that should not be used, and specific alternatives that would more clearly and accurately record what has occurred during a person's treatment
 - specify the need for accurate and contemporaneous nursing observations in relation to any observations or reports of sexual activity, harassment or assault.

MENTAL HEALTH SERVICE PROVIDERS

- Review documentation practices as part of standard quality assurance activities, with a view to identifying and addressing vague or unclear practices and providing training where a need for this is identified.
- Ensure that nursing observations are recorded at the time of completion rather than pre-recorded and signed.

2.5.8 DISCHARGE PLANNING AND REFERRALS

The Chief Psychiatrist's Guideline makes the following statement about discharge and follow-up care:

The impact of past trauma and any experience of sexual activity can have far-reaching consequences on the person's mental health and wellbeing. Where a person has been identified as vulnerable during an inpatient admission, or has experienced an adverse sexual event, especially assault, careful consideration should be given in discharge planning to their ongoing needs for counselling, psychotherapy and support.

Discharge plans and summaries should clearly identify ongoing needs, how they might be met and, where relevant, particular vulnerabilities highlighted in relapse prevention and recovery plans. Specific referrals should be made where appropriate, for example, to sexual assault counselling services, health screening services or other relevant agency.

(Department of Health 2009, p. 18)

Concerns about the adequacy of discharge planning were often raised in complaints to the MHCC about the responses of services to breaches of sexual safety during inpatient admissions. Discharge summaries sometimes omitted the information required to inform an assessment of ongoing needs and the actions required to respond to these. Consistent with the themes identified in section 2.5.7, this included deficiencies in the service's ability to factually and accurately record what had occurred during a person's inpatient admission. For example, in one instance a suspected sexual assault was referred to as an 'incident' in discharge documentation and the need for follow-up and referrals was not adequately noted. This had the result that the community team was not aware of the serious nature of the person's experience and actions required and were therefore unprepared to provide the necessary support and identify relevant referrals for the person and their family. While information about sexual safety breaches may be sensitive, discharge plans must contain accurate, factual information to enable appropriate care and support to be provided as required by Standard 2.10 (d) of the *National Safety and Quality Health Service Standards* that 'information needs for ongoing care are provided at discharge' (ACSQHC 2017, p. 18).

Robust approaches to discharge planning and follow-up care could also assist in addressing the low rates of referral to sexual assault or counselling services identified in the analysis of local complaints reports discussed in section 2.5.1.3. Only 11 per cent of complaints included in the data analysis confirmed a referral to CASA or other support service, and only 31 per cent of complaints confirmed that the individual involved had been offered counselling. It is acknowledged that these figures may represent under-reporting of the referrals that were made due to the incomplete nature of the complaints data. Regardless, accurately identifying the nature of the person's experiences while an inpatient, and any support that has already been offered, will help community teams or other clinicians (for example, general practitioners) to continue to work with the person and support them to access these services if they wish to at a later date.

The Chief Psychiatrist's Guideline currently contains no direction about the considerations for future admissions as a focus of discharge planning. Given the trauma that is likely to be associated with experiencing a breach of sexual safety while receiving acute mental health inpatient treatment, discharge planning should explicitly include whether and how future admissions can be facilitated to another unit if desired by the person or their family and an alert placed accordingly on the Client Management Interface/Operational Data Store (CMI/ODS). Whether or not there is evidence to support an alleged breach of a person's sexual safety in an inpatient unit, or a view that the allegation could have been linked to a person's mental state, a trauma-informed approach requires that steps are taken to assist the person to feel safe and to address adverse experiences in previous admissions. Identifying the person's views about treatment options and environments that would support the person to feel safe is also consistent with the principles of supported decision making.

Advance statements

One aspect where supported decision making could be significantly strengthened is in the use of advance statements. An advance statement is a document that sets out a person's preferences in relation to treatment in the event that they require compulsory mental health treatment (s 19 of the Mental Health Act). Complaints to the MHCC have identified that advance statements have rarely been used or developed to address concerns about sexual safety. Where a person has experienced a breach of sexual safety during an inpatient admission, and particularly where the person may fear returning to the unit in which the breach occurred, an advance statement should be developed jointly with the person to guide the service's actions and responses regarding future treatment. This includes preferences about admissions to a different unit as well as other factors that may support a person to feel safer within the unit, including placement in a women-only corridor, and the person's views and preferences about the interventions and approaches that are likely and unlikely to be helpful in establishing a sense of safety.

“

I was terrified and don't want to go back to there if I was hospitalised again. I think that's a fair request.”

Woman who experienced a sexual safety breach

Referrals for families and carers

It would be beneficial if the Chief Psychiatrist's Guideline was also expanded to include referrals that may be necessary for family members or carers. Themes from complaints to the MHCC, as well as consultations, identified that families are likely to experience extreme distress on being advised of sexual safety breaches. The Chief Psychiatrist's Guideline acknowledges this to an extent, in noting that families and carers should be offered debriefing following an incident of sexual assault or other sexual activity (Department of Health 2009). However, given the potential impact of these breaches on carers and families, comprehensive discharge planning should also include referrals for carers to support services or to psychological or counselling support following breaches of sexual safety.

“

I don't think [debriefing after a breach] is routinely offered and it needs to be because it's traumatic for families and carers as well.”

Mental health service carer consultant

RECOMMENDATIONS: DISCHARGE PLANNING AND REFERRALS

Ensure discharge planning clearly identifies the nature of any breach experienced, as well as planning for future admissions and outlining necessary support and referral for the person and their family/carers.

CHIEF PSYCHIATRIST

That the Chief Psychiatrist, in reviewing the Chief Psychiatrist's Guideline:

- notes the need for discharge documentation to include clear and factual descriptions of breaches of sexual safety as well as clearly outlining the referrals and supports required

- includes guidance about the need to develop plans for future admissions as part of discharge planning, including by developing advance statements and options for a person to be admitted to a different inpatient unit if admission is required in the future
- considers the need for referrals and support for families and carers.

MENTAL HEALTH SERVICE PROVIDERS

- Ensure that discharge planning and documentation accurately reflects the nature of any sexual safety breach or alleged breach as well as the steps required to respond to identified needs.
- Ensure that discharge planning processes consider advance statements or other plans about future admissions, including plans to admit the person to a different unit if an admission is required in the future.

- Consider the needs of families and carers as part of discharge planning, including the need to make referrals to carer support services or psychological or counselling supports.

APPENDICES

Appendix 1:

ORGANISATIONS AND INDIVIDUALS CONSULTED

In addition to consultations with Project Reference Group members and the MHCC's education and engagement work with mental health services, including discussion of these issues at training sessions and Grand Rounds within mental health services, the following individuals and organisations were consulted for this project.

Aged Care Complaints Commissioner	South Eastern Centre Against Sexual Assault (SeCASA): Ms Carolyn Worth
Australian Commission on Safety and Quality in Health Care: Ms Suellen Allen, Dr Andrew Moors	Tandem: Ms Marie Piu
Australian Medical Association: Professor Nicholas Keks	Transgender Victoria
Centre for Psychiatric Nursing: Associate Professor Bridget Hamilton, Ms Cath Roper	Victoria Police, Executive Command, Capability Division
Chief Mental Health Nurse, Victoria: Ms Anna Love	Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Chief Psychiatrist, Tasmania, former Chief Psychiatrist, South Australia: Dr Aaron Groves	Victorian Aboriginal Health Service
Chief Psychiatrist, Victoria: Dr Neil Coventry	Victorian Equal Opportunity and Human Rights Commission: Ms Kristen Hilton, Commissioner, and senior staff
Chief Psychiatrist, Western Australia: Dr Nathan Gibson, and Deputy Chief Psychiatrist Dr Sophie Davison	Victorian Mental Illness Awareness Council (VMIAC)
College of Mental Health Nurses: Mr James Houghton and colleagues	Victorian Transcultural Mental Health
Commissioner for Gender and Sexuality: Ro Allen	Women with Disabilities Victoria: Ms Jen Hargrave
Commissioner for Senior Victorians: Mr Gerard Mansour	Group consultations:
Department of Health and Human Services	Health Complaints Commissioners Group: Ms Karen Cusack, Ms Sue Dawson, Mr Richard Connock, Mr Stephen Tully, Ms Sarah Cowie, Ms Karen Toohey, Mr Anthony Hill and Mr Leon Atkinson
Foundation House	Mental Health Commissioners Group: Dr Peggy Brown, Mr Chris Burns, Ms Catherine Lourey, Mr Timothy Marney, Mr Ivan Frkovic, and former Commissioners Dr Lesley Von Schoubroeck and Mr John Feneley
Independent Mental Health Advocacy (IMHA): Ms Helen Makregiorgos, Ms Wanda Bennetts, Ms Hannah Dee	Royal Australian and New Zealand College of Psychiatrists Victorian Branch Committee
Mental Health Tribunal: Mr Matthew Carroll, Ms Troy Barty	Women's Honour Roll Ambassadors – Mental Health: Ms Kim Koop, Ms Brenda Appleton, Dr Ruth Nair, Ms Jocelyn Bignold and Ms Cathy Humphreys
MHCC Advisory Council: Dr Steven Moylan	Women's Mental Health Network Victoria
MHCC Advisory Council: Ms Christine Abdelmalek	Victorian Equal Opportunity and Human Rights Commission Disability Reference Group
Ms Sue Armstrong	Young people approached through youth mental health organisations
National Mental Health Commission: Professor Helen Milroy	
Office of the Public Advocate	
Orygen Youth Health	
Professor Marie Bashir Centre Mental Health Service	
Sydney Local Health District: Professor Victor Storm and senior staff	

Appendix 2:

COMPLAINTS DATA ANALYSIS

The Mental Health Complaints Commissioner (MHCC) contracted the Monash Alfred Psychiatry research centre (MAPrc) to undertake an analysis of complaints relating to issues of sexual safety (sexual assault or harassment, or other lack of sexual safety) within public acute mental health inpatient units across Victoria.

The complaints in the analysis were either reported to the MHCC via local complaints reporting (LCR) or made directly to the MHCC in the form of oral or written complaints. The following is an overview of the data analysis process and results.

Data analysis

The MHCC provided MAPrc with the initial dataset, which included a range of complaints for the period from 1 July 2014 to 30 June 2017. All data provided to MAPrc was de-identified. The initial dataset provided to MAPrc included 105 complaints (44 LCR, 26 oral, 35 written). After a detailed review of all cases by MAPrc, and with permission from the MHCC, a number of cases were removed, leaving 90 complaints in the final dataset (40 LCR, 23 oral, 27 written).

A range of variables were included in the analysis. These were identified by the MHCC and by MAPrc through the stages of data analysis. Extensive processes of data cleansing, verification and checking were undertaken. Most variables in the dataset were categorical and were analysed using frequency and descriptive statistics. Where suitable, the χ^2 test of independence was used to examine the relationship between two categorical variables, and if variables had five or fewer cases, the Fisher's exact test was used instead. Due to the qualitative nature of information provided for the MHCC oral and written complaints, a technique called thematic analysis was undertaken to further explore, describe and tally the frequency of themes emerging from this data.

Given the complexity and variability in the data provided, particularly with the three different types of complaint formats, not all variables in the data file were routinely collected, particularly for oral and LCR complaints. For some variables there are many cases where the information was simply not provided. The original data file was recoded so that cases of 'Information not provided' were classified as 'Missing data' for that variable, which improved the way the SPSS Statistic software package undertook the statistical analyses. In the tables providing the results, it is important to note the number of cases available for analysis for that particular variable. During the process of data cleaning it became evident that a number of complaints needed to be re-coded to ensure data integrity with the available information on the complaint.

Overall results

A total of 90 complaints (40 LCR, 23 oral, 27 written) were considered eligible for data analysis. Frequency statistics are presented for a range of variables for the sample overall and by complaint type in Tables 1–5.

Complaint details

Information relating to complaint details is provided in Table 1.

Complaints were generally made by the consumers themselves (61.8 per cent) and often while they were still an inpatient of the mental health unit (61.2 per cent).

Submission type

Of all complaints analysed, 44 per cent were LCR complaints, 26 per cent MHCC oral complaints and 30 per cent were MHCC written complaints. When submission type was compared according to type of complaint, a significant difference was revealed ($\chi^2(6) = 12.8, p < 0.05$). While the number of complaints regarding alleged sexual assaults was generally similar across the three submission formats, a greater proportion of gender safety complaints were LCR complaints and a greater proportion of alleged sexual harassment cases were oral complaints.

Type of complaint

Overall, the most frequently reported type of complaint was alleged sexual assault (46.7 per cent), followed by complaints regarding issues of gender safety (37.8 per cent) and alleged sexual harassment (13.3 per cent). (Note: The MHCC advises that issue categorisation is undertaken based on the issues and concerns as presented by the person making the complaint.) There were two reported cases of sexual activity (2.2 per cent) between consumers while they were inpatients, and both of these complaints were made by the consumer's parents. More than three-quarters of the complaints (76.5 per cent) described breaches occurring between consumers, while 22.4 per cent were alleged breaches involving staff.

Table 1
Environmental factors of complaints

Complaint details	Overall sample <i>n</i> = 90	LCR complaints <i>n</i> = 40	Oral complaints <i>n</i> = 23	Written complaints <i>n</i> = 27
Type of complaint (n, %)				
No. cases with data	90	40	23	27
Gender safety	34 (37.8%)	20 (50.0%)	4 (17.4%)	10 (37.0%)
Alleged sexual assault	42 (46.7%)	17 (42.5%)	11 (47.8%)	14 (51.9%)
Alleged sexual harassment	12 (13.3%)	3 (7.5%)	7 (30.4%)	2 (7.4%)
Sexual activity	2 (2.2%)	0	1 (4.3%)	1 (3.7%)
Type of assault (n, %)				
No. cases with data	85	37	22	26
Consumer to consumer	65 (76.5%)	30 (81.1%)	11 (50.0%)	24 (92.3%)
Staff to consumer	19 (22.4%)	7 (18.9%)	11 (50.0%)	1 (3.8%)
Both consumer/consumer and staff/consumer	1 (1.2%)	0	0	1 (3.8%)
Who made the complaint (n, %)				
No. cases with data	55	5	23	27
Consumer	34 (61.8%)	0	18 (78.3%)	16 (59.3%)
Mother	10 (18.2%)	3 (60.0%)	2 (8.7%)	5 (18.5%)
Father	1 (1.8%)	0	0	1 (3.7%)
Parents	2 (3.6%)	0	0	2 (7.4%)
Partner	5 (9.1%)	2 (40.0%)	2 (8.7%)	1 (3.7%)
Friend	1 (1.8%)	0	1 (4.3%)	0
Daughter	2 (3.6%)	0	0	2 (7.4%)
When the was complaint made (n, %)				
No. cases with data	49	0	23	26
During admission	30 (61.2%)	0	20 (87.0%)	10 (38.5%)
After admission	19 (38.8%)	0	3 (13.0%)	16 (61.5%)

Characteristics of the consumer

Table 2 details information about the consumers involved in the complaints. Most complaints related to female consumers of public mental health inpatient units across Victoria (80.0 per cent).

There was no data available regarding the sexual identity of consumers. Almost all of the complaints related to consumers aged over 18 years (95.6 per cent), but there were two cases (2.2 per cent) under 18 years of age. The actual age of the consumer was only reported in nine cases (10.0 per cent) and this ranged from 17 to 86 years. Of the 90 complaints, cultural background was only mentioned for three cases (two Aboriginal or Torres Strait Islander and one Bosnian).

There was only data available for 17 cases regarding experience of previous trauma, and 16 of these cases (94.1 per cent) indicated experiencing some type of previous trauma including past history of sexual assault. Three cases specifically reported experiencing past sexual assault while an inpatient of a mental health unit. Information regarding other issues of vulnerability was available for 39 cases, with 34 (87.2 per cent) indicating the presence of factors considered to increase the vulnerability of consumers, mainly being heavily sedated from the medication (12 cases, 35.3 per cent).

Direct information provided by the service was used to determine if the content of the complaint may have been assessed as being related to the mental state of the consumer. Based on all available information, a complaint was attributed to the mental state of the consumer in only seven (4 LCR, 3 oral) out of the 90 cases (7.8 per cent). It should be noted that these statements represent the service's view only and not an assessment of the facts at the centre of these complaints.

Table 2
Characteristics of consumers

Characteristics of consumer	Overall sample <i>n</i> = 90	LCR complaints <i>n</i> = 40	Oral complaints <i>n</i> = 23	Written complaints <i>n</i> = 27
Gender (n, %)				
No. cases with data	83	35	23	27
Male	17 (20.0%)	6 (17.1%)	8 (34.8%)	3 (11.1%)
Female	68 (80.0%)	29 (82.9%)	15 (65.2%)	24 (88.9%)
Sexual identity (n, %)				
No. cases with data	0	0	0	0
Age (n, %)				
No. cases with data	90	40	23	27
Under 18 years	2 (2.2%)	1 (2.5%)	0	1 (3.7%)
18+ years	86 (95.6%)	39 (97.5%)	22 (95.7%)	25 (92.6%)
65+ years	2 (2.2%)	0	1 (4.3%)	1 (3.7%)
Cultural background (n, %)				
No. cases with data	3	1	1	1
Aboriginal and Torres Strait Islander	2 (66.7%)	1 (100%)	1 (100%)	0
Bosnian	1 (33.3%)	0	0	1 (100%)
Previous trauma (n, %)				
No. cases with data	17	2	4	11
Yes	16 (94.1%)	2 (100%)	4 (100%)	10 (90.9%)
No	1 (5.9%)	0	0	1 (9.1%)
Other vulnerability (n, %)				
No. cases with data	39	4	15	20
Yes	34 (87.2%)	4 (100%)	15 (100%)	15 (75.0%)
No	5 (12.8%)	0	0	5 (25.0%)
Complaint related to consumer's mental state (n, %)				
No. cases with data	50	19	12	19
Yes	7 (14.0%)	4 (21.1%)	3 (25.0%)	0
No	26 (52.0%)	8 (42.1%)	3 (25.0%)	15 (78.9%)
Possibly	17 (34.0%)	7 (36.8%)	6 (50.0%)	4 (21.1%)

Contributing environmental factors

Information describing the environmental factors of the complaints is provided in Table 3. The MHCC requested additional information from services on the location of sexual safety breaches and details on gender-safe or women-only areas. Most complaints related to breaches that were reported to have occurred in the high dependency units (HDUs) or intensive care areas (ICAs) of the ward (40.4 per cent) or in bedrooms (34.0 per cent).

This information indicated that most services have some sort of separate gender area, but the infrastructure data was somewhat unclear. There were six reported cases (1 LCR, 1 oral and 4 written) where sexual safety breaches occurred in a 'women-only' area. All six of these complaints were described as occurring in 'the female-only corridor' or 'female area' of the ward.

Where it was indicated that there were separate gender areas, 22 cases (3 LCR, 2 oral and 17 written) were rated to indicate that the service infrastructure was not used as it was intended (see below for examples). Of the 22 cases, nine complaints (40.9 per cent) were alleged sexual assaults, representing 21.4 per cent of the total number of alleged sexual assaults.

Following an in-depth review of these 22 cases where it was indicated that the service infrastructure was not used as intended, these complaints could be described as fitting into three categories. Five complaints related to 'issues regarding staff supervision', for example, a lack of staff supervision in the courtyard area, no staff members present in the HDU, and male patients being able to make their way into the female-only areas of the ward. The second category contains the majority of the 22 cases (13 complaints, 59.1 per cent) and can be described as 'service and infrastructure issues' and includes complaints where female patients were not in the female-only

Table 3
Environmental factors of complaints

Environmental factors	Overall sample <i>n</i> = 90	LCR complaints <i>n</i> = 40	Oral complaints <i>n</i> = 23	Written complaints <i>n</i> = 27
Where did the breach occur? (n, %)				
No. cases with data	47	11	13	23
HDU or ICA	19 (40.4%)	4 (36.4%)	8 (61.5%)	7 (30.4%)
Low dependency unit	4 (8.5%)	0	0	4 (17.4%)
Bedroom	16 (34.0%)	3 (27.3%)	3 (23.1%)	10 (43.5%)
Bathroom	2 (4.3%)	1 (9.1%)	1 (7.7%)	0
Lounge	0	0	0	0
Corridor	0	0	0	0
Courtyard	2 (4.3%)	1 (9.1%)	0	1 (4.3%)
Emergency department	1 (2.1%)	0	0	1 (4.3%)
Bedroom and bathroom	2 (4.3%)	2 (18.2%)	0	0
Bedroom and corridor	1 (2.1%)	0	1 (7.7%)	0
Did the breach occur in a women-only area? (n, %)				
No. cases with data	27	1	5	21
Yes	6 (22.2%)	1 (100%)	1 (20.0%)	4 (19.0%)
No	21 (77.8%)	0	4 (80.0%)	17 (81.0%)
Does the service have separate gender areas? (n, %)				
No. cases with data	83	40	22	21
Yes	80 (96.4%)	40 (100%)	20 (90.9%)	20 (95.2%)
No	3 (3.6%)	0	2 (9.1%)	1 (4.8%)
Was the service infrastructure used as intended? (n, %)				
No. cases with data	30	4	8	18
Yes	8 (26.7%)	1 (25.0%)	6 (75.0%)	1 (5.6%)
No	22 (73.3%)	3 (75.0%)	2 (25.0%)	17 (94.4%)

area of the ward (in most cases reasons were not specified, but in some cases this was because the female-only area was full). There were also a number of complaints in this category that relate to female patients sharing a communal bathroom with male patients, or being the only female in the HDU. The third category 'issues of physical security', with four complaints, describes concerns where areas of the ward were not locked as they were intended to be.

There was a significant association between type of complaint and psychiatric service ($p = 0.001$, Fisher's exact test), indicating that some healthcare services had a greater proportion of certain types of complaints.

Perpetrator factors

Information describing characteristics of the alleged perpetrators is presented in Table 4. The majority of complaints described consumers as being the alleged perpetrator (76.5 per cent). It is important to note that 21.2 per cent of complaints identified staff members as the alleged perpetrators (7 LCR, 10 oral, 1 written). In most cases, the alleged perpetrator was male (83.1 per cent), while 10.2 per cent of complaints identified females as the alleged perpetrators. The most common pattern of sexual safety breaches was typically a male identified as the alleged perpetrator against an alleged female victim (72.4 per cent), and in 10.3 per cent of cases a male was identified as the alleged perpetrator against an alleged male victim.

Actions taken regarding alleged perpetrators

Information describing what actions were taken in relation to the alleged perpetrator was available for 23 of the 90 complaints (25.6 per cent, 13 LCR, 1 oral, 9 written). In almost half of these cases (47.8 per cent) it was reported that the alleged perpetrator was moved away, and specifically for five cases it was noted that the alleged perpetrator was moved into the HDU area of the ward.

Table 4
Perpetrator factors

Perpetrator factors	Overall sample <i>n</i> = 90	LCR complaints <i>n</i> = 40	Oral complaints <i>n</i> = 23	Written complaints <i>n</i> = 27
Alleged perpetrator (n, %)				
No. cases with data	85	37	22	26
Staff	18 (21.2%)	7 (18.9%)	10 (45.5%)	1 (3.8%)
Consumer	65 (76.5%)	30 (81.1%)	11 (50.0%)	24 (92.3%)
Visitor	0	0	0	0
Other	0	0	0	0
Staff and consumer	0	0	0	0
Security staff	1 (1.2%)	0	1 (4.5%)	0
Consumer and security staff	1 (1.2%)	0	0	1 (3.8%)
Alleged perpetrator gender (n, %)				
No. cases with data	59	15	17	27
Male	49 (83.1%)	13 (86.7%)	12 (70.6%)	24 (88.9%)
Female	6 (10.2%)	2 (13.3%)	3 (17.6%)	1 (3.7%)
Male and female	4 (6.8%)	0	2 (11.8%)	2 (7.4%)
Alleged perpetrator gender: victim gender (n, %)				
No. cases with data	58	14	17	27
Male perpetrator: male victim	6 (10.3%)	3 (21.4%)	2 (11.8%)	1 (3.7%)
Male perpetrator: female victim	42 (72.4%)	9 (64.3%)	10 (58.8%)	23 (85.2%)
Female perpetrator: female victim	2 (3.4%)	1 (7.1%)	1 (5.9%)	0
Female perpetrator: male victim	3 (5.2%)	1 (7.1%)	2 (11.8%)	0
Combination	5 (8.6%)	0	2 (11.8%)	3 (11.1%)

Service response/ outcome variables

A range of variables related to the service response to the complaint, and general outcomes are presented in Table 5. A broad definition of 'investigated by service' was taken when reviewing complaints. This included cases where there was a formal investigation undertaken by the service (for example, review by the director of psychiatry or director of nursing or a critical incident review), as well as more informal discussions between service staff (for example, a nurse unit manager), consumers and the MHCC. Most complaints were reported to have been investigated or reviewed in some way by the relevant service (87.0 per cent). Given the broad definition used, this does not, however, provide any indication of the adequacy or standards of the investigation or review undertaken by the service.

Out of the 90 complaints, information about the consumer being provided with debriefing was only available for 31 cases, and of these, 90.3 per cent were reported to have been offered counselling. This means that there is only evidence that 31.1 per cent of all consumers were offered counselling in response to the allegation/incident.

Table 5
Service response/outcome variables

Service response/ outcome variables	Overall sample <i>n</i> = 90	LCR complaints <i>n</i> = 40	Oral complaints <i>n</i> = 23	Written complaints <i>n</i> = 27
Did the service investigate the complaint? (<i>n</i>, %)				
No. cases with data	77	38	18	21
Yes	67 (87.0)	28 (73.7%)	18 (100%)	21 (100%)
No	10 (13.0%)	10 (26.3%)	0	0
Consumer offered debriefing? (<i>n</i>, %)				
No. cases with data	31	22	0	9
Yes	28 (90.3%)	20 (90.9%)	N/A	8 (88.9%)
No	3 (9.7%)	2 (9.1%)	N/A	1 (11.1%)
If the complaint was an alleged sexual assault:				
Incident reported to police? (<i>n</i>, %)				
No. cases with data	44	18	11	15
Yes	17 (38.6%)	10 (55.6%)	0	7 (46.7%)
No	4 (9.1%)	2 (11.1%)	1 (9.1%)	1 (6.7%)
Consumer declined	2 (4.5%)	0	1 (9.1%)	1 (6.7%)
Information not provided	21 (47.7%)	6 (33.3%)	9 (81.8%)	6 (40.0%)
Incident reported to the Chief Psychiatrist? (<i>n</i>, %)				
No. cases with data	44	18	11	15
Yes	0	0	0	0
No	8 (18.2%)	4 (22.2%)	2 (18.2%)	2 (13.3%)
Information not provided	36 (81.8%)	14 (77.8%)	9 (81.8%)	13 (86.7%)
Referral to Centres Against Sexual Assault (<i>n</i>, %)				
No. cases with data	44	18	11	15
Yes	5 (11.4%)	1 (5.6%)	1 (9.1%)	3 (20.0%)
No	3 (6.8%)	3 (16.7%)	0	0
Consumer declined	1 (2.3%)	0	0	1 (6.7%)
Information not provided	35 (79.6%)	14 (77.8%)	10 (90.9%)	11 (73.3%)
Carer/family/nominated person notified? (<i>n</i>, %)				
No. cases with data	46	19	12	15
Yes	12 (26.1%)	5 (26.3%)	1 (8.3%)	6 (40.0%)
No	3 (6.5%)	2 (10.5%)	0	1 (6.7%)
Information not provided	31 (67.4%)	12 (63.2%)	11 (91.7%)	8 (53.3%)

It is important to note that of the complaints that were categorised as alleged sexual assaults, only 38.6 per cent of these were reported to police, 11.4 per cent were referred to the Centres Against Sexual Assault (CASA), and 26.1 per cent of carers/nominated people were contacted. In terms of reporting alleged sexual assaults to the Chief Psychiatrist, this information was not provided for 14 LCR (77.8 per cent), nine oral (81.8 per cent) and 13 written (86.7 per cent) complaints. Therefore, it is not possible to determine if such incidents were or were not reported appropriately. Regardless, it is concerning that such detail is not routinely documented. For the complaints where this information was provided (eight cases), the data indicates that not one of these breaches was reported to the Chief Psychiatrist as required by the Chief Psychiatrist's guideline for *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units*. This is particularly significant given that there was not only an allegation of sexual assault but a complaint had also been made about the issues related to the alleged breach of sexual safety.

Service improvements

A number of service improvements were recorded as having been made following the alleged sexual safety breaches that form the basis of the complaints analysed in this report.

Overall, information reporting if service improvements were made was provided for 32 of the 90 complaints (35.6 per cent), and of these, 20 (62.5 per cent) indicated that a service improvement had been made. There were no details provided regarding service improvements for the oral complaints, while six LCR (15.0 per cent) and 14 written (51.9 per cent) complaints resulted in service improvements.

An in-depth review was undertaken of the 20 cases that reported service improvements, and the actions taken by the service can be described across four categories. Some services implemented more than one type of improvement. Following 18 complaints (90.0 per cent), it was reported that 'Training/input was provided to staff'. This included training regarding issues of gender sensitivity, risk assessment procedures and review of relevant policies/guidelines. Exactly half of these cases (*n* = 10, 50 per cent) resulted in a 'Change being made to the physical environment', which includes a range of changes such as: installing CCTV, night sensor lights and call bell systems; providing electronic wristbands

for female inpatients to access the women-only areas of the ward; and adding a women's courtyard to the unit. It was reported that 'Policy or procedural changes were proposed or made' for 11 complaints (55.0 per cent), and similarly a 'Review of service/practices' was also reported for 11 complaints (55.0 per cent).

The most frequent theme noted in 73.9 per cent (*n* = 17 of 23) of oral complaints was that the patient was not happy with the response of the staff/service when discussing or disclosing the complaint. Equally frequent themes, described in 56.5 per cent of cases (*n* = 13 of 23), were that the patient felt unsafe and that the initial complaint became less of a concern or was less salient for the patient with the passing of time.

The written complaints were the only submission type where a greater number of breaches were reported to have occurred in the bedroom than in the HDU setting. However, when the association between type of complaint and the site of the alleged breach was examined, a significant finding was revealed ($p = 0.035$, Fisher's exact test), indicating a higher proportion of alleged sexual assaults occurring in the HDU area and a greater proportion of gender safety issues being reported in bedrooms. There was a significant association between alleged perpetrator and type of complaint ($\chi^2(6) = 14.1, p < 0.05$), with the written complaints having the highest proportion of complaints against other consumers.

Results of the thematic analysis undertaken with the 27 written complaints revealed that for 92.6 per cent (*n* = 25) of these, the person making the complaint was not happy with the response of the staff/service when the issue was discussed or disclosed directly to the service. Equally frequent themes, described in 74.1 per cent of cases (*n* = 20), were that the patient felt unsafe and traumatised by their experience.

In 55.6 per cent (*n* = 15) of written complaints, documentation revealed that an apology was provided by the mental health service. For the majority of these cases (*n* = 10, 66.7 per cent), the apology was made by the service after the MHCC became involved in the complaint process.

Glossary

The following definitions are provided in addition to those provided in 'Note on language' at the beginning of this document.

Acute mental health inpatient unit: inpatient treatment services providing voluntary and compulsory short-term mental healthcare and treatment during an acute phase of mental illness.

Bodily restraint: including physical and mechanical restraint, involves methods that prevent a person having free movement of their limbs.

Department: means the Department of Health and Human Services.

Gender diverse: refers to people who do not identify as a woman or a man. In the same way that sexual orientation and gender expression are not binaries, gender identity is not a binary either. Some people may identify as a-gender (having no gender), bi-gender (both a woman and a man) or non-binary (neither woman nor man). There is a diverse range of non-binary gender identities such as genderqueer, gender neutral, gender fluid and thirdgendered. Language in this space is still evolving, and people may have their own preferred gender identities that are not listed here.

Independent Third Person (ITP): trained volunteers who assist people with a cognitive impairment, including mental illness, to understand questions posed to them by police, and assist police to understand replies to questions.

Intensive care area (ICA): a separate area within an acute mental health inpatient unit that can be locked.

Lesbian, gay, bisexual, trans (and gender diverse) and intersex (LGBTI): a term used to collectively refer to people who are lesbian, gay, bisexual, trans (or gender diverse) and/or intersex.

Prevention – primary: interventions that aim to prevent

abuse from occurring in the first instance.

Prevention – secondary: early intervention to identify and respond directly to risks or allegations of abuse.

Prevention – tertiary: responses that aim to remedy any negative and harmful consequences and to put in place measures to prevent re-occurrences.

Restrictive interventions: bodily restraint and seclusion. Restrictive interventions may only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.

Seclusion: involves a person being confined alone in a room or area from which it is not within their control to leave.

Secretary: Secretary to the Department of Health and Human Services.

Single-gender or mixed-gender units: units in which women and men are accommodated separately, either fully separately or with full separation of sleeping and bathroom areas.

Trans (transgender): refers to a person whose gender identity, gender expression or behaviour does not align with their sex assigned at birth. In Australia, children are classified as male or female at birth. Male children are raised as boys and female children are raised as girls. A person classified as female at birth who identifies as a man may use the label trans, transman or man. Similarly, a person classified as male at birth who identifies as a woman may use the label trans, transwoman or woman.

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Legislation and conventions

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United Nations Universal Declaration of Human Rights 1948

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United Nations Convention on the Rights of Persons with Disabilities 2006

United Nations' Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2006)

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