

The gender sensitivity and safety in adult acute inpatient units project

Final report



A Victorian
Government
initiative



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Project leader

Dr Margaret Grigg

Project team

Mr Rod Mann

Ms Rhonda Goodwin

Ms Kate Thwaites

Ms Deana Davis

Advisory committee

Mr Mark Thornett

Ms June Hopley

Ms Jacqui Schultz

Ms Helen Lococo

Ms Sabin Fernbacher

Ms Heather Clarke

Ms Wanda Bennetts

Ms Sue Armstrong

Mr Greg Coman

Ms Di Hawthorne

Mr Kevin Carter

Prof. Jayashri Kulkani

Ms Janice Rouhan

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Contents

Executive summary	1
Literature and policy review	3
The context of care delivery in acute inpatient units	3
Violence	4
Sexual assault	4
Victimisation and re-traumatisation	5
Culture and religion	5
Interventions to improve care	6
State and international policy	6
Summary	10
Method	11
Key stakeholder interviews	11
Local mental health service policy audit	11
Inpatient unit audit	11
Environmental grant funding review	11
Results	12
Key stakeholder interviews	12
Local mental health policy audit	13
Inpatient unit audit	13
Environmental grant funding review	17
Findings	21
Overall findings	21
Literature and policy review	21
Key stakeholder interviews	21
Local mental health policy audit	22
Inpatient unit audit	22
Environmental grant funding review	22
Recommendations	23
1. Department of Human Services – Mental Health Branch guideline development	23
2. Service key performance indicators	23
3. Allegations of sexual assault	23
4. Sexual safety on inpatient units	23
5. Choice of single-sex inpatient treatment environment	23
6. Annual provisions	24
7. Steering committee	24
8. Evaluation	24
References	25
Appendix A: Policies reviewed	27
Appendix B: Local mental health service policy audit tool	29
Appendix C: Standardised observational and interview schedule for the inpatient unit audit	31
Appendix D: NorthWestern mental health policy, guidelines and poster	33

Executive summary

Across Victoria, creating and ensuring safety within acute adult inpatient units presents a range of challenges. Mixed-sex environments, limited physical space, and the acuity of patients' illnesses are just some of the difficulties. Because there are typically more males than females in acute wards, service providers need to be sensitive to the safety and privacy needs of women admitted to these units. To examine these issues, the Department of Human Services's Mental Health Branch undertook the Improving Gender Sensitivity and Safety in Acute Mental Health Inpatient Units project. The scope, methodology, findings and recommendations of this project are the subject of this report.

An advisory committee was established to oversee this project. The committee was involved in identifying current gender sensitivity and safety policies and practices, exemplar policies, and key gaps in policy and practice. The committee also extracted key findings from the evidence and contributed to developing recommendations for future actions.

This project comprised five main components: a literature and policy review, key stakeholder interviews, local mental health service policy audits, inpatient unit audits, and an environmental grant funding review. Outlined in this report, the literature and policy review provides a background to the local and international work on gender sensitivity and safety within acute psychiatric inpatient units. The key stakeholder interviews, local mental health service policy audits, and inpatient unit audits detail the extent to which gender sensitivity and safety is incorporated within Victorian inpatient psychiatric facilities. The allocation of environmental grants was made to enhance inpatient unit physical environments to improve the delivery of gender-sensitive and safe treatment. The key stakeholder interviews, local mental health service policy audits, inpatient unit audits, and work on the environmental grants occurred concurrently.

The overall findings of the project are as follows.

1. There are key gaps within, and variable implementation of, existing policy relating to gender sensitivity and safety.
2. There is evidence of effective strategies from other jurisdictions, and locally within services, but the challenge is the systematic implementation of policy.
3. There is a need for Mental Health Branch and service-level leadership to ensure sustainable implementation of policy.
4. This project increased awareness of gender sensitivity and safety issues within services.

Eight recommendations are provided. They pertain to how gender sensitivity and safety guidelines should be developed, reviewing and expanding the set of mental health service key performance indicators to include gender issues, producing guidelines for responding to allegations of sexual assault and for promoting sexual safety on inpatient units, offering a choice between single-sex and mixed-sex inpatient environments, improving gender sensitivity in current bed-based environments through existing annual provision processes, establishing a steering committee to oversee the implementation of these recommendations, and evaluating the outcomes of this project.

Literature and policy review

Within the context of inpatient units, several gender-related issues emerged from the literature including violence, sexual assault, victimisation and re-traumatisation, and culture and religion. Interventions designed to improve the care women receive during their time as patients include single-sex units and trauma-informed services. These issues and interventions are reflected in local and international policies on gender sensitivity and safety in adult inpatient units. In this literature and policy review, information is provided about the context within which care is provided in adult acute inpatient units, gender-related issues and interventions in acute inpatient settings, and local and international policies in this area.

The context of care delivery in acute inpatient units

In well-developed psychiatric services, such as those in Australia, the threshold for admission to psychiatric inpatient units has been raised, the length of stay has shortened, and rates of readmission have increased (Quirk and Lelliott, 2001). Changes to admission thresholds has meant that a higher proportion of people who use inpatient services have complex needs and challenging behaviours (Sainsbury Centre, 1998). Inpatient wards have been described as dangerous environments, with patients displaying aggression against objects or others, engaging in self-harm, attempting to abscond, refusing medication, using illicit drugs, and breaking ward rules (Lelliott and Quirk, 2004). At times, staff responses, such as physical restraint and enforcing medication compliance, can also cause harm.

Mental illness has been identified as a risk factor for abuse (Morrow, 2002). This risk may be a direct result of mental illness, medications, or both these factors. Mental illness and medications may impair women's judgements, and make it difficult for them to protect themselves against assault and coercive sex. Hyper-sexuality is a feature of some psychiatric disorders, such as bipolar disorder and some organic brain syndromes (Ford et al., 2003), and may result in both male and female patients engaging in sexually inappropriate behaviour. Comorbid substance abuse may also contribute to increased vulnerability.

Research has shown that therapeutic superficiality has been a common characteristic of inpatient wards (Lelliott and Quirk, 2004). This minimalist approach to psychotherapeutic interventions may have emerged due to staff concerns about making matters worse if complex psychological problems were to be uncovered during brief admissions to psychiatric inpatient units.

The care for women mental health consumers following discharge from inpatient units and the care of dependent children are issues of concern (Gerrand, 1993). There are few accommodation options for women following psychiatric hospitalisation, and the risk of coercion and abuse is associated with some types of accommodation. There are also limited alternatives to psychiatric hospital admission when mental health issues become overwhelming for women with dependent children, with the children often having to be placed into care.

Violence

Experiencing or witnessing violence or trauma while in inpatient care is commonplace. In a national audit of violence in United Kingdom (UK) inpatient settings, for example, the Healthcare Commission (2005) found that 36 per cent of patients had experienced, and 46 per cent had witnessed, violence on their ward. Patients and staff had similar perceptions of the most common factors that triggered violent behaviour, including alcohol, staff behaviour, limited space and overcrowding, medication and treatment, and frustration and boredom.

Although males are more physically aggressive than females in the general population, this gender difference is markedly reduced among psychiatric inpatients (Hodgins, 1992; Krakowski and Czobor, 2004; Swanson, Holzer and Ganju, 1990). In one study, for example, similar numbers of men and women committed assaults, but a higher rate of men than women perpetrated assaults that resulted in physical injury (Krakowski and Czobor, 2004). Women had a much higher rate of verbal assaults than men. Factors that increased women's propensities to assault include positive psychotic symptoms and behavioural disturbances.

Sexual assault

Although there is limited research on the frequency of sexual assault and harassment of women in psychiatric wards (Hatch-Maillette and Scalora, 2002), those studies that exist confirm high rates of such incidents. In a United States study, for example, 8 per cent of participants reported experiencing sexual assault while they were patients in psychiatric settings (Frueh et al., 2005). In the UK, between November 2003 and September 2005, 122 incidents relating to sexual safety were reported in mental health services, including allegations of rape, consensual sex, exposure, sexual advances and touching (National Patient Safety Agency, 2006). The alleged perpetrator in rape allegations were either other patients (40 per cent) or staff members (60 per cent). The report did not detail how many of the reported incidents involved women. Due to their experiences of being sexually assaulted or of witnessing the sexual assault of other female patients, women have reported feeling unsafe while receiving care as patients in psychiatric hospitals (Graham, 1994).

In a Victorian report on women who had experienced sexual assault during their lives and who had received care in psychiatric services (Graham, 1994), several recommendations were made regarding the management of sexual assault incidences. Graham recommended that female patients have the choice of receiving care in single-sex or mixed-sex wards, patients accused of sexual harassment or sexual assault be immediately removed from the ward, mandatory reporting of sexual assaults be replaced by a process in which female patients who experience assault make informed choices about how they may respond (including specialised counselling, referral to the Centre Against Sexual Assault, completing a police report and legal representation), and that the female patients' emotional responses to the incidents be recorded in their files.

Victimisation and re-traumatisation

Acute inpatient care, by definition, is disempowering for many women. The ways in which services are provided to people who have experienced trauma may unintentionally trigger feelings of powerlessness and cause re-traumatisation (Morrow, 2002). This adverse outcome may occur with standard treatments within the inpatient setting, and may be more severe when restraint or seclusion is used.

The issue of re-victimisation in the health system is explored in the report *Hearing women's voices* (Morrow and Chappell, 1999). The authors referred to feminist writers' accounts of a wide range of abuses, such as the way in which male medical professionals patronise women, the way in which women's claims are dismissed, and the way in which professionals commit physical and sexual abuse. Findings from Victorian studies are consistent with these accounts (Graham, 1994; Hawthorne, McKenzie and Dawson, 1996). In one study, women reported that disclosures of sexual assault to mental health providers were often met with disbelief, silence, trivialisation, or denial (Graham, 1994). These responses of mental health providers may contribute to high levels of patient non-disclosure of sexual assaults. In a study with 60 psychiatric inpatients (Hawthorne et al., 1996), although 71 per cent of participants reported experiencing sexual assault during their lives, only half of these people had disclosed this information to psychiatric services staff.

Culture and religion

Australia is a culturally and theologically diverse country, with over 200 languages being spoken in the community and non-Christian religions showing the greatest increases in followers between the 1996 and 2001 censuses (Australian Bureau of Statistics, 2007). The prevalence of violence against women varies by culture, as does the willingness of women to disclose their experiences of violence (Garcia-Moreno et al., 2006). Female refugees from African countries, for example, have often been subjected to sexual violence, including rape, torture and mutilation, and sexual slavery, in addition to persecution and serious human rights violations (Foundaton House, 2005). In some Muslim societies there is systematic discrimination against women, as well as strict segregation of women and men (Saeed, 2004). Such cultural and religious diversity means that mental health professionals need to exhibit cultural competence in their care of patients. Cultural competency includes having the knowledge and skills to work within an individual's culture, and understanding how one's own cultural background and the philosophy of the treatment program can influence patient interactions (Fong and Furuto, 2001). For example, the meaning one gives violence and trauma can vary between cultures. Healing takes place within a woman's cultural context and support network, and different cultural groups may have unique resources that support healing (Elliott et al., 2005).

Interventions to improve care

Single-sex units

One suggested way of addressing safety for women has been to develop single-sex units. However, there is as yet, no clear evidence that women prefer single-sex environments or that they are safer in such units. In an interview-based study, patients from medium-secure (forensic long stay), mixed-sex units in the United Kingdom reported higher rates of physical assault and threat, and of witnessing assault than patients from similar single-sex units (Mezey, Hassell and Bartlett, 2005). Despite the high rates of threatening behaviour and violence, most women on these wards reported preferring being with male patients rather than being in a single-sex ward. The absence of male patients on the female-only units did not make the women feel safer.

In an Australian study conducted in an acute psychiatric unit in Sydney, most participants reported a preference for mixed-sex wards (Cleary and Warren, 1998). Participants perceived single-sex wards as isolating, and reported that mixed-sex wards were more interesting. Following the study, however, areas of the ward were designated as male-only or female-only. The feedback relating to this initiative was positive.

Trauma-informed care

Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimisation on an individual's life and development (Elliott et al., 2005). In this context, interpersonal violence includes childhood physical or sexual abuse, and adult experiences of domestic violence, other physical or sexual assault, or rape. Consistent with this approach, and considering mental health consumers experience high rates of traumatic events (Hawthorne et al., 1996; Hutchings and Dutton, 1993; Mueser, Goodman and Trumbetta, 1998; Saunders et al., 1989), clinicians are increasingly advocating for the importance of identifying an individual's trauma history. In a study with 505 consumers, for example, 55 per cent of participants had experienced sexual abuse, 58 per cent had experienced physical assault, and 37 per cent had witnessed violence (Cusack, Frueh and Brady, 2004). Women were more likely to have experienced sexual trauma than men, and were more than twice as likely to have experienced forced sexual assault.

State and international policy

Many local and international policies on gender sensitivity and safety were reviewed as part of this project (see Appendix A). In this sub-section, key aspects of several of these policies are highlighted.

Victorian policy

In the policy document *Victoria's mental health services: Tailoring services to meet the needs of women* (Mental Health Branch, 1997), the vulnerability of female inpatients in mixed-sex wards is recognised (see Box 1). Although facility design alone will not ensure safe and appropriate treatment for women, it is an important component along with local development of congruent policies and practices. In regards to physical layout, the policy states that it is preferable that bedrooms are separated into male and female areas to aid staff observation, to respect patient privacy, and to minimise harassment and the risk of harm.

Many of the priority areas from the *Victoria's mental health services: Tailoring services to meet the needs of women* report have been reiterated or developed in subsequent Department of Human Services documents (Department of Human Services, 2004; 2006). Key recommendations from the report *Building partnerships between mental health, family violence and sexual assault services*, for example, are focused on assisting mental health practitioners to address abuse and personal safety issues affecting women in their care (Department of Human Services, 2006).

The Office of the Chief Psychiatrist in Victoria is a further source of guidance for mental health practitioners. Although the Chief Psychiatrist has produced many guidelines that are relevant to inpatient services, they do not typically include gender issues. One exception is the 2006 seclusion guideline, in which it states that:

Ideally, managing seclusion of a person who is resisting aggressively would involve staff of both genders. Where a female person is being secluded, it is important that female staff members are present (Office of the Chief Psychiatrist, 2006 p. 8).

The gender sensitivity and safety within Victorian psychiatric inpatient facilities may be improved through developing guidelines that are more comprehensive than those that are currently available.

Box 1: Victorian policy

Tailoring services to meet the needs of women (1997) makes clear expectations that Victorian mental health services provide care that is accessible, of high quality, and responsive to the needs of women with mental illness.

This document focuses on six priority areas:

1. providing services responsive to the needs of women with mental illness who are parents
2. delivering services responsive to the needs of women with experience of sexual assault
3. developing inpatient and residential services that provide women with adequate safety and privacy
4. delivering services responsive to the needs of older women
5. providing services that are responsive to the needs of women who are carers of people with mental illness
6. increasing participation of women in psychiatric disability support services (pp. 9–10).

For each area, responsive service delivery principles are noted as well as strategies for services to implement. Indicators that measure whether services are responsive to the needs of women are also included. Such indicators relate to intake and assessment at community mental health services, service planning and implementation, medication, crisis intervention, outreach and home-based services, rehabilitation services, hospital administration procedures, use of invasive procedures, and hospital discharge planning. The main themes being family issues (such as alternative care arrangements for dependents, educating families about mental illness and treatment, effect of medication); awareness of sexual, physical, and emotional abuse; basic physical health (including sexual health and contraception); pregnancy (including the possible effect of medications); access to female mental health professionals; and adequate clothing of females while in seclusion.

Non-Victorian state policy

The advisory group identified gender sensitivity and safety policies from New South Wales and Queensland as being exemplary. These policies are summarised in boxes 2 and 3, respectively.

New South Wales policy

To prevent sexual assault, to promote sexual safety, and to improve response strategies in inpatient services, the New South Wales Department of Health (2004) developed *Guidelines for the promotion of sexual safety in NSW mental health services*. The key principles behind the guidelines are:

1. Sexual assault is a crime for which the offender is solely responsible.
2. Sexual assault and sexual harassment are always unacceptable.
3. All persons have the right to the provision of a safe and secure environment whilst in the care of mental health services.
4. All persons have the right to be treated with humanity, dignity and respect.
5. Area health services have the responsibility to provide effective and comprehensive education and training, and policies and procedures aimed at preventing violations and abuse.
6. Consumer involvement is essential in the development of policies and procedures.
7. Clear mechanisms for reporting and investigating allegations of sexual assault are essential and all reports must be followed up immediately with an effective and caring response.
8. Specialist sexual assault services should be involved in responding to all reports of sexual assaults in mental health services (p. 7).

The guidelines' three key areas deal with promoting sexual safety, providing effective responses to people who have experienced sexual assault and developing workplace cultures that support learning about sexual safety. They recommend that to promote sexual safety, services need to develop policy and procedures on risk assessment, managing sexually disinhibited behaviour, the unacceptability of sexual activity in psychiatric inpatient units, and that such units need to be appropriately designed.

To provide effective responses, the duty of care of psychiatric inpatient staff extends to recognising the rights and needs of the person who has experienced sexual assault, the reactions of staff to the disclosure or suspicions of sexual assault, the response of staff to sexual assault, the re-establishment of safety, the recording of the incident, the referral and reporting of the assault, and the follow-up with the patient.

To create a workspace culture that supports learning about sexual safety, several key strategies are recommended: services should engage in developing a mental health service policy, supporting staff who report sexual assaults, providing education and training for consumers and mental health professionals in sexual assault issues, and developing and disseminating resources for consumers and mental health professionals.

The NSW Department of Health suggested that these areas should be supported with adequate monitoring and evaluation.

Box 3: Queensland policy

Queensland Health (2004) developed *Responding to sexual assault and promoting sexual safety within Queensland Health inpatient mental health services* to act as a guide for local services to formulate their own policies on these issues.

The overarching principles in this policy document are:

1. The right of all clients to be treated with respect and dignity. To be provided with information and support where required in relation to the alleged sexual assault, their mental illness and other areas of their lives.
2. Information is provided in a manner that addresses issues of equity and access to ensure the individual needs of the client are met in regards to language, culture, age, disability, gender, sexuality, and capacity.
3. Information is provided in a way that is non-judgmental, appropriate, clear and sensitive to the needs of the client.
4. The safety, physical and psychological needs of the client are of paramount consideration.
5. The client's right to privacy and confidentiality will be respected at all times.
6. The client's informed decision will be respected at every stage of the process.
7. The client's sense of personal control will be supported and encouraged.
8. Adequate and appropriate support is provided to assist the client in making informed choices and decisions.
9. Sexual safety for clients, staff, carers and visitors within inpatient mental health services is promoted and facilitated.
10. Up-to-date and comprehensive information about external service options is provided and access to those services is facilitated on request.
11. Comprehensive care management plans are developed to ensure effective and appropriate treatment and health care management is provided.
12. All allegations of sexual assault are comprehensively documented and accurate records are kept. Documentation and records are prepared in accordance with stated Queensland Health requirements and issues of privacy and confidentiality are adhered to (p. 5).

The guidelines include information about sexual assault; responding to a report of recent sexual assault; past sexual assault and sexual abuse (including advice for managing such cases); sexual harassment; sexual safety; risk assessment; assessment of vulnerability; identifying and responding to sexually disinhibited behaviour; policies regarding sexual relationships; sexual relationships between staff and patients; impaired capacity; follow-up support and referral; safety in design of mental health services; confidentiality documentation and record keeping; staff support and debriefing; education and information provision for staff; education and information for clients, family members and significant others; service access, availability and promotion; and evaluation.

International policy

Some international policymakers have focused on gender sensitivity and safety issues through segregating male and female patients. The Department of Health (2002a) in the UK, for example, has encouraged the redesign of mental health services with recommendations that:

- each acute service provides a self-contained women-only inpatient unit with clear criteria for admission
- consideration is given to alternatives to inpatient admission (such as women-only crisis house, crisis resolutions/home treatment)
- staffing arrangements ensure women have adequate access to women staff at all times, particularly with regard to choice of a key worker, control and restraint, physical health care and counselling (p. 24).

There are different positions within UK policy with regard to single-sex units and access to female staff. The Department of Health (2002b) agreed that some women will need access to female-only services at particular stages of their treatment, but, at other times, may benefit from care in a mixed-gender setting. The Department of Health, however, does not support sexual discrimination in appointing staff, and state that, with training, staff of either gender can care for patients of the opposite sex and may provide satisfactory role models for their patients, which might otherwise have been lacking.

The World Health Organization (Dennerstein, Astbury and Morse, 1993; Gomel, 1997; World Health Organization, 2000) has a number of publications noting sex differences in the prevalence, onset and course of mental disorders. They recommend that gender is incorporated into service planning, using a public health approach, to address gender-specific risk factors and gender-based discrimination and violence in psychiatric facilities, and to provide education and training for workers to incorporate a gender-sensitive perspective in practice.

Summary

In the literature on gender-related issues in adult acute inpatient units, several issues have been identified, including violence, sexual assault, victimisation and re-traumatisation, and culture and religion. These issues have been addressed to varying extents in interventions designed to improve the care of women patients (such as single-sex units, trauma-informed services) and in local and international policies. Several challenges for psychiatric inpatient facilities remain, such as meeting the needs of women with dependent children, reducing sexual harassment and assault within ward environments, responding to trauma without re-traumatising patients, being inclusive of diversity, and providing single-sex areas within units. To meet these challenges, Victorian policies need to be strengthened. Drawing on exemplar policies from other jurisdictions may be of assistance in completing this task.

Method

In this section, an overview is provided of the methods used in this project, which include key stakeholder interviews, a local mental health policy audit, an inpatient unit audit, and an environmental grant funding review.

Key stakeholder interviews

Semi-structured interviews were conducted with key stakeholders based around the theme of gender sensitivity and safety in psychiatric inpatient units. The key stakeholders who were interviewed were representatives from the Victorian Mental Illness Awareness Council, the Community Visitors Program (Office of the Public Advocate), and the Mental Health Legal Centre, as well as one mental health service consumer.

Local mental health service policy audit

A review of Victorian mental health services policies related to gender sensitivity and safety in acute inpatient setting was undertaken. All Victorian mental health services were invited to submit policies. The audit focused on service-specific inpatient unit policies that related to delivering gender-sensitive treatment, promoted inpatient safety, and provided the direction for the reporting of, and response to, breaches of inpatient safety, especially with regard to incidents of sexual assault.

The policies were reviewed using an audit tool. This tool was designed to assist in the auditing of policies regarding staff responses to allegations of physical or sexual assault, and has 32 items representing seven domains. These domains are: scope of policy (13 items), reporting requirements (five items), medical support (one item), Centre Against Sexual Assault (two items), reporting requirements (two items), procedures for staff (seven items), and currency (two items). For each item the response categories were *yes*, *partial*, and *no*. Comments for each item could also be provided. The audit tool is provided in Appendix B.

Inpatient unit audit

Visits to five metropolitan and two regional acute psychiatric inpatient units were conducted. A standardised observational and interview schedule (Appendix C) was used to guide the visits and to collect information on what was working well in inpatient settings to improve the safety of vulnerable clients, as well as what barriers impede gender sensitivity and safe care. To assist the services in preparing for the audits, copies of the audit tools were provided ahead of the visit. Key informants were unit managers, clinical team members, clinical nurse educators, and consumer and carer consultants.

Environmental grant funding review

During the course of the gender sensitivity and safety project, one-off Environmental Improvement Grants, of \$20,000 per adult psychiatric inpatient unit, were provided to 20 mental health services in Victoria. The purpose of the funding allocation was for services to make inpatient environmental alterations to enhance safety and contribute to a sense of security among female clients.

In making alterations to improve the physical environment for female consumers, services were asked to consider the relevant recommendations of the policy *Tailoring services to meet the needs of women 1997* (Mental Health Branch, 1997) and the principles within this document. The services were asked to provide feedback on service improvements being undertaken and descriptive examples of practice changes resulting from the Environmental Improvement Grant funding.

Results

In this section, the results of the project are provided. Results are presented for the key stakeholder interviews, the local mental health policy audit, the inpatient unit audit, and the environmental grant funding allocation.

Key stakeholder interviews

Several themes emerged from the interviews. These themes include safety of women, management of sexual assault allegations, re-victimisation and re-traumatisation, and gender-specific space.

Safety of women

The key stakeholders reported that many women did not feel safe in inpatient units. Aspects of inpatient units that reduced perceptions of safety included mixed-sex areas, an inability to lock rooms or protect belongings, and limited privacy in bathrooms and toilets. For example, one key stakeholder talked of women having men walk into their bedrooms at night or into bathrooms when they were using them. Although this behaviour was sometimes disorganised and unintentional rather than predatory, it contributed to a general sense of insecurity among female patients.

The occurrence of sexual activity within psychiatric inpatient facilities was a concern of many key stakeholders. While in psychiatric wards, female patients are often vulnerable, particularly to predatory sexual behaviour. For example, one key stakeholder reported an anecdote of a female patient who was told by a male patient that her husband had left her and then pressured her to have sex with him. When her husband came into the ward the male patient told him she was having sex with other men.

Management of sexual assault allegations

A concern of all key stakeholders was how staff in psychiatric inpatient facilities responded to allegations of sexual assault. Consumers and the Community Visitors Program, in particular, highlighted this issue. The concerns related to the limited uniformity in the complaint management processes between services and to the lack of responsiveness and timeliness of investigations. All key stakeholders thought there should be mandatory reporting of alleged sexual assault in mental health settings.

Re-victimisation and re-traumatisation

Some key stakeholders reported that the responses of staff in psychiatric inpatient facilities to women's past experiences of assault were limited. Further, the key stakeholders expressed concerns that the inpatient unit was often traumatic for women, and sometimes retriggered past traumas. They stated that there seemed to be limited awareness of these issues among staff and that the extent to which staff used other agencies, such as Centre Against Sexual Assault, was variable.

Key stakeholders perceived that balancing the competing needs of patients in critical situations was a difficult challenge for staff. For example, one key stakeholder provided an anecdote of a female patient witnessing a staff member managing a patient who had become violent and agitated. Other patients were asked to go to their rooms while staff calmed and supported the patient, thereby avoiding the use of seclusion. Although this intervention was described as being supportive of the agitated patient, a female patient who had witnessed the event complained about the intervention, stating that she had felt punished because of someone else's behaviour and thought violence was being rewarded.

Gender-specific space

All informants thought women should have the choice of gender-separate areas.

Local mental health policy audit

Policies were received from five Victorian services. The policy of one service was not audited because it focused on sexual vulnerability rather than gender sensitivity and safety. The service-level policies from the other four services were limited with regard to gender sensitivity and safety. In this audit, three of the four services did not adequately include the following items in their gender sensitivity and safety policies:

- prevention of sexual assault
- visitors as perpetrators
- principles about responding to allegations of sexual assault
- inclusion of risk assessments
- contact details for the local Centre Against Sexual Assault.

None of the policies covered the:

- definition of physical assault
- requirement to report incidents to police.

There was variation between service policies in the inclusion of the remaining audit items. Generally, two services included these items, and the remaining two services did not address them.

Through the audit, however, one exemplar policy from a Victorian mental health service was evaluated. This policy from NorthWestern Mental Health is provided in Appendix D. Accompanying the policy is a set of guidelines and an informative poster. These documents assist mental health staff inquiring about, and responding to, sexual abuse of mental health service consumers. The guidelines provide good practice principles, a definition of sexual abuse, and contacts for specialist sexual assault services.

Inpatient unit audit

The findings of the inpatient unit audit are separated into seven sections: patient choice regarding the gender of treating clinicians; involvement of service-level leadership, multidisciplinary approaches and consumer consultants; design and ongoing investment of inpatient units; policies and procedures; minimising re-victimisation and re-traumatisation; privacy, safety, and vulnerability in high dependency units (HDU); and incorporating gender issues in staff training. These findings are detailed below.

Patient choice regarding the gender of treating clinicians

Clinicians in psychiatric facilities endeavoured to give patients a choice of whether they received care from male or female nurses and doctors. For consumers who are known to staff, there is often an endeavour to allocate the same primary nurses who cared for them on previous admissions. Sometimes allocation of staff to meet these preferences is challenging because of gender imbalances within the treating teams.

Service-level leadership, multidisciplinary approach and consumer consultant involvement

Psychiatric inpatient units that had a strong emphasis on providing gender-sensitive and safe patient care typically had clinicians responsible for and providing leadership in this area, multidisciplinary approaches to managing such issues, and the active involvement of consumer consultants.

Although the auditors requested consumer consultants be involved in the inpatient unit audits, this was not achieved on most visits. Consumer consultants who were involved observed that their involvement was a positive factor influencing all staff being more attuned to providing gender-sensitive care. One consumer consultant perceived that his inclusion within the treating team, clear and open staff communication, a multidisciplinary and open-minded approach to care, and strong awareness of trauma and assault issues contributed to a safer ward milieu. The consumer consultant of another service noted that the ward environment could be improved, and that the unit manager was attempting to increase the ambience and the facilities.

Design of and investment in inpatient units

In some of the inpatient units, the ward layout allowed for male and female patients to be separated. In these units, there was wide variation in the levels of security provided for patients. Due to the physical layout of wards in the other units, maintaining separate male and female areas was more difficult. Whether physical separation occurred or not, however, staff were aware of the vulnerability of female clients and increased their safety through observation, not allowing patients in each other rooms, and locating the most vulnerable patients nearest to nursing stations.

In general, the accommodation within Victorian acute inpatient units consists of single rooms with ensuite bathrooms. Some units have a number of conjoined rooms, which share an ensuite between them. Nurse managers interviewed pointed out that in these instances they endeavour to assign patients of the same sex to the adjoining bedrooms and that there are locks on ensuite doors. In inpatient units, where ensuites were not available, secure separate-sex toileting and bathing facilities were provided.

There was wide variation between inpatient units regarding the capacity to, and the practice of, locking bathroom and bedroom doors. In some units, patients could lock doors to achieve privacy and staff could override these locks if necessary. In other units, however, no locks were provided on doors. The locking of bathroom and bedroom doors is an issue of noted concern to service management. Of the units visited, staff were exploring solutions to enable patients to gain privacy without risking their safety (for example, to enable staff access if patients barricaded themselves inside their rooms).

Most inpatient units reviewed in the audit did not provide a female-only day lounge for patients, which is a recommendation of *Tailoring services to meet the needs of women* (1997). Staff and consumers at some units, however, identified that it would be desirable to have female-only lounges, and plans were underway to provide such areas instigated by the \$20,000 Environmental Improvement Grants.

Inpatient unit staff reported that family visiting areas were generally available in their services. In one case, a family visiting area was located proximal to a women's-only area, which meant that visiting children did not need to be in the main ward. Concern was expressed however, over the adequacy of available space for families in other services. Staff reported limitations in the family visiting areas, such as visitors having to walk down the bedroom hallway to access the family area, the small size of visiting rooms, the difficulties in supervising such areas, and the immediate need to frequently use such space for other purposes.

Staff at the psychiatric inpatient units visited identified several priority interventions that they thought would improve the delivery of gender-sensitive practice in safe environments. These interventions can be synthesised into five main themes:

1. A range of structural and organisational changes that need to occur in the units. Changes included defined male- and female-only areas within wards, locked corridors, quiet sensory rooms that are protected and safe, sensor alarms operating at night, areas for recreation that include female-only spaces, more accessible spaces in which families can meet with patients, and satisfactory door locking mechanisms.
2. The development of informative material for patients, which includes input from key stakeholder groups, such as Centres Against Sexual Assault.
3. The development of ward-based programs to meet gender-specific needs.
4. Additional professional development for staff, with specific emphasis on trauma-based models of service delivery with specific reference to sexual abuse.
5. The employment of additional staff, specifically female consumer consultants and full-time psychologists.

Policies and procedures

Staff at the inpatient units used a wide range of practices to assist in creating a sense of safety for female and markedly vulnerable patients. In some units, staff attended to structural issues, such as separating male and female bedrooms and using an 'out-of-the-fishbowl' nursing desk in the patient lounge with a staff member working from the desk at all times. One facility had a motion sensor system that registered night-time movement in corridors on a board in the nurse's station. Two facilities limited the use of mobile phones.

Most facilities used nursing practices to support the safety of female and markedly vulnerable clients. Such practices included risk assessments incorporating vulnerability assessments, using higher levels of observation for those identified as being at risk, details of risk assessments and observations being handed over between shifts, engaging patients in group programs and activities so as they remained occupied, therapeutic activities focusing on gender issues, including gender awareness within clinical supervision, involvement of the consumer consultant as part of the treatment team, and using Centres Against Sexual Assault for secondary consultation around difficult issues. One service was developing an inpatient admission brochure for consumers on privacy that was to provide guidance regarding self-care responsibilities.

Most inpatient units had policies (formal and informal) that did not permit sexual activity between consumers within the services. On one unit, a proactive measure was taken with patient orientation materials incorporating guidelines prohibiting sexual behaviour within the unit. In this unit, the consumer consultant worked as part of treatment team, attending clinical and community meetings, and explaining acceptable behavioural norms for the unit to inpatients. Staff at another unit provided education for their workforce about relationship boundaries.

Inpatient unit staff responded to incidents of sexual activity in a variety of ways, including reporting the activity to senior management, notifying police, monitoring client behaviour, separating patients who have engaged in sexual activity, and organising sexually transmitted disease (STD) and pregnancy testing.

Most inpatient unit staff reported that policy and procedures existed to guide staff actions when a possible sexual assault was reported. During the inpatient audit however, not all policy documents were immediately available for review. When detailed content of policy was available, sound procedures were described.

Staff at four of the units reported a total of nine alleged incidents of sexual assault during the previous six months; the range was zero to six incidents per unit. The staff from the other three units, who were unsure of the frequency of alleged incidents of sexual assault in their facilities, were able to recall two incidents between them.

When there were incidents that occurred during hospitalisation, staff at some facilities indicated that they debriefed consumers after the event.

Minimising re-victimisation and re-traumatisation

Services varied in the extent to which they inquired into, and recorded, whether patients had histories or recent experience of sexual abuse, violence, or both types of trauma. In some inpatient units, this type of information was routinely collected, whereas in other organisations no written policy or procedural documentation was evident. In some units, staff were experienced in the areas of sexual assault and mental health, and used their knowledge to recognise behaviours of patients that may be indicative of having experienced sexual abuse or violence. There was also variation between units in how staff acted upon information indicating that patients had experienced sexual abuse or family violence. Some organisations included this information in the individual care plan, as well as using it to determine the extent to which nurses observed patients, to allocate staff to patients (considering gender and personality factors), and to ascertain the need for services (such as Centre Against Sexual Assault, clinical psychologist). In units where a comprehensive inquiry of sexual abuse and family violence issues was not undertaken, staff sometimes noted behaviours that raised concerns (such as self-harm, fearfulness, withdrawal).

Changing clinical practice to minimise the re-traumatisation of patients with histories of trauma when they are admitted to psychiatric units appears to be an emerging issue. Although some facilities have given little consideration to this issue, other organisations have policies on responding to people with histories of past trauma, and training programs in place to facilitate their implementation.

Privacy, safety, and vulnerability in high dependency units

There was broad variation in the practices of HDU staff, and in the environments in which they worked. Some environments presented major challenges to staff in protecting patient privacy, safety, and vulnerability. The limitations inherent in such environments may however be partially compensated for with changes to staff practices. In an area of one HDU for example, staff leave male and female patients unmonitored and there were no call buttons for patients to use. Some services report improving care of high dependency patients by including practices, such as not routinely putting patients into pyjamas, not asking female patients to give up their underclothes or to wear hospital gowns when they are secluded, and having nurses lead emergency responses to aggression rather than security personnel. Of note were high dependency facilities that accommodated patients being able to lock their doors and which were designed to allow nursing staff to have a good line of vision to enable observation at all times.

Incorporating gender issues in staff training

Limited information about gender issues was available to staff being inducted to work within inpatient units. Gender safety was typically addressed in an informal manner and occurred via clinical team interactions and was specific to individual patient needs. Some staff stated that training and development approaches that focused on gender safety and trauma informed care would be beneficial.

Environmental grant funding review

The funding allocated to each area mental health service for the Gender Sensitivity Environmental Grants (\$20,000 per inpatient unit) was sufficient to identify and complete a range of projects.

In deciding how to improve gender sensitivity and safety within inpatient units through the allocated once-off environmental grants, staff in each of the inpatient units engaged in collaborative processes with consumers. The methods by which consumers were consulted about possible improvements differed between services. Examples of how consumers were consulted include:

- using consumer consultants to meet with female consumers during inpatient unit community meetings
- individually consulting with female patients during planning, purchasing of materials and redevelopment activities
- discussing the progress of the implementation of the changes with female patients
- obtaining consumer feedback through workgroups, focus groups and consumer feedback cards
- involving female consumers in project meetings.

Services developed a variety of initiatives to improve gender sensitivity and safety in their acute inpatient units. These initiatives can be grouped into three main themes:

1. creating female-only spaces
2. improved security (locks)
3. improved privacy.

Examples of the initiatives for each of these themes are listed in Table 1. A description of one initiative is provided in Box 4.

Table 1: Initiatives to improve gender sensitivity and safety in psychiatric inpatient units

Theme	Examples
Creating female-only spaces	Female-only quiet room (2)
	Upgraded family room
	Female-only 'self-soothing' space (massage chair, hairdressing)
	Decorative changes to improve inpatient experience
	Female/family-only room (2)
	Female-only areas (3)
Improved safety	Locks on bedroom doors (2)
	Sensors on HDU doors (2)
	Locks on bathrooms
	Dome mirror (improved visual observation of corridors)
	Portable duress systems
	Female-only bathroom and toilets
Improved privacy	Screening curtains for shared bedrooms
	Reflective windows on bedrooms facing courtyards and walkways

Box 4: Environmental Improvement Grant at Alexander Bayne Centre

The Environmental Improvement Grant awarded to this service enabled staff to improve the homeliness of the female-only areas, to establish a private courtyard for female patients, and to expand female-only group programs (to include self-care/pampering, gardening and leisure groups). Decisions on how best to spend the grant funding were based on consumer preferences, consultations with staff, research and literature, and the existing physical layout of the unit.

In the initial planning phase of the project, female consumers were individually asked to provide feedback on how the ward environment could be enhanced to increase their feelings of safety and privacy. Common suggestions emerged from their responses, which were used as the foundation for purchases and redevelopments. Following the first phase of the project, staff reviewed the funding situation. Further consultations with consumers were then conducted to seek their opinions on what additional changes could be made.

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Several changes were made within the inpatient unit. A timeworn room at the end of a corridor has been repainted, using subtle warmth in colour, and redecorated to create a cared for and homely female-only space. The room has been stocked with books, magazines, DVDs and games to provide a relaxing retreat from the mixed-gender areas. Glass doors that were permanently open have been closed to reduce noise and further delineate the area. Female patients have been provided access to a small garden and lawn area that is fenced off from the mixed-gender area. Rebecca, a horticulturalist with Bendigo Health, has redeveloped this drought-stressed area for the patients. She has created a natural sensory haven for female patients with care having been taken to comply with rigid health and safety restrictions (such as no thorns, no poisonous bulbs or plants, no climbing points or tripping or drainage hazards). Recycled water is used from air conditioning units. Attractive garden furniture has been added. Staff now have the resources to enable them to offer activities for women, such as gardening or pamper sessions. This work-in-progress is an exciting project with some unexpected flow on results. The project has raised awareness and interest in what creates a safer, gender-responsive environment on the acute ward.



Rebecca, a horticulturalist with Bendigo Health, working on the female-only garden.

Some services identified improvements to their inpatient environments that did not require additional funding. These improvements included:

- initiating female-only gym groups
- developing female-only group programs that included activities, such as self-care and pampering, gardening, and leisure
- incorporating a gender sensitivity plan into business and quality planning processes.

The Environmental Improvement Grants also served to raise awareness about gender sensitivity and safety issues. The collaboration between consumers, carers, clinicians, and service managers promoted rich learning and provided the impetus for ongoing quality improvement and education initiatives. An example of such an initiative is the gender sensitivity project (*KYA WEAVE*) at Peninsula Health (see Box 5).

Box 5: KYA WEAVE

To improve the care of women within mental health services, health care professionals from Peninsula Health and Monash University (J Barnfield, F Reed, C Hoppner and K McCauley) obtained \$8,000 from their cluster to develop and deliver an education package on gender sensitivity. Invited professional, consumer, and carer representatives will assist in this process. The title of the project *KYA WEAVE* contains the indigenous term *kya*, meaning ‘wise women’, and an acronym *WEAVE* that represents the outcomes to be achieved for women (Wellbeing/Worth, Empowerment, Advocacy, Voice/Value, Enlightenment).

The goals and objectives of this project are to:

1. provide staff with knowledge and skills to enhance understanding and attitude of the development and delivery of women-sensitive practices in a supportive environment
2. develop, deliver, and monitor a comprehensive staff training package that is evidence based
3. enhance the planning and delivery of gender-sensitive care within mental health services
4. evaluate the knowledge, skills, and attitudes of staff as a direct result of implementing gender-sensitive practices.

Findings

In this section, the key findings of the project are reported.

Overall findings

1. There are key gaps within, and variable implementation of, existing Department of Human Services and service-level policy relating to gender sensitivity and safety.
2. There is evidence of effective strategies from other jurisdictions, and locally within services, but the challenge is systematically implementing policy.
3. There is a need for Mental Health Branch and service-level leadership to ensure sustainable policy implementation.
4. This project increased awareness of gender sensitivity and safety issues within services.

Literature and policy review

1. There has been a lack of alternatives to psychiatric hospital admission when problems became overwhelming for women with dependant children, with the result that children had to be placed in care.
2. Hospitalised women have been at risk of sexual harassment and assault from other patients and staff.
3. Many female consumers have experienced abuse, trauma and violence, both within mental health services and at other times during their lives. Inpatient care has frequently triggered feelings of powerlessness and has re-traumatised female consumers.
4. Gender sensitivity needs to be inclusive of diversity, including culture and religion.
5. Although there is evidence of women's lack of safety on mixed-sex wards, the efficacy of providing single-sex wards remains equivocal within the literature.
6. Victorian policy on gender sensitivity and safety is limited.
7. Exemplary gender sensitivity and safety policies are available from other jurisdictions.
8. Tailoring services to meet the needs of women (1997) remains a relevant policy.

Key stakeholder interviews

1. Gender sensitivity and safety are key issues across all inpatient units.
2. The processes by which sexual assault allegations are managed differ between services and lack of responsiveness and timeliness with investigations is common.
3. Inpatient units can re-traumatise consumers.
4. Stakeholders emphasised the importance of women-only areas and supported the idea of women-only wards.

Local mental health policy audit

1. There is inconsistency in service-level policies related to gender sensitivity and safety, including:
 - prevention of sexual assault
 - visitors as perpetrators
 - principles about responding to allegations of sexual assault
 - inclusion of risk assessments
 - contact details for the local Centre Against Sexual Assault
 - definition of physical assault
 - the requirement to report incidents to police.
2. Exemplary service-level policy on gender sensitivity and safety has been identified in one Victorian mental health service.

Inpatient unit audit

1. There is strong interest and commitment towards improving gender sensitivity and safety.
2. The active involvement of consumer consultants within inpatient units seemed to promote gender sensitivity and safety issues.
3. Environments are limited by the unit design.
4. There is variability in health services' investment in environmental maintenance to promote a positive ward atmosphere.
5. All services demonstrated some level of innovation; none had a comprehensive approach in the development of policies and procedures.
6. Care planning to minimise re-victimisation and re-traumatisation is not systematic.
7. Measures to protect privacy, safety and vulnerability were more difficult to implement in HDU areas.
8. No services included gender issues in their training programs.

Environmental grant funding review

1. Funding stimulated local processes for services to consult with consumers about environmental improvements.
2. The process identified some improvements that did not need additional funding.
3. Services have used the funds in different ways.
4. \$20,000 was a sufficient amount of money to stimulate valuable improvements, but there are continuing needs.

Recommendations

There are eight main recommendations from this report.

1. Department of Human Services – Mental Health Branch guideline development

The Mental Health Branch should develop guidelines on gender sensitivity and safety in inpatient units. These guidelines should take into account:

- policies and procedures needed at the local level to ensure services promote safety and are responsive to gender needs
- practical examples of good practice that can be shared
- inclusion of an implementation plan that incorporates training for staff in orientation and induction programs, as well as training tools
- trauma-informed care for patients with a history of physical and sexual assault, including referral to specialist services where appropriate, that is inclusive of vulnerability issues (such as triggering of previous abuse experiences)
- strategies to support the implementation of the guidelines.

2. Service key performance indicators

The Mental Health Branch should review key performance indicators and consider developing additional indicators to monitor mental health services' performance on gender.

3. Allegations of sexual assault

The Chief Psychiatrist should develop clinical guidelines on responding to allegations of sexual assault, including thresholds and processes for reporting incidents to the Department of Human Services.

4. Sexual safety on inpatient units

The Chief Psychiatrist should develop clinical guidelines on preventing and responding to sexual activity and promoting sexual safety on acute inpatient units.

5. Choice of single-sex inpatient treatment environment

The Department of Human Services should adopt a policy of providing choice for patients to be treated in single-sex environments. This policy should be incorporated into the design guidelines for adult acute inpatient units, thereby ensuring that future units provide single-sex treatment environments. In adopting this policy, creative strategies to provide single-sex environments, such as designating or developing female-only wings, should also be implemented within existing units.

6. Annual provisions

The Department of Human Services should explore opportunities to improve the gender sensitivity of current bed-based environments through existing annual provision processes with priority on:

- single-sex choice of space within existing ward environments
- encouraging local planning processes, such as establishing local committees
- facilitating door-locking systems for patient bedroom and bathroom areas
- improving safety within HDU areas.

7. Steering committee

A steering committee should be established to monitor the implementation of these recommendations and provide advice to the Director of Mental Health on additional strategies. Membership should be sought from key stakeholders including the Victorian Mental Illness Awareness Council (VMIAC), the Victorian Women and Mental Health Network (VWMHN), Carers Network, Office of the Public Advocate, and mental health service representatives.

8. Evaluation

The outcomes of this project should be formally evaluated by 2011.

References

- Australian Bureau of Statistics 2007, *2007 Yearbook Australia*. Commonwealth of Australia, Canberra.
- Cleary, N and Warren, R 1998, An exploratory investigation into women's experiences in a mixed sex psychiatric admission unit. *Australian and New Zealand Journal of Mental Health Nursing*, 7, 33–40.
- Cusack, Frueh and Brady 2004, Trauma History Screening in a Community Mental Health Center. *Psychiatric Services*, 55, 157–162.
- Dennerstein, L, Astbury, J and Morse, C 1993, *Psychosocial and mental health aspects of women's health*. World Health Organization, Geneva.
- Department of Health 2002a, *Mental health policy implementation guide: Adult acute inpatient care provision*, London.
- Department of Health 2002b *Women's mental health: Into the mainstream. Strategic development of mental health care for women*, London.
- Department of Human Services 1997, *Tailoring services to meet the needs of women*, Melbourne.
- Department of Human Services 2004, *Victorian strategy for safety and quality in public mental health services 2004–2008*, Melbourne.
- Department of Human Services 2006, *Building partnerships between mental health, family violence and sexual assault services: Project report*. Melbourne.
- Department of Human Services 2006, *Chief Psychiatrist Guideline, Seclusion*, Melbourne.
- Elliott, D E, Bjelajac, P, Fallot, R D et al. 2005, Trauma informed or trauma denied: Principles and implantation of trauma informed services for women. *Journal of Community Psychology*, 33, 461–477.
- Fong, R and Furuto, S (Eds.) 2001, *Culturally competent practice skills, inventions and evaluations*. Pearson Allyn and Bacon, Boston.
- Ford, E, Rosenberg, M, Holsten, M et al. 2003, Managing sexual behaviour on adult acute care inpatient units. *Psychiatric Services*, 54, 346–350.
- Foundaton House 2005, *Sexual violence and refugee women from West and Central Africa Victorian Foundation for Survivors of Torture*, Melbourne.
- Frueh, B C, Knapp, R G, Cusack, K J, et al. 2005, Patient's reports of traumatic or harmful experiences within the psychiatric Setting. *Psychiatric Services*, 56, 1123–1133.
- Garcia-Moreno, C, Jansen, H A F M, Ellsberg, M 2006, Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, 368, 1260–1269.
- Gerrand, V 1993, *The patient majority: Mental health policy and services for women*. Centre for Applied Social Research, Deakin University, Melbourne.
- Gomel, M K 1997, *A focus on women*. World Health Organization, Geneva.
- Graham, C 1994, *Certified Truths. Women who have been sexually assaulted-their experience of psychiatric services*. Southeast Centre Against Sexual Assault, Monash Medical Centre Melbourne.
- Hatch-Maillette, M A and Scalora, M J 2002, Gender, sexual harassment, workplace violence, and risk assessment: Convergence around psychiatric staff's perceptions of personal safety *Aggression and Violent Behaviour*, 7, 271–291.
- Hawthorne, D, McKenzie, A and Dawson, J 1996, *Critical admissions: A study of family violence, physical and sexual abuse in a psychiatric inpatient population.*, Institute of Psychiatric Nursing Research, Royal Park Hospital, Melbourne.

Healthcare Commission 2005, *The national audits of violence (2003-2005): Final report*. The Royal College of Psychiatrists' Research Unit, Healthcare Commission, London.

Hodgins, S 1992, Mental disorder, intellectual deficiency and crime: Evidence from a birth cohort. *Archives of General Psychiatry*, 49, 476-483.

Hutchings, P S and Dutton, M A 1993, Sexual assault history in a community mental health centre clinic population. *Community of Mental Health Journal*, 29, 59-63.

Krakowski, M and Czobor, P 2004, Gender differences in violent behaviours: Relationship to clinical symptoms and psychosocial factors. *American Journal of Psychiatry*, 161, 459-465.

Lelliott, P and Quirk, A 2004, What is life like on acute psychiatric wards? *Current Opinion in Psychiatry*, 17, 297-301.

Mental Health Branch 1997, *Tailoring mental health services to meet the needs of women*. Aged, Community and Mental Health Division, Victorian Department of Human Services, Melbourne.

Mezey, G, Hassell, Y and Bartlett, A 2005, Safety of women in mixed sex and single sex medium secure units: Staff and patient perceptions. *British Journal of Psychiatry*, 187, 579-582.

Morrow, M 2002, *Violence and trauma in the lives of women with serious mental illness: Current practices in service provision in British Columbia*. Columbia Centre of Excellence for Women's Health, Vancouver.

Morrow, M and Chappell, M 1999, Hearing women's voices. *Mental health care for women* British Columbia Centre for Excellence for Women's Health, Vancouver.

Mueser, K T, Goodman, L A and Trumbetta, S L 1998, Trauma and post traumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66, 493-499.

National Patient Safety Agency 2006, *With safety in mind: Mental health service and patient safety*, London.

New South Wales Department of Health 2004, *Guidelines for the promotion of sexual safety in NSW mental health services* (2nd ed) North Sydney.

Queensland Health 2004, *Responding to sexual assault and promoting sexual safety within Queensland Health inpatient mental health services*, Brisbane.

Quirk, A and Lelliott, P 2001, What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Social Science in Medicine* 53, 1565-1574.

Saeed, A 2004, *Muslim Australians. Their beliefs, practices and institutions. A partnership under the Australian Government's Living in Harmony initiative.*, Commonwealth of Australia, Canberra.

Sainsbury Centre for Mental Health 1998, *A survey of the quality of care in acute psychiatric wards*, London.

Saunders, B E, Kilpatrick, D G, Resnick, H S et al. 1989, Brief screening for lifetime history of criminal victimisation at mental health intake. *Journal of Interpersonal Violence*, 4, 267-277.

Swanson, J, Holzer, C and Ganju, V 1990, Violence and psychiatric disorder in the community: Evidence from the epidemiological catchment area survey. *Hospital and Community Psychiatry*, 41, 761-770.

World Health Organization 2000, *Women's Mental Health: An evidence based review*, Geneva.

Appendix A: Policies reviewed

Organisation	Policy
Department of Health (United Kingdom)	<i>Mainstreaming gender and women's mental health implementation guidance</i> (2003)
	<i>Mental health policy implementation guide: Adult acute inpatient care provision</i> (2002)
	<i>Women's mental health: Into the mainstream – Strategic development of mental health care for women</i> (2002)
Department of Human Services (Victoria)	<i>Building partnerships between mental health, family violence and sexual assault services – Project report</i> (2006)
	<i>Responding to allegations of physical or sexual assault</i> (2005)
	<i>Responding to allegations of physical or sexual assault – Departmental instruction</i> (2005)
	<i>Victoria's mental health services – Tailoring services to meet the needs of women</i> (1997)
	<i>Victorian strategy for safety and quality in public mental health services 2004–2008</i> (2004)
Mental Health Branch, Commonwealth Department of Health and Family Services (Australia)	<i>National practice standards for the mental health workforce</i> (2002)
	<i>National standards for mental health services</i> (1997)
New South Wales Health	<i>Guidelines for the promotion of sexual safety in NSW mental health services</i> (2nd ed.) (2004)
Office of the Chief Psychiatrist (Victoria)	<i>Access to beds</i> (1997)
	<i>ECT manual licensing, legal requirements and clinical practice guidelines</i> (2002)
	<i>High dependency unit guidelines</i> (2002)
	<i>Illicit substance use in acute inpatient mental health services</i> (2001)
	<i>Mechanical restraint</i> (2006)
	<i>Non-psychiatric treatment and special procedures</i> (2005)
	<i>Physical examination, annual examination and attention to client's general medical health needs</i> (2002)
	<i>Seclusion</i> (2006)
	<i>Working with families and carers</i> (2005)
Queensland Health	<i>Responding to sexual assault and promoting sexual safety within Queensland Health inpatient mental health services</i> (2004)
	<i>Response to sexual assault: Interagency guidelines for responding to adult victims of sexual assault</i> (2001)
World Health Organization	<i>A focus on women</i> (1997)
	<i>Psychosocial and mental health aspects of women's health</i> (1993)
	<i>Women's mental health: An evidence-based review</i> (2000)

Appendix B: Local mental health service policy audit tool

Gender Sensitivity and Safety in Adult Acute Mental Health Inpatient Units

Audit Tool for Policies Responding to Allegations of Physical or Sexual Assault

	Yes	Partial	No	Comment
Scope of policy				
Does the policy recognise DHS Policy and guidelines?				<i>Comment if it notes which policy it is referring to</i>
Does the policy cover allegations of sexual assault?				
Does the policy address preventative measures?				
Does the policy include definition of sexual assault?				<i>Note here whether the definition is consistent with DHS definition</i>
Does the policy include a definition of physical assault?				
Are there any types of sexual or physical assaults excluded from the policy (list in comments)				
Does the policy cover all patients as victims?				
Does the policy cover staff as perpetrators?				
Does the policy cover patients as perpetrators?				
Does the policy cover visitors as perpetrators?				
Does the policy outline principles about responding to allegations of SA (i.e. rights, believing etc) for the organisation/unit?				
Risk assessment				
Does the policy include a consideration of risk assessment?				
Reporting requirements				
Does the policy require mandatory reporting of the incident to police?				
Is consent required to report the incident to police?				
Are there any exceptions to mandatory reporting? (list in comments)				
Does the policy outline responses if person doesn't want the incident reported?				
Does the policy cover protection of incident?				
Medical support				
Does the policy indicate the type of medical support that should be available?				
CASA				
Does the policy indicate in what circumstances CASA should be contacted?				
Does the policy include contact details for the local CASA				

Reporting				
Does the policy outline incident reporting procedures?				
Does the policy identify escalation procedures in case of sexual and/or physical assaults?				
Procedure for staff				
Are there clear procedures to follow if the assault occurred from a consumer; visitor; staff member?				
Does the policy outline what an 'adequate' response by staff to the consumer might entail (i.e. counselling, assessing safety needs etc), which go beyond a purely medico/legal response				
Does the policy provide information about debriefing for staff if they have been involved in counselling/responding to a consumer who has disclosed SA?				
Does the policy suggest what emotional support the consumer ought to be provided with following a SA? (this could be internal or external support)				
Does the policy indicate in what circumstances the next of kin should be notified?				
Does the policy consider the role of an independent advocate?				
Does the policy consider prevention of future contact between the victim and the perpetrator?				
Currency				
Is the policy current?				
Does it have a review date?				

Appendix C: Standardised observational and interview schedule for the inpatient unit audit

Unit #	Reviewer	Date:	Info Source	Observation/ Evidence	Yes	No	Comment
	Practice Questions						
1A	On admission -do staff inquire & record whether pts have HX of/or current issues with, sexual abuse, & /or family violence?						
1B	How are these issues addressed in terms of care planning to minimise re victimisation and traumatisation?						
2	What assessment practices identify sexual vulnerability /risk for both newly admitted and existing in-patients?						
3A	Do pts have a choice (male or female) of contact nurse and /or DR?						
3B	Is this possible at all hours whether the consumer is in HDU/seclusion or an open unit?						
4A	What measures are taken to protect privacy, safety and vulnerability of pts in seclusion and /high dependency?						
4B	How do these measures address gender differences in approaches to care?						
5A	Is there a unit policy and procedure that guides staff actions when a possible sexual assault is reported?						
5B	When is it due for review?						
6A	How many alleged incidents of sexual assault have been reported over the past 6 months?						
6B	What is the gender breakdown of the victims of these reports?						
6C	What practice changes and/or procedural improvements have been put in place to address such incidents?						
6D	As for 6 A,B&C only inquire re: "physical assault"						
	Environmental Factors						
8A	Are bedrooms separated into male and female areas?						
8B	How is separation of male and female pts managed? ie. Female bedrooms allocated within closest range to staff observation/office						
9	Is there a safe and accessible child friendly family visiting area?						
10	Is there access to a female only day lounge?						
11	Are there secure separate sex toileting and bathing facilities?						
12	What types of locks are on bathrooms and bedrooms?						

Service/Unit # _____ Date: _____

Open Ended Queries

1. How is sexual activity within the unit responded to? What about staff (professional and non professional) understandings of relationship boundaries?
2. What practices within the unit contribute most to creating a sense of safety for female and markedly vulnerable clients?
3. How is clinical practice focused to minimise re-traumatisation of clients who have a history of trauma, such as sexual assault and domestic violence, when they are admitted to the unit?
4. How are incidents that occur during hospitalisation communicated?
 - With consumers on the ward who are directly and indirectly involved - debriefing?
 - With family of those affected directly and indirectly?
 - (On discharge) to community treatment providers, mental health and others?
5. What are the views of consumer and carer consultants?
6. How do staff regard involvement of consumer advocates -such as Community Visitors, or the VMIAC?
7. What aspects of current staff training and development do you value as helping the unit to achieve a gender sensitive and safe treatment environment?
8. Are there training and development approaches that you think would provide additional benefits?
9. What are three priority interventions/actions that could improve delivery of gender sensitive and safe treatment and care in inpatient units?

Appendix D: NorthWestern mental health policy, guidelines and poster

North Western Mental Health - Melbourne Health

Section:	Continuum of Care	Policy No:	CC 2.3
Sub Section:	Assessment	Issue Date:	May 2007
Subject:	Sexual Assault and Trauma – Disclosures of Past Sexual Assault by Registered Consumers	Revision No:	1
		Next Review:	May 2008
		Page:	1 of 4

PURPOSE AND SCOPE

This policy is designed to ensure that routine mental health assessments include appropriate questions about sexual abuse/trauma, and that disclosure is sensitivity managed. It is written in response to research literature findings and feedback from clinicians, that despite the demonstrated relationship between child abuse and adult psychopathology, many clinicians are not routinely inquiring about abuse histories. The high prevalence of mental health clients with a history of sexual abuse reported in the literature indicates a professional obligation to inquire about abuse histories and offer appropriate treatment where indicated.

This policy outlines NWMH's responsibilities in relation to registered consumers from any mental health program for incidences of past or present child or adult sexual assault/abuse. It applies to all NWMH clinicians.

Definitions

Term	Definition
Assault/Abuse/Trauma	The current or past harming (whether physically emotionally or sexually), ill treatment, abuse, victimisation, neglect or deprivation of any person. Common terms include child molestation, child sexual maltreatment or child rape
Child	A boy or girl under the age of 17 years

(See Appendix for detail of sexual offence charges in Victoria)

POLICY

The Policy on Sexual Assault And Trauma – Disclosures Of Past Sexual Assault By Registered Consumers is:

- **Routine mental health assessments should include appropriate questions about sexual abuse/trauma**
- **The service will endeavour to provide ongoing therapeutic support to those consumers who disclose incidences of past or present child/adult sexual assault/abuse or trauma.**
- **The service will consistently seek to link such consumers to professional sexual assault counselling services or mental health professionals with specialised skills and expertise.**

PROCEDURE

Principles & recommended best practice

Policy & Procedure Manual

Authorised By



ALEX COCKRAM
Director, NorthWestern Mental Health

North Western Mental Health - Melbourne Health

Section:	Continuum of Care	Policy No:	CC 2.3
Sub Section:	Assessment	Issue Date:	May 2007
Subject:	Sexual Assault and Trauma – Disclosures of Past Sexual Assault by Registered Consumers	Revision No:	1
		Next Review:	May 2008
		Page:	2 of 4

1. Assessment of Mental Health clients must include questions about possible trauma/sexual abuse to ensure that appropriate support and therapy is made available.
2. Clinicians should routinely ask about any history of trauma, especially occurring during the client's childhood.

Follow the steps below to ensure appropriate assessment of trauma/abuse/assault.

PREFACING CONTEXT

1. Any enquiry about abuse should take place:
 - In the context of a general psychosocial history
 - When rapport has been established with the client
 - When there is sufficient time to ensure appropriate and immediate support is available
2. Other reasons why such enquiry is sometimes delayed could include issues of:
 - Culture
 - Gender
 - Mental state
 - Presence of family members
 - Ability to provide continuity of involvement
 - Non-availability of records of last known contact with the Mental Health Service

EXCEPTIONS

Where information has been previously disclosed, and:

- The client indicates that the effects of the abuse have either been dealt with to their satisfaction,
- They do not wish to deal with them
- They do not feel the abuse had any adverse effects.

CONFIDENTIALITY

All staff undertaking clinical assessment must comply with NorthWestern Mental Health policy.

RECORDING IN CLIENT'S FILE

Information about history of abuse/ trauma should be clearly recorded on the initial assessment or within documentation notes.

If no enquiry about sexual abuse/ trauma has been made, record the reason for this and develop a plan detailing when this will occur and by whom.

CURRENT SAFETY

To guarantee safety, confidentiality may be waived in the case of a client who discloses that they are abusing or being abused currently, or suspect abuse of others is continuing. (N.B. For children under 17, consider mandatory notification to Child Protection)

Action –

Policy & Procedure Manual

Authorised By



ALEX COCKRAM

Director, NorthWestern Mental Health

North Western Mental Health - Melbourne Health

Section:	Continuum of Care	Policy No:	CC 2.3
Sub Section:	Assessment	Issue Date:	May 2007
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		Next Review:	May 2008
		Page:	3 of 4

- The clinician will counsel the client to contact the appropriate statutory agency.
- If this cannot be achieved, the clinician will consult with the team supervisor, as to the appropriate action.

RESPONDING TO DISCLOSURE

- It is not necessary or desirable to immediately gather details of any disclosed abuse. Refer to Guidelines for abuse inquiry and response for mental health workers
- Previous records should always be checked to establish the status of previous assessments of sexual abuse/trauma.

TRAINING

Clinical staff are recommended to undertake *at least* a one-day skill based training (currently one day per year at Mental Health and Development Training Unit, facilitated by Bouverie Family Centre) and/or other training that may be developed, to ensure that questioning techniques are appropriate. Details are contained in the Guidelines/Resource Pack/Training Manual issued to each participant. A copy is also held with each team/service for reference.

In addition, staff will seek to consistently update their awareness of the issues in line with evidence-based practice.

OUTCOMES

Clinician's competence and confidence are increased with regard to inquiring and responding to disclosures of sexual abuse with the ultimate aim of improving services offered to consumers.

REFERENCES**Associated Documents**

The table below indicates other documents associated with this policy

Type	Document title
Legislation	<ul style="list-style-type: none"> • Crimes Act • Privacy Act • Children and Young Persons Act 1989 Victoria
Melbourne Health Policy	<ul style="list-style-type: none"> • Policy SP1.0 Sexual Assault Of Registered Consumers [1998] (recent assault) • Privacy Policy (2002) • Responding to the Needs of Women (1997)
National Mental Health Standards	<ul style="list-style-type: none"> • Cultural Awareness • Assessment • Quality Consumer Focused Treatment and Care
DHS/MHB (Victorian State Government Policies)	<ul style="list-style-type: none"> • Victoria's Mental Health Services tailoring services to meet the needs of women

Policy & Procedure Manual

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		Next Review:	May 2008
		Page:	4 of 4

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|---|
| <ul style="list-style-type: none"> Building partnerships between mental health, family violence and sexual assault services. Project report. |
|---|

Major reference and acknowledgement to: Auckland Healthcare Services LTD, Service, Policy and Procedure Manuel, Recommended Best Practice section 2, Trauma and Sexual Abuse.

Other references

Agar, K., Read, J. & Bush, J-M. (2002) Identification of abuse histories in a community mental health centre: The need for policies and training. *Journal of Mental Health*, 11, 533-543.

Rosenberg, S.D., Drake, R.E. & Mueser K. (1996) New directions for treatment research on sequelae of sexual abuse in persons with severe mental illness. *Community Mental Health Journal*, 32, 387-400.

Young, M, Read, J., Barker-Collo, S., & Harrison, R. (2001) Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice*, 32, 407-414.

Victorian Government Department of Human Services (1997) Victoria's Mental Health Services tailoring to meet the needs of women. Department of Human Services, Melbourne.

Victorian Government Department of Human Services/Mental Health Branch (2006). Building Partnerships between mental health, family violence and sexual assault services. Project report. Department of Human Services, Melbourne.

For Further Information:

Contact Directors of Clinical Service or Area Managers.



North Western Mental Health - Melbourne Health

Section: Continuum of Care
Sub Section: Assessment
Subject: Guidelines

Issue Date: May 2007
Revision No: 1
Next Review: May 2008
Page: 1 of 12

GUIDELINES FOR ABUSE INQUIRY AND RESPONSE FOR MENTAL HEALTH WORKERS

Scope

This document was written for mental health workers working with adult clients. While the document's primary focus is sexual abuse/assault, it may also be utilised for working with general trauma and physical or emotional abuse.

The guidelines were developed by members of the 'Sexual Abuse Policy Implementation Group' of NWMH, which comprises representatives from across NWMH. This document is predominately based on guidelines developed by colleagues in Auckland New Zealand (Auckland Rape Crisis) and has been adapted to the local context as appropriate. The guidelines have been developed in recognition of the fact that a high number of consumers who have a mental illness also have a history of (sexual) abuse and that mental health services and staff need to take this history into account and respond appropriately and sensitively.

The guidelines should be used in conjunction with professional development, training and other forms of education and provide guidance on a number of areas such as 'asking about sexual abuse', 'confidentiality' and 'good practice'. Whilst the sections can be read separately, it is advisable that the document is worked through in its entirety.

The document is divided into sections it begins with a section on "Asking about Abuse", incorporating 'guiding principles', 'confidentiality', 'prefacing/context', 'asking specific questions', 'recording if questions not asked', and 'documentation'. It then provides guidance about "Responding to Disclosure of Abuse" in sections on 'guiding principles', positive affirmation of the disclosure and acknowledgment, 'empowerment/support', 'current safety of client', 'others currently at risk from client', 'others still at risk from abuser', 'check feelings & predict possible emotional upset', and 'follow up'. A brief "Intervention Check List" is provided as well as a section on "Good Practice" and "Safety for Clinician"; the appendix provides definitions of the terminology.

Asking About Abuse

GUIDING PRINCIPLES

It is important for mental health professionals to know whether a client has been abused so as to facilitate proper formulations regarding the origins of their current problems and to be able to offer appropriate support and treatment (eg Abuse focussed counselling/psychotherapy).

Therefore it is recommended:

- That staff members routinely ask about their client's trauma history, especially that trauma which occurred in childhood.

North Western Mental Health - Melbourne Health

Section: Continuum of Care

Sub Section: Assessment

Subject: Guidelines

Issue Date: May 2007

Revision No: 1

Next Review: May 2008

Page: 2 of 12

- That questions regarding the client's trauma history should not be asked if this information has been previously shared by the client and the client has stated that the effects of that abuse have either been dealt with to their satisfaction, that they do not want to deal with them, or that they do not feel the abuse had any adverse effects.
- There are some situations where survivors may also have abused another person and/or still be abusing. In this situation it is important for the staff member to access professional advice to reduce the risk of to others.

(1) Confidentiality

It is important for the client to know what happens to the information they give (during assessment and treatment). The client should be aware of the specific confidentiality policy of NorthWestern Mental Health and the limits of that policy (i.e. when confidentiality will be broken in relation to situations of safety of self and others). A client should know what happens to the information they are giving, who will see it and where it goes after disclosure, and what it is used for. Information about confidentiality should be given at the initial assessment and repeated at anytime the client asks about the confidentiality of any information they have given.

Clinicians must respect the extreme sensitivity of the personal information, gender issues, as well as specific needs related to a person's cultural and religious background and beliefs.

Information concerning the abuse will only be conveyed to family/associates of the person according to their expressed wishes. No information will be given without the person's direction.

The manager and treating team are to be informed that an assault has occurred but the details need not be disclosed. The need to inform the doctors and treating team of the *issues but not the details* will be discussed with the person. Their wishes will be respected where possible.

(2) Prefacing/Context

Inquiry about abuse should take place in the context of a general psychosocial history (i.e. should not be asked 'out of the blue'). It is also advised that where possible the staff member establishes a relationship with the client before asking about trauma history. The staff member should ensure that they have enough time to ensure the client has appropriate support immediately after disclosure if support is required.

Please note; the following pages include suggestions for ways of asking and receiving disclosures about abuse. The following examples of suitable working should be used as a guideline only. It is important to acknowledge and validate how the person is feeling on a case-by-case basis and to respond appropriately.

When taking a psychosocial history, questions about trauma can be introduced with a question such as:

 North Western Mental Health - Melbourne Health

Section: Continuum of Care

Sub Section: Assessment

Subject: Guidelines

Issue Date: May 2007

Revision No: 1

Next Review: May 2008

Page: 3 of 12

- *Would you tell me a bit about your childhood? Or*
- *Can you tell me what your childhood was like?*

This might be followed with slightly more specific questions such as:

- *What was the best thing about your childhood?*
- *What was the worst thing? Or*
- *What was the worst thing that ever happened to you as a child?*

(3) Asking a specific question

If these questions do not elicit information about abuse it is necessary to ask a specific question such as:

- *Did a parent or another adult ever hurt or punish you in a way that left a bruise, cut, scratches, or made you bleed.* (this question evaluates for possible childhood physical abuse)
- *Did anyone ever do something sexual with you or to you that made you feel uncomfortable as a child?* (This question evaluates for possible childhood sexual abuse).

The reason for including uncomfortable is that some people who were sexually abused as children may have felt confused at the time about whether or not they wanted the event to happen but might nevertheless have felt uncomfortable.

- *Did anyone older than you ever do anything sexual to you that was against your will?*
- *Has anyone ever done something sexual to you against your will, or that you didn't feel comfortable about?* (This question evaluates for possible adult sexual assault).
- *Have you ever been beaten or hit or battered in a sexual or marital relationship?* (This question checks for possible spouse or partner abuse.)
- *Have you ever been physically attacked or assaulted by someone who wasn't a sexual partner or spouse?* (This question evaluates for possible non-domestic assault.)
- *Have you ever been in a situation, where you thought you were going to die?*

It is advisable not to ask 'Were you sexually, emotionally or physically abused?' because many people who were abused will not have used this term to describe their experience.

If the client responds with "*No I haven't been abused*", the staff member may like to respond in a way that lets the client know that support is available in the future if they wish to re-visit this topic at a later date:

- *That's fine – the reason we ask is that we like to offer people the opportunity to get some support if they want it.*

North Western Mental Health - Melbourne Health

Section: Continuum of Care

Sub Section: Assessment

Subject: Guidelines

Issue Date: May 2007

Revision No: 1

Next Review: May 2008

Page: 4 of 12

(4) Recording if Question not asked

There are occasionally good reasons for not asking about abuse at a specific time, but if this is the case it should be recorded that abuse inquiry has not occurred and a plan made as to when this will be done and by whom.

For example: client should be asked in culturally appropriate assessment by gender appropriate worker; level of rapport should already be established; there should be a strong likelihood of an ongoing working relationship with the client; time available to attend this properly; current mental status.

(5) Documentation

It is recommended that information as to whether or not the client has been asked about abuse/trauma history is recorded in an easy to access form so as to avoid repeat questioning by multiple agencies.

Brief details of the assault to be documented; clinical notes can reflect the feeling state of the person; for the purpose of other clinical staff being aware the support needs at that time.

Collaborative note taking is advised where possible.

It is suggested that every file (computerised or hard copy) include a section as below:

Has the client been asked about abuse/trauma history?

YES NO

NOTES:

Responding to disclosures of abuse

GUIDING PRINCIPLE:

It is not necessary, or desirable, on first being told by a client that they have been abused, to immediately gather details of that abuse. It is important that the client feels that the staff member has understood the importance of what has been disclosed and that this will, if the client wishes, be returned to later.

(1) Positive affirmation of the disclosure and acknowledgment

People are going to have a range of responses to disclosing abuse. They might feel shock, anger, shame, self-blame, fear, relief, a lack of connection with their feelings; appear numb or ambivalent about the abuse. For the person at this point what is important is that they are believed and the fact that they have disclosed is met with an immediate and positive response from a staff member. For example:

- *That is a good and important thing you did to tell us*

North Western Mental Health - Melbourne Health

Section: Continuum of Care

Sub Section: Assessment

Subject: Guidelines

Issue Date: May 2007

Revision No: 1

Next Review: May 2008

Page: 5 of 12

- *It is OK to have said it and we believe what you have said*

Acknowledge that abuse can sometimes be difficult to talk about and that it is a positive thing to talk about. It is also important to gauge from the person how they feel about disclosing rather than making judgements of what they should be feeling. It is also important to normalise the disclosure by using statements like:

- *In my experience talking with people about this, people often find that although it is difficult, it is often really helpful to talk about it. How has it been / is it for you talking about this now?*
- *Often this can have a real effect on someone's life and often it can be quite difficult to talk about.*

Acknowledge how the client is reacting:

- *I can see you are really upset*

People who have experienced abuse often experience much self-blame. If self-blame does occur it is important to affirm that self-blame is a common reaction; and, if appropriate to state that any abuse they have experienced is not their fault. Some clients feel ambivalent about the abuse. In this case it is important not to frame the abuse as either positive or negative. Staff members may in this case also offer support to the client.

(2) Empowerment/Support

This section focuses on initiating discussion around treatment/support for symptoms and effects of the disclosed abuse.

Ask about previous disclosure and support/treatment:

- *Have you had the opportunity to talk to anyone about this before?*
- *Have you had any support or help to deal with your feelings about what happened?*

Ways of asking if the client wishes to have counselling:

- *Do you have any support or how do you feel about what happened? Some people find talking to a counsellor to be very supportive. If you are interested we can find a counsellor for your support.*
- *There are people trained in counselling in these issues – would you like to think about seeing someone? I am willing to assist you to find some support for yourself.*
- *Would you like to talk to someone about how you feel about it all now?*

Or (if you are trained and are able to offer counselling yourself):

- *Would you like to talk to me about it at some point?*

Note: Sometimes people have concerns about their physical/sexual health resulting from the abuse. (See resources section for more information on available resources)

North Western Mental Health - Melbourne Health

Section: Continuum of Care

Sub Section: Assessment

Subject: Guidelines

Issue Date: May 2007

Revision No: 1

Next Review: May 2008

Page: 6 of 12

(3) Current safety of client

If the client discloses that they are being abused currently, confidentiality may need to be waived to guarantee safety. The staff member will first counsel the client to contact the appropriate statutory agency. However, if she or he is not responsive to this or is unable to act the staff member may, in conjunction with the team, report the situation to maintain client safety. (Please also note that if the adult client has disclosed historical abuse and now not at risk there is no mandatory reporting although the client has the right to report the assault to the Police when and if they wish to.)

Ways to check out the safety of the client:

- *Do you feel safe now?*
- *Is there anything still going on?*
- *Are you safe to leave?*
- *Is anyone treating you like that at the moment?*
- *I need to check if you are now safe.*

(4) Others currently at risk form client

If the client discloses that they are currently abusing another person, confidentiality may need to be waived to guarantee the safety of others. The staff member must first counsel the client to contact the appropriate statutory agency. However, if he or she is not responsive to this or is unable to act, the staff member may, in conjunction with the team, report the client to the appropriate agency.

Note: it may be useful to inquire about the safety of others especially children – if under 17 then NWMH has a responsibility to report abuse to Protective Services.

(5) Others still at risk from abuser

If the client discloses that somebody they know is currently at risk from an abuser, confidentiality may need to be waived to guarantee safety. The staff member will first counsel the client then contact the appropriate statutory agency. However if he or she is not responsive to this or unable to act the staff member may, in conjunction with the team, report the relevant agency.

- *I need to check if you or the people around you are safe.*
- *If anything like that still going on?*

(6) Check feelings & predict possible emotional upset

Before ending session clinician should check-in with the client about how they feel after talking about their abuse:

- *Telling someone about what happened can sometimes bring up a lot of feelings, so I'm just wondering how you are feeling about having told me?*
- *If you feel upset about what we have talked about today later this evening you can talk to (staff members name) about how you are feeling. (Tell (staff member) that client may approach them re disclosure of abuse so they are aware of the client's needs during their shift)*

North Western Mental Health - Melbourne Health

Section: Continuum of Care**Sub Section: Assessment****Subject: Guidelines****Issue Date: May 2007****Revision No: 1****Next Review: May 2008****Page: 7 of 12**

If client is in crisis over the disclosure, staff members should respond to the situation as a crisis situation and remain with client/access resources within the facility to help stabilise the client.

It may be important to assist the client to identify his or her own support systems.

- *Do you have someone that is a real support person that you could talk to or call if you needed to?*

Check out support and offer some if there is nobody the client could talk to. The staff member can offer names of support people from inside the agency as well as offer telephone numbers of sexual assault support groups outside the agency.

(7) Follow up

Check that it is ok for you (or another worker) to check-in with the client about the abuse if you are going to be seeing them again. Arrange a time that suits you both so that the client is aware of when this will take place.

North Western Mental Health - Melbourne Health

Section: Continuum of Care

Sub Section: Assessment

Subject: Guidelines

Issue Date: May 2007

Revision No: 1

Next Review: May 2008

Page: 8 of 12

INTERVENTION CHECKLIST

- 1. Affirm that it is positive to tell. Tell the person you believe them, offer validation.**
- 2. Support – offer information, resources, support, information about counsellors etc.**
- 3. Safety – of client, of others**
- 4. Follow up – make a time with client to follow up**

Reference & acknowledgement (for the above sections):

Auckland Rape Crisis
PO Box 105 241
Auckland central
www.rapecrisis.org.au

Good Practice

- Validate and recognise the courage of the disclosure. This will occur even in circumstances where information reported appears confused and conflicting.
- Clinicians will endeavour to understand the links between experiences of sexual assault and presenting psychotic symptoms and/or behavioural disturbances when working with disclosures.
- For past and present disclosures clinicians will follow up with the person to ensure safety and provide support. The time frame in which this occurs will be negotiated with the victim/survivor and reflect clinical decision making in reference to the victim/survivors coping skills.
- Being aware of professional responsibilities, a clinician may suggest that another clinician with more specialised expertise would be more appropriate to address issues of disclosure.
- Literature indicates that it is unhelpful to tell the client that 'nothing can be done' because the incident occurred in the past.
- It is not the role of clinicians to make decisions as to the reality base of a disclosure – this is the role of the Police
- Clinicians to refer to manual 'WORKING TOGETHER IN RESPONDING TO SEXUAL ASSAULT' (WestCASA and MWAMHS – 1999) for information detailing possible cognitive and/or emotional reactions victim/survivors may experience following disclosure.
- Particular care needs to be taken when working cross-culturally and with interpreters. Clinicians are advised to carefully take into consideration complicating factors when working with interpreters, working with refugee populations as well as gender issues for all of these situations.

Information Provision

- Clinicians will ensure that consumers are given information about this policy as part of the Statements and Rights and Responsibilities.
- Clinicians to provide information on available support options; such as CASA, Case Manager, or Community Health Centre.

**Western Region CASA
3 Ballarat Rd Footscray
Crisis and counselling
Ph: 9687 5811**

CASA House
Royal Women's Hospital
270 Cardigan St, Carlton
Counselling Line: 9635-3610
Administration: 9635-3600

Northern CASA
Ground Floor, Leslie Jenner Building
Austin Hospital
Ph: 9459 3190
AH – 9349 1766 Crisis – 9496 5770

Sexual Assault Crisis Line (after hours business days, weekends and public holidays) ph: 9349 1766 Toll Free 1800 806 292

For example - WestCASA provide free counselling to sexual assault survivors who live in the Western Region. They also offer free secondary consultation to any worker in the field working with sexual assault issues, and like to do so. The 24hr Crisis Line provides confidential telephone and face to face counselling, information and referral for both victims/survivors.
(There are 15 CASA's throughout Victoria plus the after hours crisis line)

- If the person is wishing to seek support from CASA and/or Community Health Service the clinician will offer to arrange an initial appointment and facilitate attendance.
- Person to be informed that they can have a support person with them at appointments if they wish.
- Provide the person with written information including legal information about Sexual Assault and the Law, Crimes Compensation and Victims Assistance Program.
- Inform the person that they can apply to access past clinical notes through Freedom of Information should they wish to do so.
- Clinician to provide the above resources to empower the person to make informed decisions.
- Clinician will allow the person to make decisions at their own pace.

SAFETY FOR THE CLINICIAN

- Clinicians should also consider participation in support systems, for example 'Network for Mental Health Workers Addressing Sexual Abuse Issues' that began late in 2001. Monthly meetings are advertised on the NWMH intranet.
- Clinicians may also contact Sexual Assault Services to seek advice in supporting the person or for debriefing.
- Clinicians have the right to request debriefing services, or utilise worker supports such as peer support.
- Clinicians are encouraged to make use of their regular supervision

Appendix

From 'Sexual Assault, The Law, Your Rights' booklet (1998)
Brimbank Community Centre and Victorian Legal Aid

What is Sexual Assault?

Sexual Assault is any sexual behaviour that makes a person feel uncomfortable or frightened or threatened. It is any sexual activity that is non-consensual. Sexual harassment is also covered by the legislation on sexual assault.

Sexual assault is a violation of human rights. Women and children are the most frequent victims of sexual assault and men are almost always the perpetrators.

Men can be victim survivors of rape or child sexual abuse.

The terms client and person are used in this guideline to refer to the person who experienced the sexual abuse.

Definitions

Wording taken from Victorian Legal Aid booklet 1999 (currently being updated):
Sexual Assault, the law, your rights.

"In Victoria sexual offences include the following:

Child Sexual Assault: Sexual offences against children

- Sexual penetration of a child under the age of 10 years;
- Sexual penetration of a child aged between 10 and 16 years;
- Indecent act with a child under the age of 16 years;
- Sexual relationship with a child under the age of 16 years who is under the care, supervision or authority of the adult in the relationship.

Consent is only a defence to these charges in limited circumstances, for example, the person had reasonable grounds for believing the child was 16 or older.

Sexual penetration means the introduction of the penis into the vagina, anus or mouth of another person. It also means the introduction of an object or another part of the body (eg. finger or tongue) into the vagina or anus of another person. The penetration can be to any extent and it is irrelevant whether there is an emission of semen.

Incest involves an act of sexual penetration is committed by a relative, for example, a father, grandfather, uncle or brother. It is still incest even if a person is not a blood relative but is a close family member, for example, a stepfather or a parent's defacto. Consent is not a defence.

Rape occurs if he or she sexually penetrates another person without that person's consent while being aware that the person *is not consenting* or might not be

consenting. Or after sexual penetration he or she does not withdraw after becoming aware that the person is not consenting or might not be consenting.

Consent means free agreement. Circumstances where a person is not seen as freely agreeing include where the person:

- Submits because of fear or force to the person or someone else;
- Submits because of fear of harm of any type to the person or someone else;
- Submits because the person was unlawfully detained (eg. locked in a house, or unable to leave);
- Is asleep, unconscious or so affected by alcohol or drugs to be incapable of freely agreeing;
- Is incapable of understanding the sexual nature of the act;
- Is mistaken about the sexual nature of the act or the identity of the perpetrator;
- Mistakenly believes that the act is for medical or hygienic purposes.

If there is no consent the act is rape regardless of the relationship. (A man can be guilty of raping his wife, defacto or girlfriend.)

Indecent Assault

Covers sexual acts other than those involving sexual penetration, such as touching breasts or buttocks without consent.

Sexual Harassment

Sexual harassment is when sexual assault occurs in the workplace or service centre. (See definition for sexual assault).

Sexual offences against people 'with impaired mental functioning'

People who provide medical or therapeutic services to people with 'impaired mental functioning' must not take part in an act of sexual penetration or an indecent act with those people. Consent is not a defence.

Sexual offences against residents of residential facilities

Workers at residential facilities must not take part in an act of sexual penetration or an indecent act with residents of the facility. Consent is not a defence.

Sexual offences are serious crimes. Maximum penalties range between five and twenty five years imprisonment."

Please refer to NWMH Policy SP1.0 SEXUAL ASSAULT OF REGISTERED CONSUMERS section 3.2.5 for guidelines for notification of the Police.

References

Victorian Government Department of Human Services 'Child Sexual Abuse – Understanding and Responding' 2000

Brimbank Community Centre and Victorian Legal Aid 'Sexual Assault, The Law, Your Rights' booklet (1998)

Responding to consumers with mental health and family violence / sexual abuse issues in the Cities of Darebin & Whittlesea

How often does it occur?

- ▶ An estimated 50-80% of women with mental illness have experienced some form of violence (Muenzenmaier et al 1993)
- ▶ Just under half of all abused women suffer from clinical depression (Golding, 1999)
- ▶ A Victorian Study found that consumers often did not disclose abuse because "they were never asked" (Hawthorne et al 1992)
- ▶ Men diagnosed with mental illness are more likely to have experienced childhood sexual abuse than those without diagnosis
- ▶ Psychological abuse accompanies all forms of abuse and victims / survivors often withhold disclosure due to internalised fear, self-blame and feeling ashamed

Key principles in responding

Provide opportunities for disclosure: Consumers need to be sensitively asked about current violence or past trauma

Validation: Affirm that it is positive to disclose

Safety: Assess current safety and respond to physical, mental health and cultural needs

Choice: Ensure consumer control of process as far as possible

Support: Provide information, resources and referral as appropriate

Contain: Post disclosure distress can overwhelm the client

Sexual Assault Services

Northern Centre Against Sexual Assault
Ph: 1800 806 292 (24 hours)

- ▶ Counselling & Advocacy for people who have recent or past sexual assault trauma
- ▶ Information / support re: legal / medical options
- ▶ Professional consultation and debriefing
- ▶ Advocacy and referrals

24 hour response to recent sexual assault (within last 2 weeks)

Community Health Services

- ▶ Casework / Counselling
- ▶ Support groups for women dealing with effects of violence and abuse

Darebin - Intake workers Ph: 8470 1111
Plenty Valley - Intake workers Ph: 9409 8724

Children & Adolescents

CPS

- ▶ Counselling for children aged 3-18 who have been sexually abused
- ▶ Service for children up to 10 with problem sexual behaviour & young people displaying sexually abusive behaviour

Intake Worker: Ph: 9450 0900 (Mon-Wed)

Legal System

Darebin Community Legal Centre
Ph: 9484 7783

- ▶ Darebin Intervention Order Support Service (part of the Family Violence Division at Heidelberg Magistrate's Court), Family Violence

Heidelberg Magistrates Court
Family Violence Court Division Registrar
Ph: 8458 2000

Whittlesea Community Legal Centre
Ph: 9409 6655

Police
Ph: 000

Clinical Mental Health Service

Northern Area Mental Health Service Triage
Ph: 1300 650 295

- ▶ Triage: psychiatric referrals / enquiries & consultation
- ▶ Psychiatric crisis assessment & treatment
- ▶ Case management for people with serious & enduring mental illness
- ▶ Assessment of anxiety & depression, perinatal depression, eating disorders & young people at risk of serious mental illness (Primary MH Team)

Psychiatric Disability Rehabilitation Support Services (PDRSS)

- ▶ Outreach support / recovery / social contacts / groups / skill development / supported housing / day programs
- ▶ Mental Illness Fellowship
Ph: 8486 4200 Respite (a/h) Ph: 9625 0497
- ▶ NEAMI
Darebin Ph: 9484 0333
Whittlesea Ph: 9464 6455
- ▶ Richmond Fellowship
Chiron Ph: 9462 3700
Rosa Gilbert Ph: 9480 0260
- ▶ Victorian Aboriginal Health Service
Family Counselling Service Ph: 9403 3300
- ▶ WISHIN Ph: 9381-1333
PDRSS for Women with Children in City of Darebin & information / support for housing

Family Services

Child FIRST North East
Ph: 9450 0955

- ▶ A central intake & referral services for family support services for vulnerable children, youth and families

Victorian Aboriginal Child Care Agency
Ph: 8388 1855

- ▶ Run Aboriginal Play Groups & provide cultural responsive support to Aboriginal families

Victorian Aboriginal Health Service
Family Counselling Service Ph: 9403 3300

Family Violence Services

Women's Domestic Violence Crisis Service
24 hour Crisis Line
Ph: 9373 0123 / 1800 015 188

- ▶ Refuge accommodation for women escaping family violence
- ▶ Some refuges have specific provision for women with disabilities

Berry Street Victoria
Northern Family Violence Service
Intake worker Ph: 9458 5788

- ▶ Support & information for women in or who have left a violent relationship re: legal / financial / housing / counselling / groupwork options
- ▶ Outreach & court support
- ▶ Children's counselling & groupwork
- ▶ After hours support

Elizabeth Hofmann House
Ph: 9373 0123 / 1800 015 188

- ▶ Aboriginal Women's Services
- ▶ Culturally appropriate holistic service for women & children having experienced family violence and / or sexual assault

Immigrant Women's Domestic Violence
Crisis Service
Intake Line Ph: 8413 6899 9.30am 5.15pm

- ▶ Information, support and referral for immigrant and refugee women affected by domestic violence

Domestic Violence and Incest Resource Centre
DVIRC Ph: 9486 9866

- ▶ Resources, information & training for workers

Men's Referral Service

Men's Referral Service
Ph: 9428 2899 or 1800 065 973

Monday to Friday 12 noon – 9:00pm

- ▶ Call for information on Men's Behaviour Change Programs (Plenty Valley CHS, Kildonan)