

Department of Health

health

Promoting sexual safety,
responding to sexual activity,
and managing allegations
of sexual assault in adult
acute inpatient units

Chief Psychiatrist's guideline

**Promoting sexual safety, responding to sexual activity,
and managing allegations of sexual assault
in adult acute inpatient units**

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Chief Psychiatrist's guideline

Key message

Mental health services should ensure that they provide a safe environment for every person admitted to an adult acute inpatient unit. Sexual activity, or unwanted sexual advances from others, is one of a range of risks that need to be considered, assessed and managed. Any sexual activity in an adult acute inpatient unit is incompatible with the acute treatment environment and is unacceptable. Any sexual activity between staff and patients is an offence and should be dealt with through existing criminal and disciplinary processes.

Services should develop local policies and procedures consistent with this guideline to promote sexual safety and guide staff in preventing sexual activity, and responding appropriately to allegations of sexual assault or harassment.

Background

People with a mental illness are vulnerable to sexual risk because of their illness and frequent history of sexual abuse, especially women. People with a past history of trauma may experience some aspects of hospital admission and mental health care as traumatic, highlighting a need for more trauma informed care. *The gender sensitivity and safety in adult acute inpatient units project report (May 2008)* identified a range of issues relating to the treatment and care of patients in acute inpatient environments, including a need for clearer policy and guidelines to promote more consistent and responsive practice.

Existing instructions on responding to allegations of sexual assault

The Department of Human Services Instruction *Responding to Allegations of Physical or Sexual Assault* (August 2005) (the Instruction) replaced the previous instruction *Reporting Allegations of Physical or Sexual Assault to the Police* (June 1993). Specialist mental health services have been expected to follow the Instruction's principles and framework but may use clinical discretion in deciding when to report some allegations of sexual assault to police. The absence of a clear statewide policy on the management of sexual activity and allegations of sexual assault in mental health services has led to variable practice.

Purpose

This Chief Psychiatrist's guideline sets out the relevant legislation and policy, and establishes minimum standards for the clinical management of sexual activity, and the appropriate staff response to patients who report inappropriate sexual activity in adult acute inpatient units. It provides guidance on decision making processes and clarifies the circumstances where clinical discretion may apply.

The guideline is intended to assist mental health service managers, clinical directors and clinical staff in their obligations to promote a therapeutic culture and environment that recognises sexual vulnerability, and actively manages sexual behaviour to minimise sexual risk and support disclosure of sexual assault and harassment. Services are expected to develop local policies based on the guideline to promote awareness of gender related issues and sexual safety. The guideline provides a framework for local innovation and best practice in implementing the principles.

Scope

The guideline applies to all adult acute inpatient units in public specialist mental health services.
The guideline is not directed at community mental health services or longer-term bed based services.

About the Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice. Mental health service management should ensure that procedures are developed and implemented consistent with the purpose and intent of the guideline.

If mental health staff have queries about individual cases or their legal obligations, service providers should obtain independent legal advice.

Acknowledgements

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Introduction

Sexual activity, including sexual assault and harassment, does occur in psychiatric facilities and is an issue of concern. Studies suggest the majority of women and men do not report their experience of sexual assault and harassment. Greater awareness of the vulnerability of some patients and promotion of sexual safety can prevent the occurrence of such adverse events.

Adult acute units in Victoria are all co-located with general hospitals other than the forensic unit. Most are mixed-sex environments in which male patients tend to outnumber females. In a community focussed mental health system, acute inpatient units increasingly provide brief admissions for acutely unwell persons and levels of acuity tend to be high.

Mental illness may impair a person's judgement, and a significant number of persons with a mental illness or disorder have past histories of sexual abuse, neglect or violence, which may make them more vulnerable to sexual assault and harassment in mixed sex wards and to re-traumatisation. Sexual disinhibition is a feature of some psychiatric disorders, and may result in both male and female patients acting in ways they might not otherwise do. A person's cultural background may further influence the impact of any sexual behaviour or intimidation whilst an inpatient, and their willingness to disclose sexual activity. Women and men experience mental ill-health differently and have particular needs that should be taken into account in the way mental health services are delivered. Both male and female patients may need protection from acting in ways that interferes with their treatment or their longer term wellbeing.

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

Mental health services have an obligation to provide a safe, therapeutic and healing environment for all service users. A consistent approach is required to prevent sexual activity, manage sexual risk and respond to allegations of sexual assault or harassment in adult acute inpatient units. Any instance of sexual activity between a staff member and a patient should be reported to police.

Relevant legislation

Mental Health Act 1986 – is the principal Act governing the delivery of mental health treatment and care in mental health services in Victoria. The Act provides the framework and principles of treatment and care, including relevant provisions pertaining to patient rights, consent, involuntary treatment, confidentiality and the disclosure of information¹.

Victorian Charter of Human Rights and Responsibilities Act 2006 – the charter enshrines a number of rights derived from the *International Convention on Civil and Political Rights*². The charter provides a legislative framework that protects and promotes human rights in Victoria including the circumstances under which these rights may be limited. All public authorities and their employees are required to act in accordance with the Charter.

The *Crimes Act 1958* defines sexual offences in the Victorian jurisdiction, including provisions relating to sexual offences against people with a cognitive impairment. 'Cognitive impairment' is defined to include impairment because of mental illness, intellectual disability, dementia or brain injury. The Act also contains provisions relating to persons providing treatment and care in approved mental health services.

The *Health Records Act 2001* is the principal law regulating the collection and use of health information by mental health services.

¹ *International Convention on Civil and Political Rights*. Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

² *International Convention on Civil and Political Rights*. Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

Relevant policy

National and state policy development has increasingly emphasised safety in the provision of quality mental health care, and established harm-reduction priorities which all mental health services must work towards. Relevant policies include:

- *National Standards for Mental Health Services, 1996*³
- *National safety priorities in mental health: a national plan for reducing harm 2005*
- *Victorian strategy for safety and quality in public mental health services 2004-2008*
- *National Practice Standards for Mental Health Services 2002*.

The document *Victoria's mental health services: Tailoring services to meet the needs of women* (DHS 1997) recognised the vulnerability of women in mixed-sex wards, and identified priority areas, with service delivery principles and strategies, to make services more responsive to the needs of women, including adequate safety and privacy in inpatient and residential services.

The *Victorian Women's Health & Wellbeing Strategy Stage 2: 2006-2010* is part of the Victorian whole-of-government women's policy framework that identifies women's health and wellbeing as a key priority area.

Because Mental Health Matters Victorian Mental Health Reform Strategy 2009-2019 reaffirms Victoria's commitment to building more responsive, tailored and respectful services that recognise individual difference and diversity and the need for more consumer focused care.

The Departmental Instruction *Responding to Allegations of Physical or Sexual Assault* (August 2005) sets out the department's current policy for dealing with allegations of physical or sexual assault in department managed or funded services for people with a disability⁴ as defined in the instruction.

The *Protocol between Victoria Police and the Department of Human Services Mental Health Branch 2004*⁵ establishes guidelines for police and mental health services staff on handling situations, where either agency has requested assistance from the other, involving people who have, or are believed to have a mental illness, including the reporting of allegations of sexual assault.

A note about language

A number of terms are used to refer to consumers of mental health services. This guideline uses the term patient to refer to a person receiving treatment and care in an adult acute inpatient unit consistent with the description used for any person admitted to a general hospital for treatment. The term also recognises that at any given time fifty to seventy percent of persons admitted to an inpatient unit are involuntary patients under the Mental Health Act.

3 The Standards are currently under review and the new Standards were not available at the time of writing this Guideline.

4 "...a disability attributable to an intellectual, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is permanent or likely to be permanent, and results in substantially reduced capacity in at least one of the following: self care or management, mobility, communication, which require significant ongoing or long term episodic support and which is unrelated to ageing." (p4)

5 The Protocol was under review at the time of writing this Guideline.

Definitions

Alleged offender – a person who is alleged to have sexually abused or assaulted a person.

Authorised psychiatrist – every approved mental health service must have an authorised psychiatrist appointed by the board of the relevant health service. The authorised psychiatrist has specific powers and duties under the Mental Health Act. The authorised psychiatrist can delegate any of these powers, other than the power of delegation, to another qualified psychiatrist. Consultant psychiatrists in area mental health services are routinely delegated the powers, duties and functions of the authorised psychiatrist.

Clinical incident – an event or circumstance that could have resulted, or did result, in unintended or unnecessary harm to a person receiving care. A clinical incident can be an *adverse event*: an incident in which harm resulted to a person receiving health care, or a *near miss*: an incident that did not cause harm.

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

Inappropriate sexual activity – includes sexual assault and sexual harassment.

Independent Third Person (ITP) – a person called by police to facilitate communication during an interview between police and a victim, witness or suspect, who police believe has a cognitive impairment. The ITP may be a close relative or friend who is not associated with the police enquiry or a volunteer trained by the Office of the Public Advocate, but not mental health service staff or the treating medical practitioner.

Re-traumatisation – delayed onset or reactivated symptoms related to something traumatic experienced in the past, for example, domestic violence, physical or sexual abuse, rape, assault, combat.

Sexual assault – any behaviour of a sexual nature which is unwanted, making the victim feel uncomfortable or afraid. This includes rape, abuse, harassment and indecent assault. This behaviour can take various forms including unwelcome kissing or touching in the areas of a person's breasts, buttocks or genitals. Indecent assault can also include behaviour that does not involve actual touching such as forcing somebody to watch pornography or masturbation⁶.

Sexual disinhibition – an inability to restrain sexual impulses and involves behaviour or talk which is considered inappropriate for a particular environment.

Sexual harassment – unwelcome sexual advance, unwelcome request for sexual favours or other unwelcome conduct of a sexual nature in relation to another person.

Sexual health – a state of physical, emotional, mental and social wellbeing related to sexuality; not merely the absence of disease, dysfunction or infirmity.

⁶ This definition is consistent with the Victorian Crimes Act 1958 (s35-60A). DHS Instruction on Responding to Allegations of Physical or Sexual Assault, August 2005, p6.

Sexual safety⁷ – a state in which physical and psychological boundaries of individuals are maintained and respected. Individuals can promote their own sexual safety by engaging in protective behaviours, assertive communication and respectful relationships. Systems can promote sexual safety by developing and operationalising policies and procedures which:

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

Victim – a person who has experienced sexual harassment, assault or abuse.

Guiding principles

- All persons have the right to a safe environment whilst in the care of an inpatient mental health service.
- All persons with a mental disorder have the right to be treated with humanity, dignity and respect.
- All persons have the right to be treated in a way appropriate to their needs, and in the least restrictive manner consistent with the safe and effective giving of treatment and care.
- Interference with a person's rights (including their privacy) must be kept to the minimum necessary in the circumstances.
- All persons have the right to participate in decisions about their treatment care and wellbeing.
- Sexual activity and sexual relationships in an acute unit are not appropriate to the treatment setting, and are not acceptable.
- Sexual assault, abuse and harassment are potential crimes and always unacceptable.
- Area mental health services have a responsibility to provide comprehensive education and training for staff in gender sensitive practice, sexual safety and sexual health.
- Area mental health services have a responsibility for developing policies and procedures to prevent and respond to sexual activity, assault and harassment.
- Consumers and carers should be involved in the development and review of local policies and procedures.

Promoting sexual safety

Services will already have established structures and processes to promote a safe environment. Sexual safety sits within this broader risk management framework. Promoting sexual safety requires particular attention to identifying vulnerabilities and sexual risk in individuals, and applying relevant risk management strategies to the environment, policies, practices and all aspects of service delivery.

What is sexual safety?

Sexual safety has been defined as a state in which physical and psychological boundaries of individuals are maintained and respected. Mostly people take care of this for themselves in their everyday decisions and choices about who they engage with and relate to, including their sexual relationships.

In a treatment environment however, mental health services have a duty of care to protect all patients from the unwanted behaviours of others, and behaviours of their own that they might not choose to engage in when well. It is generally recognised that sexual activity in a treatment setting is not appropriate and should be actively discouraged.

All parties, patients, staff, and visitors can contribute to a culture of sexual safety. Patients can contribute to their own safety through their behaviour. Organisational systems can minimise sexual risk and promote sexual safety through well-defined policies, procedures and monitoring processes. Families, carers, visitors, advocates and others also have an important role to play in endorsing and supporting appropriate behaviour.

Inappropriate sexual activity may involve patients, family members, visitors, members of the public or even mental health services staff. All need to be considered in strategies to promote a sexually safe environment.

Sexual safety also includes recognition of patients' sexual physical health.

What is a sexually safe environment?

A sexually safe environment is one that:

- Recognises the right of all patients to an environment free from inappropriate sexual activity.
- Balances personal autonomy and decision making with duty of care to provide a safe and therapeutic environment for all patients.
- Has clear policies about acceptable and unacceptable behaviour.
- Recognises the common need of patients for privacy and personal space, and that these needs may vary in different genders.
- Recognises the need for routine identification of sexual risk in all patients.
- Recognises the particular vulnerability of some patients due to past history, illness, emotional turmoil or need.
- Promotes treatment and early recovery, and actively manages potential disruptions to treatment and wellbeing as a result of sexual activity.
- Encourages and models positive relationships and mutual respect between staff, between staff and patients, and between patients.
- Responds sensitively to disclosures of past or current sexual assault.
- Promotes personal self-care, respect, resilience and self-determination.

The role of service management

Service management has a clear role in providing leadership and direction at all levels of the organisation to underpin a culture of sexual safety.

Mental health services should:

- Establish systems, policies and procedures emphasising the right to physical and psychological safety.
- Promote a policy that sexual activity in adult acute inpatient units is inappropriate.
- Develop local guidelines to prevent sexual activity and manage sexually disinhibited behaviour.
- Develop a culture that promotes, encourages and models mutual respect in its relationships between staff, between staff and patients, and between patients.
- Consider the different needs of men and women in all aspects of service planning and service delivery.
- Establish accessible complaints mechanisms that support patients to speak out and that recognise they may need someone, such as a staff member, consumer consultant, advocate, or significant other, to help them do so.
- Regularly review the safety of the physical environment for all patients.
- Conduct periodic clinical audits to review the extent to which the different needs of women and men are considered in service delivery.
- Receive and review regular reports on sexual safety incidents by gender, and complaints about inappropriate sexual activity, personal safety or privacy issues.
- Ensure staff education and training addresses gender specific matters including sexual safety, sexual health, and assessing and responding to people with histories of sexual abuse.
- Have clinical supervision systems to support staff in developing their understanding of gender sensitive practice, trauma informed care, and professional boundaries.
- Have debriefing and support systems to facilitate the therapeutic functioning of the unit.
- Have established links with agencies such as the Centre Against Sexual Assault (CASA), police and other relevant services.
- Conduct periodic surveys or forums of consumers, carers and families on the quality of the inpatient services, including matters relating to sexual safety.

The physical environment

Physical design can go some way towards ensuring a safe and comfortable environment but in itself cannot completely ensure safety and privacy. It is equally important that services follow practices that minimise risks and provide a safe environment that fosters trust and feelings of security. Steps can be taken in any unit to make it safer and to prevent sexual activity. For example:

- Adopting a unit policy that patients are not permitted in each other's rooms.
- Allocating a bed or room that affords the greatest level of safety to vulnerable patients or those at risk of harming others; for example, near the nurses' station, in a gender specific area, shared room or high dependency area.
- Noting communal or outdoor areas where there is a reduced staff presence as high risk areas that may require an increased level of observation.
- Assigning same sex patients to adjoining bedrooms.
- Ensuring locks on ensuite doors or well-identified secure, private, separate-sex toileting and bathing facilities.
- Designating separate unit areas for male and female patients such as bedroom corridors, lounge areas and bathroom facilities.
- Considering the placement of patients of same sex orientation on a case by case basis.

When new facilities are being developed or existing ones refurbished, opportunity should be taken to incorporate design features that enhance safety and gender sensitive practice.

Assessment of sexual risk

Early identification of those who are vulnerable to risk of sexual activity, harassment, abuse or assault is required so that strategies can be implemented to manage the risk.

Obtaining some of this information may take time until a patient feels comfortable to disclose such a history. If it cannot be obtained at the point of admission, then subsequent attempts should be made once a level of therapeutic rapport and trust has been established. A patient cannot be forced to provide such information.

Assessment of a person's sexual vulnerability should be a component of psychiatric and risk assessment along with other risks such as risk to self and others, risk of violence, physical health risk or other vulnerability.

Assessment of a person's sexual risk should include past history of exposure to inappropriate sexual activity as part of a developmental history. The relationship between childhood abuse and the development of mental health problems is well known. Yet the routine assessment of past abuse is often neglected. Mental health professionals need to be aware of possible past sexual abuse and how this may increase a patient's vulnerability to further inappropriate sexual activity.

Assessments should also include:

- vulnerability to sexual assault or harassment
- potential for sexual activity due to illness, emotional state or personality factors
- potential for sexually inappropriate behaviour
- any concerns relating to visitors that may contribute to the person's vulnerability

- history of inappropriate sexual behaviour, especially during previous admissions
- history of violence
- history of sexual assault or harassment
- basic sexual history including inquiry regarding HIV status⁸ and any other sexually transmitted diseases.

Patients should be also assessed for their capacity to manage their sexual behaviour in hospital and, to the extent possible, identify strategies with them that might assist them to feel and keep safe. This should include assessment of mental status, level of orientation and level of understanding of the rules on the unit, including the psychological and physical consequences of sexual behaviour, such as pregnancy and infection.

General history and physical examination should also include physical sexual health, such as contraceptive status and exposure to sexually transmitted disease. For women this might also include enquiry regarding their participation in routine screens for cervical and breast cancer.

Risk category allocation

Following the sexual risk assessment patients should be allocated a sexual risk level corresponding to the factors identified; for example, high, moderate or low risk, and be assigned the appropriate level of nursing care.

Factors to be taken into consideration include:

- hypomanic presentation
- sexual disinhibition
- heightened sexual activity
- minimal insight into the consequences of sexual activity
- disorganisation or other vulnerabilities associated with illness
- wandering
- intellectual or cognitive impairment
- history of sexual assault or harassment
- history of sexual offending
- violent behaviour
- influence of drugs or alcohol
- sedation from medication
- history of inappropriate behaviour while an inpatient previously.

Appendix 1 provides an example of a sexual safety risk assessment and allocation format.

As with all risk category assignment, the level of risk should be reviewed regularly and updated to reflect any changes in the patient's presentation or actions of others that might pose a risk to the patient.

⁸ Enquiry regarding HIV status should be in accordance with established protocols.

Treatment planning

As with any other risk, all patients identified as vulnerable to or at risk of sexual activity, assault or harassment should have a detailed treatment or care plan that:

- is known to all staff (not just the treating doctor or primary nurse)
- specifies the risk behaviours or vulnerabilities
- details the approach to be adopted to protect the patient
- describes specific interventions
- is regularly reviewed by the treating team.

Where possible the plan should be developed in collaboration with the patient and their families and carers (unless the patient objects). The patient should be advised, to the extent their mental status allows, what staff are doing to keep them safe and how they might contribute to their own safety, regardless of the risk level identified.

Where a patient's vulnerability is largely a function of their mental illness, an active approach needs to be maintained to the assertive treatment of their acute symptoms and disturbed behaviours.

Orientation to the unit

Orientation of patients to the unit is the first step in establishing a therapeutic relationship, familiarising them with their surroundings, and beginning the discussion about expectations and how their care will be organised. How often orientation needs to occur and the level of detail provided will depend on the person's capacity to take in information at the time.

Orientation should include a written and verbal explanation covering:

- the patient's right to a safe and therapeutic environment, including sexual safety
- expected behaviour, including that sexual activity on the unit is inappropriate and not permitted
- the rules of the unit, including that intimate behaviour or sexualised contact with other patients or staff is not acceptable
- explanation about how to keep safe, how to summon help if the person feels uncomfortable, unsafe or is subject to inappropriate sexual activity
- how to make a complaint or report any incidents of inappropriate sexual activity
- information for families, carers and visitors about the unit, its procedures (e.g. visiting hours, contact details, family meetings) and expected behaviours.

Other strategies to promote sexual safety and prevent sexual activity

- Prominent display of the service's position on sexual safety in the adult acute inpatient unit.
- Use of gender specific evidence based practice to inform the treatment and care for women and men.
- All staff being aware that any instance of inappropriate sexual activity must be taken seriously.
- Clear management strategies be in place to respond to any report or concerns about inappropriate sexual activity.
- Recognise the specific needs of women e.g. woman only amenities, activities and spaces.
- Discuss behavioural expectations and sexual safety in patient unit meetings and programs.
- Development of risk alert systems to identify patients with a history of sexual risk behaviour in previous admissions; for example, alert notice in the medical record.
- Highlight at risk patients in handover procedures between nursing shifts, multidisciplinary teams and treating medical staff.
- Consider personal alarm or duress systems (bracelets) for vulnerable patients.
- Provide gender specific programs, groups and activities.
- Increased vigilance and observation at particular times when staff are less available, for example, night time, handover and ward rounds when patients are more vulnerable to inappropriate sexual activity.
- Allocate female staff during examinations, seclusion, restraint and assistance with daily living activities such as bathing/showering for female patients.
- Ensure that women who are secluded are adequately clothed.
- Avoid situations where male staff are alone attending to female patients' hygiene needs or are in isolated or unobservable spaces with female patients.
- Encourage patient presence or involvement in unit activities and programs to minimise isolation and vulnerability.
- Clinically review every episode of sexual activity as a matter of urgency.
- Monitor visitor interactions for inappropriate behaviour particularly of a sexual nature.
- Report every episode of sexual activity through the mental health service incident reporting system. (See *Managing allegations of sexual assault* for further information.)
- Pre-discharge assessment for patients should include consideration of sexual activity while in the inpatient unit to reduce the known risk of self-harm in the immediate post discharge period.

Responding to sexual activity

General approach

Social attitudes to sexual expression and individual rights have changed over time and people may hold diverse views about sexual social norms. Some staff may have difficulty making judgements about what is appropriate and what is their duty of care to patients regarding sexual activity.

There are a number of reasons why some patients may engage in sexual activity in an adult acute inpatient unit and it is important that staff understand the possible motivating factors. Some patients will have disinhibited behaviour as a result of their mental illness, others may see sexual activity as an expression of their needs, and even be perplexed at staff concern. Others may seek gratification in relationships because of their emotional state or inner turmoil and not consider their longer term wellbeing or the wellbeing of others. Others may not be able to resist advances due to their level of disorganisation and may passively comply. In some instances, there may be the appearance of consent with neither party showing any distress or harm.

However, sexual activity even when seemingly consensual can negatively affect a person's mental status, impede their treatment and have longer term consequences such as sexually transmitted infections or pregnancy. Self esteem may be damaged, and other relationships harmed when the full consequences of the activity are realised.

Particular sensitivity is required in dealing with these situations so that the parties do not feel demeaned, humiliated or exposed. At the same time, staff have a duty of care to intervene and explain that the behaviour is not appropriate because they are unwell and in hospital. As a general therapeutic principle, patients should be cautioned about the pitfalls of forming relationships or making major life decisions whilst unwell.

General strategies

Staff should:

- request the sexual activity stops
- intervene without delay and create an opportunity for discussion with the patients concerned
- sensitively counsel those involved about the inappropriateness of sexual activity on the unit
- re-state the no sexual activity policy in the unit and its rationale
- review the treatment and management strategies to reduce the likelihood of reoccurrence
- discuss the incident with the treating team and the authorised psychiatrist
- clearly document the incident in the medical record
- follow local reporting procedures.

Where staff suspect inappropriate sexual activity, rather than consensual activity, has taken place they should refer to the procedures for *Managing allegations of sexual assault*.

Responding to patients with a history of trauma or abuse

Patients with a history of abuse, violence or victimisation may be more vulnerable to exploitation and be unable to resist advances from other patients. Past personal history may also motivate them to form indiscriminate relationships that simply perpetuate their vulnerability. They may also be re-traumatised not only by the admission itself, but the perceived insensitivity of staff actions. The high risk of re-traumatisation in this group may lead them to fear future hospitalisation and treatment. A patient with a history of past abuse or victimisation may be afraid of going to sleep at night, or being in close proximity to unwell and disinhibited patients, and even fear staff. Staff need to be particularly alert to the person's need for privacy and sense of personal security.

Where initial assessment indicates past trauma further enquiry should be made to enable sound formulations regarding the current problems and the tailoring of appropriate support and treatment⁹. Such assessment should seek to identify:

- the trauma history such as childhood physical, emotional or sexual abuse
- any adult experiences of domestic violence
- any other physical or sexual assault or harassment
- any experience of witnessing a violent event.

Exploration of these events will need to be approached sensitively to enable the person to reveal information at a pace and in a manner they are comfortable with. It is important for the patient to retain a sense of control over the disclosure yet be supported to speak about painful experiences. Patients cannot be forced to disclose such information.

Additional strategies

- If the previous sexual assault occurred in the admitting mental health facility the patient may wish to be treated at another mental health service.
- The patient should not be allocated a bed or room where a previous assault has taken place.
- The alleged offender should not be treated in the same unit at the same time.
- Particular triggers that may be distressing for the patient should be identified in the treatment plan.
- Particular strategies for keeping safe should be discussed with the patient. This should focus on what staff will do and what the patient can do in terms of personal behaviour and how to get help.
- If the alleged offender is known to be in the community, the patient's wishes should be obtained regarding visiting or contact.
- The need for ongoing follow up and referral to specialist sexual assault counselling and support services should be addressed in discharge planning.

For further information see also *Responding to disclosures of a past history of sexual abuse or recent sexual assault outside the unit* (p18).

⁹ See "The gender sensitivity and safety in adult acute inpatient unit's project Final report".

Responding to patients with sexually disinhibited behaviour

Sexual disinhibition is a common presentation in acutely unwell patients and may be evidenced by an increase of sexual thoughts, activities and demeanor, or a more general disinhibition, with a sexual element. Behaviours may include:

- removing clothing inappropriately
- wearing inappropriate clothing
- being over familiar, over friendly or touching others inappropriately
- hypersexuality, e.g. sexually provocative behaviour, masturbation in public, approaching others for sex, engaging indiscriminately in sexual activities
- intrusiveness and disregard for interpersonal space.

Some unwell patients may act on their sexual impulses in an inappropriate manner or misinterpret the behaviour of others. Where a patient is exhibiting disinhibited behaviours, protection of the patient and others from physical or sexual activity is paramount. Where a patient is assessed as being at acute risk because of disinhibition, immediate measures should be taken to ensure safety. Timeliness is of the essence as even a short delay in providing appropriate care may result in an adverse incident occurring.

Disinhibited patients who engage in sexual activity may give the appearance that it is consensual. However, informed consent cannot be given when the person does not have the requisite mental capacity to give consent.

Additional strategies

- Increase the level of nursing presence and care to help maintain the patient's boundaries and explain the reasons for this to the patient. Patients may experience increased observation levels or medication as punitive so care is needed in explaining the reason for the intervention.
- Ensure the patient is adequately clothed or afforded privacy at all times.
- Counsel patients about their behaviour and remaining safe. Even the most unwell patient may be able to modify their behaviour.
- Maintain clinical vigilance to prevent patients acting in ways that are uncharacteristic of them when well, based on previous knowledge of the patient or collateral information from family or carers in the case of new patients.
- Talk to families and carers about how best to understand and respond to their relative who may be acting in a sexually disinhibited way.

Responding to patients who are potential offenders

Identification of patients at risk of engaging in inappropriate sexual activity is important in promoting sexual safety and preventing harm. Some patients may be potential offenders because of their mental illness, for example, a patient with sexual disinhibition may act out their impulses. Others may be more predatory in intent and engage in opportunistic behaviour, targeting vulnerable patients.

Such individuals need to be closely monitored and regularly assessed throughout their admission and at times of transition, such as movement to high or lower dependency areas, or imminent discharge.

Additional assessment should include:

- history or reports of disinhibition or aggression from whatever cause, for example, mental illness, substance use, acquired brain injury
- history of sexual activity in previous admissions
- history or reports of inappropriate sexual activity
- history of violent behaviour, threats or intimidation
- history of domestic violence.

Additional strategies

- Close attention should be paid to the level of observation required, and the most appropriate bed allocation in relation to other patients and staff safety.
- A clear plan should be developed with specific strategies targeting the identified risks.
- Staff should be alert to the fact that persons who engage in sexually inappropriate activity might use subtle means of coercion, grooming and manipulation, not only overtly violent behaviour.
- Communication with the patient should be assertive and direct about the rules of the unit, behavioural expectations, and the consequences of sexual behaviour such as psychological harm, infection or pregnancy.
- Consider the need for a forensic psychiatric assessment.

Responding to disclosures of a past history of sexual abuse or recent sexual assault outside the unit

Some people may disclose a history of past sexual abuse during an inpatient admission. This might be the first time they have had the opportunity to talk to somebody about their experience, or even thought it might be relevant to their condition. Others may disclose that they have recently been sexually assaulted. Whatever the circumstances such disclosures may be a vital step in the person's recovery journey.

People with a history of abuse may have experienced their needs, wants and thoughts being persistently invalidated, and disclosures met with disbelief or repudiation. Staff attitudes and reactions to disclosure or suspicion of sexual assault can significantly impact the person's experience. Staff need to be aware of the many ways in which a past history of trauma may manifest in an individual, and the vulnerability of the person to re-traumatisation (see section on *Responding to patients with a history of trauma or abuse*). At all stages, where possible, staff should ensure that a person consents to disclosure of information, and the action that will be taken by staff on disclosure of that information.

It is important that staff acknowledge and support the person's disclosure. A person should be encouraged to reveal information at a pace and in a manner that is acceptable to them. The next step is to help the patient commence the process of thinking through what they want to do regarding the alleged behaviour or offence, including reporting to police (see also section *Managing allegations of sexual assault*), and their ongoing support needs. With the patient's consent, staff may wish to discuss with police possible options for the patient for pursuing an allegation of past sexual abuse or recent sexual assault outside the unit. Issues may also be discussed with police without providing identifying information where consent has not been provided

Staff should:

- respond sensitively and support the disclosure
- acknowledge that the recovery process will take time and will largely occur in community follow up
- offer the patient a referral to CASA or other relevant service
- consider their responsibilities to the patient and the implications the inappropriate sexual activity may have on treatment, especially where it may still be occurring
- examine the issue in the context of the patient's current mental and legal status e.g. an involuntary patient may not be well enough or have the capacity to pursue the allegation without the assistance of the authorised psychiatrist who may be required to take steps to protect the patient or report the allegation
- consider their increased vulnerability during the admission e.g. restricting visitors if known to be the alleged offender, or if the offender is another patient requiring admission, ensuring they are not admitted to the same unit
- outline the processes for making a police report and ensure the patient is assisted to make a report
- ensure discharge planning addresses any ongoing support and treatment needs.

Discharge and follow up care

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

For some patients, it may become apparent during their assessment and admission that they have a poorly developed understanding of sexual health and interpersonal boundaries, including sexual relationships, and would benefit from some skills acquisition and education. For example, social skills training, interpersonal skills development, conflict resolution, problem-solving, and sex education. The possible impact of medication on sexual function and the person's quality of life should also be discussed openly. Other patients may benefit from ongoing counselling regarding high-risk behaviours and developing healthier relationships.

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

Responding to allegations of sexual assault and sexual harassment

Sexual assault and harassment are serious matters and a consistent approach needs to be taken to the assessment, recording, reporting and follow up of all allegations. Staff may become accustomed to sexualised ideas, comments and behaviours in psychiatric patients, and may attribute a patient's complaint of sexual assault or harassment to their mental illness or personality. Others may find it difficult to know when to consider the behaviour of mentally disturbed adults as potentially criminal and warranting police involvement.

A patient in a mental health unit may not know how to make a complaint about sexual assault or harassment, and in some cases, even what constitutes sexual assault or harassment. A patient assaulted in a service may find it even more difficult to disclose such an event for fear of the perceived repercussions.

Staff attitudes and reactions to disclosure or suspicion of sexual assault and harassment can significantly impact a person's experience, and longer-term wellbeing. Likewise, how services are delivered may also trigger or exacerbate past traumas or cause re-traumatisation.

The management of allegations of sexual assault and harassment should be driven by the victim's wishes or their chosen advocate, their rights to recovery and justice, their future wellbeing, and the duty of care of mental health services and staff. Staff need to be mindful that a victim may require support to pursue the allegation as the unequal power relationship may leave the patient reluctant or unable to do so.

The role of service management

- All allegations of sexual assault and harassment should be taken seriously and followed up immediately with an effective and caring response.
- Clear procedures for reporting and investigating allegations of sexual assault and harassment must be established and staff trained in their application.
- The safety, physical and psychological needs of the patient, and their preferences about the management of the allegation, are the paramount consideration.
- Staff need to be able to recognise the rights and needs of the person who has experienced sexual assault and harassment.
- The authorised psychiatrist and senior management must be informed of all allegations of sexual assault and sexual harassment, and be involved in any decision to report the allegation to relevant authorities such as the police, carers or advocates and the Department of Health.
- Ensure debriefing is made available to those affected i.e. victim, other patients, staff, families and carers to support those involved and facilitate the ongoing functioning of the unit.
- Ensure post investigation feedback is provided to the victim and any learning from a review is used to inform practice improvement.

Procedure to be followed in the case of an allegation of sexual assault and harassment

Indicators of possible assault

There are various ways an allegation of sexual assault may come to attention. A patient may report an allegation or staff may suspect an incident has occurred; for example, a patient may be distressed, fearful or withdrawn, or exhibit other physical or behavioural signs suggestive of such an incident.

Staff need to be vigilant for any signs of sexual activity between patients, and have a low threshold for raising their concerns with the clinical team. While women are more likely to be the victim of sexual assault, men may also be victims of assault.

Assessing the situation

When an allegation is made, or a staff member becomes aware of an assault, staff should immediately assess the situation to ensure a safe environment for the victim, offender, other patients and staff. Staff should take whatever immediate steps are necessary to re-establish safety. First priority then is to care for the victim, and give them maximum support and assistance. At the same time the consultant psychiatrist and nurse unit manager, shift leader or nurse in charge on the unit, should be notified as well as the authorised psychiatrist.

Re-establishing safety

The first task is to ensure the safety of the victim by placing them in a safe area with appropriate staff support preferably a staff member of the victim's choice.

The alleged offender should also be removed to a safe environment to minimise contact with the victim, ideally off the unit, although this will depend on the available facilities. Where the patient accused of sexual assault or harassment requires continued treatment and care, consideration should be given to relocating them to another unit within the service, or to another area mental health service. Staff should ensure that the alleged offender is provided with appropriate support and care and treated fairly and reasonably by mental health staff.

Inter-service transfers should be negotiated between the authorised psychiatrists of each service. If necessary, the assistance of the Chief Psychiatrist may be sought to facilitate a transfer.

The needs of other patients in the unit should also be considered and addressed as appropriate to restabilise the therapeutic environment.

Where a staff member is the alleged offender, further contact between the victim and the accused staff member should be avoided. See also section on *Allegations of inappropriate sexual activity involving staff*.

Responding to the victim

Staff initial reaction to a reported allegation is crucial. Validating the person's experience, listening and believing, is important in alleviating short and long-term distress and restoring a sense of personal control in dealing with the incident.

It is not the responsibility of unit staff to determine the veracity of the allegation. Staff have an obligation to treat the allegation as serious until formal processes involving the authorised psychiatrist and, if appropriate, the police, determine otherwise.

Staff should listen and show concern, and obtain sufficient information to get a basic understanding of what occurred much in the same way as they would for any other incident or situation. It is the role of police to interview the patient and gather evidence about the allegation.

However, it is important to preserve evidence where sexual penetration is alleged or suspected. See section following on *Preserving evidence*.

When able to discuss the situation, the victim should be gently guided through the potential avenues of action. The aim is to help them make an informed decision about how they want to proceed. When a person is traumatised, good practice is to calmly talk them through each step so that they know what is happening and can decide accordingly. It is important the person does not feel pressured to act in a particular way but rather supported to reach their own decisions.

The victim should be informed that:

- Their immediate medical needs are first priority. Forensic medical examination is also important to obtain evidence should they want the police to investigate.
- They can have the support of the consumer consultant, family, friend, key worker, case manager, advocate or other significant person in any interviews.
- They can have access to CASA for counselling, help in completing a police report and legal representation, or to simply assist them make informed choices and decisions.
- Their right to privacy and confidentiality, within the limits of legislation, will be respected at all times.
- Their informed decisions will be respected at every stage of the process.
- It is their decision whether or not to involve the police and participate in a police investigation. If they do, the police will want to interview them and take a statement.
- Police will decide whether or not to proceed with charging and, if the matter goes to court, the patient may be required to give evidence.

Information should be provided in a manner and language that the person is most likely to understand. An interpreter should be used where there is any concern about the person's understanding of English. The interpreter should, wherever possible, be the same sex as the alleged victim.

Medical examination

On identification or reporting of an allegation of sexual assault or harassment, immediate medical review should be conducted by the treating medical staff as part of their responsibility for the patient's welfare and mental health treatment. The purpose of the review is to assess the patient's physical and mental health needs following the incident, respond to any immediate treatment and support needs, and make any necessary changes to the mental health treatment plan and management strategies.

This examination is not for the purpose of gathering evidence although information obtained at this time may be relevant to any future investigation. Any injuries or trauma noted should therefore be documented accurately and be available for interpreting by forensic medical officers.

Where further physical examination appears indicated, the patient should be given the option of a forensic medical examination or referral to another medical specialist, especially in the case of a female victim, where an internal examination may be necessary. Treating medical staff should discuss with the patient the role of a forensic medical examination.

Where appropriate, the risk of infection or pregnancy should be discussed with the victim, and testing recommended.

Where the victim is unwilling to consent to a physical examination, staff should do as much as they can to assess the person's needs, document the information that can be ascertained, continue talking with the patient about the purpose of an examination, and endeavour to complete or conduct an examination as soon as possible. The patient's capacity to give informed consent should also be evaluated. Where immediate medical treatment is indicated, and the victim is unable or unwilling to consent due to their illness, the authorised psychiatrist should follow the procedure for consent to non-psychiatric treatment.

The medical needs of any other persons involved in the assault or harassment should also be met.

Forensic medical examination

Medical needs are a priority in cases of sexual assault to minimise any adverse impact on the victim's health and facilitate the gathering of evidence. Where a sexual assault is suspected, the treating medical staff should discuss, with the victim's consent, the need for specialist assessment by a forensic medical officer.

Police may suggest that a forensic medical officer from the Victorian Institute of Forensic Medicine (VIFM) examine the victim. The examination of people who have been sexually assaulted is a specialised area, and the VIFM provides a 24 hour service (Tel: 03 9684 4480) for attendance when requested by police or hospital staff. Forensic medical officers assess and collect evidence for use in the investigation and possible prosecution, and undertake tests for sexually transmitted diseases and pregnancy, if appropriate. Forensic medical officers will also treat any immediate medical needs where appropriate.

Where a person is unable or unwilling to consent to a forensic medical examination, and the authorised psychiatrist is satisfied that relevant medical information may be gathered as part of necessary medical treatment, the procedure is considered non-psychiatric treatment to which substitute consent provisions apply under the Mental Health Act. Where there are no treatment needs, and the sole purpose of the examination is to collect forensic evidence, the procedure does not fall within the realm of non-psychiatric treatment, and substitute consent provisions cannot be used. In such cases, the advice and support of CASA or other sexual counselling agency should be sought for the patient and to assist the treating team in determining the best course of action.

Preserving evidence

It is important to preserve any potential evidence of sexual assault, and local police can advise the best way to go about this. The Code of Practice for the investigation of sexual assault on the Victoria Police (VicPol) website <www.police.vic.gov.au> can also be used to provide assistance.

Generally, the victim should be discouraged from showering or changing their clothes. The victim should be advised that showering or changing clothes may destroy evidence that could be used in any later court proceedings. The room where the offence is alleged to have occurred should be sealed off, so that the area remains undisturbed until police examination. If the person feels compelled to wash or change, the clothing they were wearing at the time should be labelled and secured in a bag. These steps also apply to any potential evidence obtained from the alleged offender. Any witness to the assault should be asked to wait separately until they have been interviewed by police.

Staff should record in the medical record a detailed account of the evidence they have stored for safekeeping including who took it, where and how it has been secured, and to whom they have handed the evidence.

A victim does not need to decide immediately about such matters as making a complaint or prosecution while in a state of distress. However some evidence that will later assist police investigation is only available in the immediate period following the assault and needs to be collected should the victim wish to proceed in the future.

Assessment of a person's decision making capacity

Whether a person has capacity to make informed decisions in relation to an incident of sexual assault, including reporting to police, is an important consideration.

The treating team should ensure that a thorough mental status assessment is performed by an authorised psychiatrist or his or her delegate to evaluate:

- The person's capacity to make informed judgements and give informed consent about their health care.
- The person's capacity to understand the process of reporting an allegation to the police, and what it might mean for them.
- The person's capacity to process and communicate information and effectively exercise their rights.
- The person's suitability to attend for police interview and any likely detrimental effects on their mental health.
- The person's capacity to collaborate with an investigation.
- The required resources and supports to assist the person.

This will assist the authorised psychiatrist to form an opinion about the person's wellness, the likely impact of police interview on their mental state, and any other clinical considerations, and advise police accordingly. It is typically the forensic medical officer's role to formally assess fitness for police interview.

Special attention is required in the case of involuntary patients under the *Mental Health Act*. Involuntary status refers to the person's capacity to consent to psychiatric treatment and does not automatically extend to a person's capacity to make decisions about non-psychiatric medical treatment or other wellbeing or lifestyle matters. Where it is determined that an involuntary patient does not have capacity to consent to non-psychiatric treatment, the Mental Health Act provides a process for obtaining substitute consent. Where concerns are held about a person's capacity to make informed decisions regarding other wellbeing or lifestyle issues, urgent application can be made for a guardian to make some decisions in the person's best interests. The Office of the Public Advocate website also has useful information relating to guardianship matters <www.publicadvocate.vic.gov.au>.

However, just because a person is unable to make an informed decision at one point in the process, does not mean they might not be able to do so at a later date. It is important to constantly monitor the person's capacity and provide all possible support to enable them to fully participate in the process and make their own decisions.

See also the *Chief Psychiatrist Guideline: Managing Persons required to attend police interview or court* (January 2005) for further information.

For further information see the Chief Psychiatrist's Guideline *General medical health needs, annual examination, non-psychiatric treatment, special procedures and medical research procedures - January 2008*.

Reporting an allegation to police

The *Protocol between Victoria Police and the Department of Human Services Mental Health Branch* (2004) requires all area mental health services to have:

- a Mental Health Emergency Services Liaison Committee¹⁰
- detailed procedures and local protocols for critical incidents involving allegations of physical and sexual assault, including
 - directions as to when staff are to report the allegations to Victoria Police
 - procedures for contacting police
 - and actions to be taken to protect evidence.

When to report an allegation to police

All allegations of sexual assault should be reported to police where an assault is known or suspected to have occurred.

However, in an acute mental health setting there may be some occasions where clinical judgement will need to be exercised. For example, where a patient does not consent to police involvement, or where an allegation appears related to a person's mental state or condition. It is the authorised psychiatrist's role to determine reporting in these instances, on a case-by-case basis. If in doubt the authorised psychiatrist may wish to discuss the matter with police.

Factors to consider in reporting should include:

- the victim's wishes
- current mental status examination
- past history
- carer, guardian or advocate view.

Where a patient wishes to report an allegation of sexual assault

Where the victim wants the allegation reported to police, the service's role is to facilitate the reporting and enlist the necessary services to support the patient through the process.

The authorised psychiatrist should notify the police and facilitate their investigation. The patient should be offered the services of CASA or other relevant agency.

¹⁰ The purpose of the Committee is to provide a forum to promote effective collaboration, discuss and review any problematic incidents, and develop local agreements regarding the interaction between emergency services, including the reporting of physical and sexual assault.

Where a patient does not wish to involve police, but there is information to support an allegation of sexual assault

Clinical staff may believe an assault has occurred, and have information supporting that presumption but, despite counselling and support, the patient may not want the allegation reported to police. While the patient's choice should be uppermost, the authorised psychiatrist has a duty of care to consider and act in the person's best interests. The patient may also wish to continue to process this with clinical staff. Refer to the factors for consideration above for *Assessment of a person's decision making capacity*.

Where an involuntary patient has been assessed by the authorised psychiatrist and the patient does not have capacity to make informed decisions in relation to an incident of sexual assault, the authorised psychiatrist has a duty of care to report the allegation to police.

Where an involuntary patient has been assessed and the patient does have capacity, the patient's wishes must be respected. The authorised psychiatrist should however take the necessary steps to protect the patient's interests should they change their mind over time. This may involve the authorised psychiatrist ensuring the incident is well documented and any objective evidence is collected and preserved should the person wish to proceed at a later date. The patient should be fully informed about the actions that will be taken and the reasons behind them.

Follow up care should also be provided including ongoing counselling about the event to understand their wish not to report, and help them exercise their rights, which may still include a choice not to proceed with any further action. Referral to CASA or other agency is recommended in these circumstances.

Where a patient believes the sexual activity was consensual, but staff suspect an assault

Sometimes patients may be of the view that they have engaged in consensual sexual activity. Neither party expresses any concern or wishes to take any action. Staff may have concerns about one or both patient's capacity to make an informed judgement, based on their mental state, and knowledge of the patient(s) and their circumstance when well; for example, their age, relationship status, cultural context and values.

Where staff believe the activity may constitute an assault, they should follow the process outlined in instances where there is information to support an allegation of sexual assault but a patient does not consent to police involvement. (See above).

Staff should counsel both patients and implement preventative strategies (see section on *Responding to Sexual Activity*). Any other precautions such as contraceptive status, pregnancy or screening for sexually transmitted diseases should be undertaken.

Where a patient wants to report an allegation to police but there is no information supporting the allegation

The authorised psychiatrist has a role in determining the threshold for reporting to police in instances where clinical assessment and available information does not lend any support to the occurrence of the allegation, or indeed there may be information contradicting the possibility that an assault could have occurred. When unwell some patients experience psychotic symptoms which may have them firmly believe that an event of a sexual nature has occurred. For example, a patient in seclusion reporting they were assaulted by a particular co-patient during the seclusion episode, or a patient reporting that they had been impregnated by a person who could not have had access to them.

Unit staff should ensure appropriate documentation and still report all such allegations to the authorised psychiatrist and senior management as required by local policies and procedures; it is not appropriate for clinicians at the unit level to decide the validity of an allegation.

Care needs to be exercised in assessing such allegations, or overriding a patient's wish to report to police on clinical grounds, so that allegations of sexual assault are not minimised and patients rights infringed. It also needs to be remembered that supporting information is often not available or self evident in cases of sexual assault.

The involvement of an independent agency such as CASA may be helpful in reaching the most appropriate decision and responding to the patient's perceptions.

Where a determination is made not to report an incident to police, details of the clinical assessment and decision should be fully documented in the medical record. Follow up and referral as appropriate should also be made for the patient.

Role of the authorised psychiatrist

Under the Mental Health Act the authorised psychiatrist has an overall responsibility for the treatment and care provided in the approved mental health service. The authorised psychiatrist should be informed of all incidents relating to the sexual safety of patients, and all allegations of inappropriate sexual activity. The authorised psychiatrist in conjunction with senior management should:

- coordinate and oversee the response to an allegation
- make a preliminary determination about whether the incident constitutes inappropriate sexual activity
- evaluate the patient's capacity to consent to reporting to police and appropriate follow-up
- assess the role of the person's current mental state in the allegation
- decide in consultation with the patient and relevant others the reporting of an allegation to police
- identify any systemic or practice issues related to the incident, and institute action to address them.

Role of staff in assisting police

Staff should assist police to conduct their investigation and make themselves available as appropriate. At the time of contact it is important that police are advised if the client has impaired mental functioning and will need the support of an Independent Third Person (ITP) during interview or when a statement is being taken.

After an interview, staff should also assess how the patient might have been affected by the interview process and any clinical implications arising from this, and take appropriate action to respond to the patient's needs.

Role of police

The role of police is to investigate the reported allegation, and to identify, apprehend and prosecute the offender(s). Useful information is available on the VicPol website regarding the investigation of sexual assault in the *Code of Practice for Investigation of Sexual Assault*.

Where the investigation requires a mentally ill person to be interviewed, Victoria Police Operating Procedures¹¹ state that an independent third person (ITP) is to be present. A close relative or friend who is not associated with the police inquiry or an ITP who is specially trained by the Office of the Public Advocate and is familiar with police procedures and the difficulties that may arise in police interviews should be used. This applies whether the mentally ill person is being interviewed as a witness, a suspect, or as an alleged victim.

The ITP's role is to help communication, help the person understand the questions asked by the police, and help police understand the reply. Police will organise an ITP to be present. This is why it is important to inform police that such a person is required at the time of reporting the allegation.

Police will investigate all alleged assaults reported to them. In some cases, particularly where there is a lack of physical evidence, there will be insufficient evidence to prosecute the offender. Under these circumstances, it is important the individual is made aware of their ability to undertake civil action if appropriate.

The responsible investigating police officer will provide feedback to the victim regarding progress of the case and as appropriate, advise the mental health service on the outcome of the investigation.

Contacting the Centre Against Sexual Assault (CASA) or other sexual assault counselling agency

If the patient consents, in instances of alleged sexual assault, the local CASA, or other sexual assault counselling agency, should be contacted at the same time police are informed of the allegation, or earlier where the victim may be in doubt about how best to proceed. CASA provides a range of crisis, counselling and support services for recent and past victims, male and female, of sexual assault. The support of a CASA counsellor-advocate can be of benefit to the victim in assisting them to think through what action they wish to take in respect to the alleged offender and navigate the legal processes. CASA has an agreement with the Office of the Public Advocate that counsellor/advocates can act as ITPs for sexual assault forensic medical examinations and presentations.

CASA may be of assistance in cases where the patient chooses not to involve police, or where a report is not made on clinical grounds. Patients should be given the offer of assistance and allowed to make their own decision whether they wish to use the CASA services.

The need for further support or counselling from CASA or other relevant agency should be considered in discharge planning and referrals made where appropriate.

¹¹ *Protocol between Victoria Police and the Department of Human Services Mental Health Branch 2004 – under review at the time of writing the Guideline.*

Allegations of inappropriate sexual activity involving staff

Any sexual activity between staff and patients in any component or level of the service is always unacceptable. Staff are bound by professional codes of conduct and owe patients a duty of care, which requires them to take reasonable care of their patients. Sexual activity between staff and persons with a cognitive impairment is a criminal offence, irrespective of who initiated the relationship or whether it is considered consensual or not.

Any instance of known or suspected sexual activity between staff and a patient should be reported to senior management. Services should have local protocols for responding to such allegations through the usual investigation processes and disciplinary procedures.

The response to the patient should follow these guidelines with regard to their care, including that they should be protected from any further contact or association with the staff member concerned, even while an allegation is pending investigation.

The staff member should be informed of the allegation made against them, the responsibility of the service to investigate the allegation, how the investigation will proceed and the immediate implications for the staff member. The staff member's rights should be protected and they should be given advice about the supports available to them e.g. union, or employee assistance program. The employment status of the staff member accused should be determined by the circumstances and local protocols for managing professional conduct issues.

Documentation

Services should already have established procedures for documenting clinical care and incidents that comply with requirements of the Health Records Act and the Mental Health Act in relation to the collection, use and disclosure of health information.

In documenting instances of inappropriate sexual activity reports should include a factual account of events as known, including staff perceptions and, where possible, verbatim accounts from the victim and other parties involved. Terms or language that may be open to interpretation should be avoided. For example, clinical terminology such as psychotic, deluded, thought disordered should be substituted with actual descriptions of the patient's beliefs, behaviours or content of speech.

Particular attention should be given to the comprehensive and accurate recording in the medical record of:

- time, date, place and description of the alleged incident based on available and reported information
- any clinical assessments and interventions taken following the alleged incident
- details of steps taken to preserve evidence
- all discussions with the victim about referral and follow up
- the name of the alleged offender and any witnesses
- the notification of the authorised psychiatrist, nurse unit manager and mental health service management
- completion of adverse incident forms and reports.

Consideration should also be given to the following:

- mention of the incident in the discharge summary to the community team or practitioner e.g. community mental health service, general practitioner, private psychiatrist or other clinician
- naming the alleged offender or offender, where also a patient, in both medical records
- alert systems for patients with a history of inappropriate sexual activity e.g. alert stickers or other measures to flag the risk in the medical record.

Disclosing information

Services and staff have a legislative and professional obligation to protect health information from unauthorised use or disclosure. Disclosure of health information in mental health services must comply with section 120A of the Mental Health Act. The Act prescribes general and specific circumstances when identified consumer information may be disclosed to external organisations and individuals.

The first principle in disclosing information is to seek the patient's consent and ensure they understand the purpose of the disclosure, to whom it will be disclosed and any possible adverse consequences of disclosure. For example, an unwell patient may not be able to think through the possible implications of unlimited disclosure to partners, friends and family. This may be a very sensitive area in the case of sexual activity, and all steps must be taken to protect the patient's privacy and future wellbeing. Offenders of inappropriate sexual activity are also frequently known to the victim and may be family members.

There may be instances where information may need to be disclosed to other agencies without the patient's consent, and guidelines should be available to staff on determining the permitted disclosures under section 120A of the Mental Health Act. Where such disclosure is made, it is good practice to inform the patient.

All decisions to disclose information should be documented in the patient's medical record. Records should show who made the decision, to whom the information was disclosed, when and why, and what information was disclosed.

If staff have queries about their duty to protect health information from unauthorised use or disclosure, the service should obtain independent legal advice.

Further information may be obtained from the *Program Management Circular: Confidentiality under the Mental Health Act 1986* (November 2008).

Notification of primary carers, family or guardians

Most carers and families are an important source of physical and emotional support to their relative with a mental illness. Carers need access to information to fulfil their caring role. Clear and open communication and sharing of information between clinicians, patients and carers and family is strongly encouraged.

At the same time, it is well known that most sexual assault happens within families. This may be past abuse, a recent assault, or violence of some other form. Staff need to be alert to this possibility and obtain sufficient information to guide their decisions about notifying or involving families or carers in any discussion of sexual assault or abuse to ensure they are not exposing the patient to further risk.

Involvement of families, carers and significant others in relation to sexual activity or assault should be guided by the patient's wishes and, where available, knowledge of the alleged offender. Where patient consent is not given, section 120A(3)(ca) of the Mental Health Act only allows information to be disclosed to family, primary carers and guardians if the information is reasonably required for ongoing care and the person who receives the information will be involved in providing the care. Disclosure under this provision is a clinical decision taking all factors into account.

For further information refer to *Chief Psychiatrist Guideline: Working together with families and carers* (April 2005).

Further information on disclosing information to carers, family or next of kin is also available in the *Program Management Circular: Confidentiality under the Mental Health Act 1986* (November 2008).

Support and debriefing

Allegations of sexual assault or other sexual activity can have a profound impact on patients other than those directly involved, and on the morale of staff and the operation of the unit. Carers and families may also be negatively affected and question the service's ability to safely care for their relative.

Senior management need to ensure that debriefing is offered to all those who may be impacted directly or vicariously by the incident to reduce any potential post-traumatic effects. Senior management need also to be aware that the operation of the unit may be affected by an allegation or assault, and should take appropriate steps to restore effective functioning of the unit.

Everyone likely to be affected should be offered support and debriefing. The type of support and debriefing offered, however, will vary depending on who is involved. For example, debriefing for the victim and or their family, and other co-patients, may differ from that for a staff member or treating team.

Reporting to the Department

Incidents in public hospitals or approved mental health services under the *Mental Health Act 1986* are reported via the usual hospital process.

Reporting to the Chief Psychiatrist

The authorised psychiatrist or clinical director should inform the Chief Psychiatrist of any occurrence of sexual assault in an acute inpatient unit. Where there is any doubt about reporting, the authorised psychiatrist should seek the Chief Psychiatrist's advice.

Education and Training

Staff attitudes, knowledge and skills are a core component in promoting sexual safety and responding to patients who have experienced sexual abuse and assault. Yet training in sexuality and sexual behaviour is rarely provided to staff who are required to respond to sexual activity in the clinical setting, which may lead to variable responses devoid of any underlying theoretical framework.

Services have a responsibility to:

- provide training in gender sensitive and evidence based practice as a component of induction and orientation for all mental health service staff
- provide training in the relationship between past sexual abuse and mental illness, and the assessment and management of past trauma
- provide training in the prevention and management of sexual assault
- provide training in the implementation of local sexual safety policy and procedures
- provide general awareness training on personal attitudes regarding sexuality and how this can impact on patient care
- use service data to inform ongoing quality monitoring and improvement in relation to sexual safety education.

Further information

For further information regarding this Guideline contact the Office of the Chief Psychiatrist

Telephone: 1300 767 299 or 03 9096 7571

Acknowledgements

The Guideline has drawn on existing policies and procedures from Australia and the United Kingdom, in particular the New South Wales and Queensland Sexual Safety Guidelines. Their contribution is gratefully acknowledged.

Self assessment tool

The following indicators are provided to assist services in the internal quality monitoring of practices, and form the basis for the Chief Psychiatrist's clinical review of mental health services.

- Each service has policies and procedures for the promotion of sexual safety and the management of sexual activity in acute adult inpatient units.
- Each service has systems to collect and analyse data on sexual incidents by gender to inform service improvement and quality.
- Periodic audits are conducted to assess the safety and adequacy of the physical environment.
- Each service has a Mental Health Emergency Services Liaison Committee and local protocols for reporting and responding to allegations of sexual assault.
- There is evidence of consumer and carer input in the development and review of local guidelines and practice regarding sexual safety.
- Medical records show evidence of attention to sexual safety risk assessment and defined strategies to address identified risk.
- Medical records show evidence of sexual physical health assessment and appropriate follow up action.
- Medical records demonstrate the use of relevant evidence based practice.
- Periodic audits are conducted to assess the standards of documentation in relation to sexual safety, and staff compliance with written policies and procedures.
- Clinical staff are able to identify the key principles of the management of sexual activity and assault in the unit.

References

Chief Psychiatrist guideline: *High dependency units*, August 2002

Chief Psychiatrist guideline: *Managing Persons required to attend police interview or court*, May 2005.

Chief Psychiatrist guideline: *Working together with families and carers*, April 2005.

Department of Health, *Mental health policy implementation guide: Adult acute inpatient care provision*, London, 2002.

Department of Human Services, *Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019*, February 2009.

Department of Human Services, *Program Management Circular: Confidentiality under the Mental Health Act 1986*, November 2008.

Department of Human Services, *Protocol between Victoria Police and the Department of Human Services Mental Health Branch, 2004*. (This protocol is currently under revision)

Department of Human Services, *The gender sensitivity and safety in adult acute inpatient units project: Final report, 2008*.

Department of Human Services, *Responding to Allegations of Physical or Sexual Assault, 2005*.

Department of Human Services, *Review of the Mental Health Act 1986: Consultation paper* – December 2008.

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

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

World Health Organisation Collaborating Centre for Evidence in Mental Health Policy: Treatment Protocol Project. *Acute Inpatient Psychiatric Care: A source book 2nd edition*. 2003.

Appendix 1

Sexual Safety Assessment Tool

(taken from *Acute Inpatient Psychiatric Care: A source book*)

Factors to be considered in risk assessment

High risk factors

- sexual disinhibition (seductive gestures, stance, gaze, body movements, sexual talk, touching others in a sexual manner, revealing clothing)
- heightened sexual activity
- states intent to have sexual relations
- means and opportunity to carry out intent
- minimal insight into consequences of sexual activity e.g. impact on family and reputation, psychological impact, sexually transmitted diseases, and exposure to assault
- history of childhood abuse
- previous history of sexual assault
- history of sexual offences
- violent behaviour, abusive language, threats and intimidation
- disorganisation associated with psychotic illness
- intellectual/cognitive impairment
- under the influence of drugs or alcohol
- sedation from medication
- not responsive to contracting with staff not to engage in sexual activities
- not accepting of medications and physical treatments in the presence of other stated risk factors.

Moderate risk factors

- sexual disinhibition (seductive gestures, stance, gaze, body movements, sexual talk, touching others in a sexual manner, revealing clothing)
- some heightened sexual activity
- no stated intent to have sexual relations
- history of childhood abuse
- previous history of sexual assault
- disorganisation associated with psychotic illness
- intellectual/cognitive impairment
- receptive to information regarding consequences of sexual activity, e.g. reputation, sexually transmitted diseases and exposure to assault
- under the influence of drugs or alcohol
- past history of sexual offences
- agreement to contracting with staff not to engage in sexual activities
- accepting of medications and physical treatments in the presence of other stated risk factors.

Low risk factors

- The person exhibits no inappropriate sexual behaviour and no intent to engage in sexual activity whilst an inpatient is expressed.
- The person is not vulnerable to sexual coercion/assault as a result of disorganisation associated with psychotic illness.

