The right to be safe: ensuring sexual safety in acute mental health inpatient units

Responses from services to project recommendations

Outline

This document provides a summary of responses from Victorian public mental health services to the recommendations of *The right to be safe*: *ensuring sexual safety in acute mental health inpatient units report* (the sexual safety project report) released by the Mental Health Complaints Commissioner (MHCC) in March 2018. This document includes:

- the background to the sexual safety project
- an outline of recommendations from the sexual safety project report
- a summary of the MHCC's approach to working with services in relation to their implementation of the recommendations, particularly how they respond to complaints raising concerns about sexual safety
- a summary of responses, including innovative approaches to implementing some areas of recommendation

Key points:

- Complaints made and reported about sexual safety breaches in inpatient mental health units have increased since *The right to be safe* report.
- This suggests both that people are more prepared to raise their concerns and report sexual safety breaches. However, it also suggests that services need to do more to fully implement the report's recommendations.
- From services' responses to the recommendations, as well as complaints received and feedback from consumers, it appears that services are more likely to take decisive action to prevent sexual safety breaches once a serious breach has occurred within their service, rather than all services implementing prevention strategies and using targeted interventions to address risks.

Background

Reviews, surveys and advocacy documents over many years have consistently identified that many people do not feel or are not sexually safe when accessing acute mental health inpatient treatment, with women's experiences of mixed-gender acute inpatient mental health treatment being a particular concern.

In recognition of this, the Victorian Department of Health and Human Services (the department) and the Chief Psychiatrist have previously developed guidelines to promote

sexual safety and gender sensitivity and safety, rolled out training for mental health services on providing gender sensitive care and provided funding to mental health services for infrastructure improvements, including women-only corridors, lounges, courtyards and bathrooms, as well as lockable bedroom doors and swipe-band access to women-only corridors.

Nevertheless, over its first three years of operation to 30 June 2017, the MHCC identified concerning themes in complaints about sexual safety in mental health services. While the nature of these complaints varied, the gravity of many of the concerns raised and the variability in service responses indicated the need for closer examination of these issues to identify ways to prevent these significant avoidable harms.

What is sexual safety?

Sexual safety in acute mental health inpatient environments is defined to include feeling and being sexually safe in these environments, including being free from sexual activity, alleged sexual harassment and alleged sexual assault.

Sexual safety breaches are experiences in which a person is not, or does not feel, sexually safe, including experiences of sexual activity, alleged sexual harassment and alleged sexual assault.

In 2017-18, the MHCC undertook *The right to be safe: ensuring sexual safety in acute mental health inpatient units* project, in accordance with our statutory function under the *Mental Health Act* to identify, analyse and review quality and safety issues and make recommendations for service improvement (s 228(j)). This project included:

- an analysis of relevant complaints made to the MHCC as well as complaints made directly to services
- findings of four MHCC investigations into complaints about sexual safety breaches
- a review of the literature, research and relevant policies, standards and initiatives from local and other jurisdictions
- consultations with key stakeholders, including people with lived experience, families and carers, service providers and staff, professional bodies, peak bodies, government and advocacy organisations.

Key findings of the project included that most complaints about sexual safety related to men breaching the sexual safety of women (72 per cent), with intensive care areas (ICAs) being high risk areas for sexual safety breaches (40 per cent of complaints where data was available). Most (77 per cent) complaints identified other people accessing services as alleged perpetrators, and complaints were most commonly about alleged sexual assault (47 per cent), followed by broader concerns about gender safety (38 per cent).

Consistent with broader under-reporting of sexual assault, complaints are unlikely to represent a full picture of people's experiences in mental health services. While all sexual safety breaches are likely to be somewhat under-represented in complaints, there may be additional barriers to making a complaint about some kinds of breaches, or for particular groups of people. For example, people may experience more barriers to making a complaint about a staff member (including fear of not being believed) than about a co-consumer. In addition, many groups including men, people from culturally diverse backgrounds, LGBTI

people, older people and younger people may experience additional barriers of stigma and shame that prevent them from making a complaint about a sexual safety breach.

Recommendations arising from the project

Recommendation for a comprehensive sexual safety strategy

In March 2018, the MHCC published its report on the sexual safety project. In addition to the above findings, this report outlined a range of recommendations for the department and the Chief Psychiatrist to help ensure people's sexual safety in acute mental health inpatient units. The MHCC's overarching recommendation was for the department to develop a comprehensive sexual safety strategy to plan, coordinate and monitor action to prevent and respond to breaches of sexual safety. The MHCC notes that the department has advised that work on this strategy has commenced and is underway.

The MHCC is pleased to contribute to the department's work in responding to the recommendations of *The right to be safe* through membership of the Chief Psychiatrist's Sexual Safety Committee which includes consumer, carer and clinical leaders from across Victoria, as well as representation from Women's Mental Health Network Victoria, Transgender Victoria, VMHILN and VAHI.

The MHCC notes the range of actions being taken or recently completed by the department to progress the report's recommendations, including:

- establishment of a reporting process for all public acute mental health services to report sexual safety breaches directly to the Office of the Chief Psychiatrist. Reports are reviewed individually and responded to as needed, and are collated and analysed quarterly to inform the Mental Health Branch's sexual safety work plans.
- a completed audit of adult inpatient mental health facilities, which has included assessment of what infrastructure is in place to support sexual safety
- progressing review of the Chief Psychiatrist's Guideline: *Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault* to respond to the recommendations of *The right to be safe,* and commencing review of DHHS's Service Guideline for gender sensitivity and safety
- creation of the *Mental Health Intensive Care Framework* (2020) which promotes more person-centred care within Intensive Care Areas (ICAs) and presents several strategies for providing intensive care in ways that do not rely on using restrictive spaces.
- fully implementing the Safewards model, designed to improve safety for consumers and staff and reduce the use of potentially re-traumatising restrictive interventions, across all mental health inpatient units in 2020, and trialling this model in Emergency Departments.
- Preparation of a Chief Psychiatrist's *Guideline on Risk assessment and Safety Planning on Mental Health Inpatient Services.* The department advises that this guideline is currently being developed and is close to completion. It supports a comprehensive, individualised approach to safety planning including risks relating to vulnerability to sexual assault or exploitation and risk of sexually inappropriate or assaultive behaviour.
- Responding to recommendations from *The right to be safe* in development of other guidelines and frameworks including the Chief Psychiatrist Guideline - Working

together with Families and Carers (2018), Chief Psychiatrist's Guideline and Practice Resource: Family Violence (2018) and Equally Well in Victoria (2019).

The MHCC continues to advocate with the department about the need for more transparent reporting and accountability for the prevention of sexual safety breaches, e.g. by reporting sexual safety breach indicators in statewide quality and safety performance reports, and possibly including sexual safety breaches in services' Statements of Priorities.[1]

Recommendations to services

Specific recommendations were also made to public mental health services. These recommendations were framed as strategies for primary / universal prevention or targeted prevention of sexual safety breaches, and tertiary interventions to respond to sexual safety breaches. Primary prevention recommendations were for whole-of-population initiatives that address the underlying drivers of sexual safety breaches within mental health services. Targeted prevention recommendations aimed to identify and respond to individuals who are at risk of experiencing or perpetrating sexual safety breaches. Recommendations for tertiary interventions aimed to improve support for people who have experienced sexual safety breaches, hold perpetrators to account and aim to prevent reoccurrence. A total of 50 individual recommendations were made to mental health services in relation to 15 areas.

[1] This has been raised for instance through the MHCC's input to the on 'Progress Measures Working Group' convened by the department's Mental Health Branch.

Summary of responses by services to the recommendations

A range of outreach activities were undertaken to disseminate the findings and recommendations of the sexual safety project, including a forum to launch the report in March 2018 and meetings with individual services. In late 2018, the MHCC sought responses from designated mental health services about the actions they had taken in response to the recommendations of the sexual safety project. All services provided a response about actions they had taken in response to the recommendations, with most services indicating that some recommendations had been met, others were currently in progress and some had not yet commenced.

The approach to implementation varied across services, with some services taking an in-depth approach to reviewing policies and programs across the service to better ensure sexual safety, and others adjusting existing approaches. The responses of services are summarised below, including areas of good practice as well as areas where further work is required to ensure sexual safety in mental health inpatient units.

Primary prevention

Area of recommendation 1: Establish clear reporting and monitoring mechanisms to ensure accountability for preventing sexual safety breaches

Specific recommendations made to services in relation to this area were

- Developing systems to monitor sexual safety breaches, including inclusion of sexual safety in service risk registers
- Reviewing policies and procedures to ensure that suspected or alleged sexual assaults are classified as at least incident severity rating 2 (ISR2) in incident reporting systems and reported to senior management for review and decision making.

All services indicated that sexual safety incidents were reported in Riskman/VHIMS. However, only 11 services confirmed that all suspected or reported sexual assaults were classified as at least ISR2, meaning that in some services, suspected or reported sexual assaults are not necessarily immediately escalated to senior management for review and response. We note that since the time that services reported to us, changes have been implemented to VHIMS Central to ensure that sexual safety breaches will be initially classified as at least an ISR2.

Some services outlined detailed reporting, review and monitoring mechanisms for sexual safety breaches, including escalation to executive clinical staff, clinical, quality and risk committees or CEOs for review, including reviews of recommendations arising from investigations. However, higher-level oversight of reported sexual safety incidents was unclear for many services. We understand that all services are now providing reports of sexual safety breaches to the Chief Psychiatrist.

A minority of services confirmed in their responses that sexual safety is included in their service risk registers. This was recommended in *The right to be safe* to ensure that sexual safety breaches are recognised as a significant risk to consumers and to ensure that services have clear plans and accountability for preventing breaches. We continue to advocate for the department to include the prevention of sexual safety breaches as a performance indicator for services, and note that in the absence of a formal indicator

services can show leadership by ensuring they are transparent and accountable in how they manage sexual safety within their service.[2]

Area of recommendation 2: Build leadership to support best practice in preventing and responding to sexual safety breaches

Specific recommendations made to services in relation to this area were:

- Taking steps through training and workforce development to build staff knowledge of sexual safety, recognition of sexual harassment and sexual assault, and why sexual activity in acute inpatient units should be treated as a breach of sexual safety
- Ensuring that guidelines, policies and procedures for identifying and responding to sexual safety concerns are clear and easy to follow
- Ensuring that responsibility for building capability to ensure sexual safety is clearly allocated
- Considering how peer support in acute mental health units can be expanded or refocused to support sexual safety.

At the time of response, some services advised that they provide comprehensive training for all staff that specifically addresses recognition of sexual harassment and sexual assault, and why sexual activity is a breach of safety, while other services were planning or developing specific sexual safety training programs. However, not all services reported having training that is aimed specifically at understanding and recognising sexual safety issues, is mandatory or provided to all levels of staff. While all services confirmed that they have guidelines, policies and procedures in place for identifying and responding to sexual safety concerns, only some services reported making a specific effort to ensure that these are clear and easy to follow, e.g. through the development of supportive resources and tools such as acronyms, flowcharts and checklists.

A few services identified key senior personnel or working groups with a specific mandate to build capability to ensure sexual safety. However, at other services this responsibility was spread among many staff or not allocated. Most services reported that they have peer support workers or consumer consultants with whom consumers can discuss sexual safety concerns, or who are involved in responding to complaints about sexual safety breaches. However, currently sexual safety does not appear to be a specific focus for peer support, although some services advised that they are planning to provide additional training to peer workers in relation to sexual safety.

Area of recommendation 3: Trauma-informed care as a primary prevention strategy

Specific recommendations made to services in relation to this area were:

- Enhancing supported decision-making, including the development of advance statements
- Supporting staff to access training in trauma-informed care and principles
- Continuing to work to minimise and eliminate the use of restrictive interventions

[2] Ibid

- Integrating principles of sexual safety, trauma-informed care and supported decision making into supervision models and practice.

Most services reported facilitating and encouraging the use of advance statements and providing some training on supported decision making and the completion of advance statements to staff and peer support workers. However, services could improve how they think about and promote the use of advance statements, trauma-informed care and supported decision making in the specific context of sexual safety (for example, asking people proactively what would help them to feel safe at the start of an admission, and workshopping ideas and options with the person).

Most services provide training in trauma-informed care, with some services taking unique approaches including extending this training to ED staff and local police, liaising with Centres Against Sexual Assault (CASAs) and Victoria Police's Sexual Offences and Child abuse Investigation Teams (SOCITs) to develop training, and undertaking evaluations. A key consideration for services would be incorporating sexual safety into trauma-informed care training, including ensuring all staff understand the link between previous trauma and sexual risk.

The implementation of trauma-informed care also supports services' ongoing efforts to minimise and eliminate the use of restrictive interventions, which have included the implementation of Safewards, the use of sensory modulation and sensory rooms, and the establishment of relevant governance, training, audit and review mechanisms.

Supervision models at a few services included a focus on sexual safety, trauma-informed care and supported decision making, but for most services, supervision models were either under review or did not address these issues specifically. For changes in practice to be truly adopted as cultural change, it is important that providing trauma-informed and safe care is a focus of supervision and other professional development opportunities including reflective practice within services.

Area of recommendation 4: Ensuring unit planning, design and maintenance supports sexual safety, particularly for women and other vulnerable populations

Specific recommendations made to services in relation to this area were:

- Ensuring that systems are in place to prioritise infrastructure that supports sexual safety, including prioritising this infrastructure for repair if broken
- Ensuring that bedroom doors can be locked by people accessing inpatient treatment and are re-locked by staff
- Ensuring that systems are in place to prevent unauthorised access to women-only or gender-safe corridors
- Ensuring that systems are in place to monitor whether infrastructure to support sexual safety is used as intended.

Most services reported that a range of infrastructure to support sexual safety had been implemented, including women's only corridors, lounge and courtyard spaces, allocation of bedrooms to vulnerable consumers closest to the nursing station, and providing ensuites to all rooms or gender-specific bathrooms. However, some services acknowledged an ongoing practice of locating male consumers in bedrooms in women-only corridors when demand for beds was high.

One service noted that that there was a ‘swing room’ at the start of the women’s only area that could be locked two ways, enabling it to be either a secure part of the women’s only area or a part of the general ward, depending on need. While we note that ‘swing rooms’ are available at a number of services; our observation from complaints to our office is that their use could be improved.

Some services are in the planning/architectural phase for making improvements to infrastructure to support sexual safety and a few services highlighted processes for identifying and escalating needed infrastructure repairs.

Most services reported that consumers could lock their own bedroom doors, either manually or by using swipe cards or wristbands. Only some services confirmed that consumers were advised that they could lock their own rooms on admission, and few services confirmed there were policies and procedures in place for staff to ensure that doors were re-locked after night-time observations. We note that people continue to report that they were either not aware they could lock their door, or that their door was left open after overnight observations[3]. There is no acceptable reason for this to continue to occur.

Swipe card or wristband access to women’s only areas was available at some services, but even these services acknowledged that consumers with access to these areas could provide access to others. Strategies to mitigate this risk included informing consumers during orientation about the requirements for accessing gender-specific areas, visual and CCTV monitoring by staff of these areas, signage, and deactivation of lost swipe cards or wristbands.

Some services confirmed that breaches of gender-specific areas are reported and investigated via VHIMS or Riskman, and that environmental, gender sensitivity, and swipe-card usage audits are undertaken.

Area of recommendation 5: Developing a plan to improve the safety of ICAs as well as alternative strategies to support people who are at risk in these environments

Specific recommendations made to services in relation to this area were:

- Considering options for using resources flexibly to ensure sexual safety in ICA environments, such as designating an ICA women-only if possible
- Reviewing policies and procedures to ensure that sexual safety is a key consideration when deciding to place a person in an ICA and that other options are explored for vulnerable people
- If there is no alternative to placing a vulnerable person in an ICA, reviewing policies and procedures to ensure that a plan is developed with that person to ensure their safety
- Implementing strategies and monitoring systems to ensure that risks of breaches of sexual safety are managed in ICA environments.

Some services advised that they have the capacity to create gender-specific areas in their ICAs. Other services advised using other strategies to ensure sexual safety, such as using

[3] We are also aware that consumer advocates continue to raise this as an issue for people receiving inpatient treatment.

one-to-one nursing or 'specialling' (either in ICAs or in low dependency units). Other strategies reported included allocation of bedrooms closest to the nurses' station to vulnerable consumers or consumers who may be a risk to others, maintaining adequate staffing or regularly moving consumers to maintain an appropriate balance. While we acknowledge that moving consumers regularly is disruptive, it is preferable where the only other option is to have an unsafe mix of highly vulnerable people and people who are at high risk of perpetrating violence. Despite this, many services were unable to clearly articulate whether and how sexual safety is considered in deciding whether to place a person in an ICA, and for other services, policies and procedures regarding use of ICAs are still under review or development.

Positively, one service advised that risk assessment undertaken at the time of decision about whether to place a consumer in the ICA includes consideration of the person's unique vulnerabilities/risk to others in the context of the makeup of the ICA *at that time*. This responds to the MHCC's observations in *The right to be safe* about the need for services to think of the changing environment of the unit as a dynamic risk, and to consider this in individual risk planning.

Few services were able to articulate how safety planning would occur when placing a consumer in an ICA, including how it would happen with direct input from the person. One service reported that they had developed a sexual safety policy that requires that discussions take place with consumers about what would support them to feel and be safe to inform treatment and safety plans. Another service's risk assessment form prompts the development of a plan with the consumer to ensure their safety. These are positive examples, but still not common enough for the MHCC to be confident that consumers are regularly having meaningful input to risk and safety planning. This may be reflective of the broader pressures on services, as well as lack of training in supported decision making, which impacts services' ability to meaningfully and consistently engage consumers to participate in decisions about their treatment.

While services have processes for reporting and responding to sexual safety breaches as noted above, few services reported specific strategies for managing sexual safety risks in the ICA. Based on complaints made to the MHCC, this is of concern, as in many complaints to our office, risks were known but inadequately managed. However, positive responses from services included the employment of safety nurses to oversee management of safety issues, holding safety huddles to highlight risk profiles of consumers, involvement of families/carers to identify uncharacteristic behaviour and help develop strategies to support consumers with sexual disinhibition, and maintaining adequate staffing and observations. One service reported that they have a process to escalate behaviours of concern through an early intervention approach to identify clinical deterioration early.

Targeted prevention

Area of recommendation 6: ensure that orientation to the inpatient unit clearly outlines that sexual activity is not permitted, that breaches of sexual safety will be addressed by staff and working with the person to identify what will help them feel safe

Specific recommendations made to services in relation to this area were:

- Having systems in place to ensure that verbal and written explanations that sexual activity is not permitted are routinely provided as soon as practicable following admission

- Ensuring that orientation includes a discussion that staff will take action to prevent and respond to all breaches of sexual safety
- Ensuring that safety plans are developed for and in conjunction with all people accessing inpatient treatment.

Less than half of all services clearly outlined how they communicate to consumers and their families that sexual activity is not permitted on the inpatient unit, and fewer still articulated that consumers were advised that staff will take seriously and respond to all breaches of sexual safety. However, at the time of response, work was underway at several services to review their orientation documentation to ensure that these messages are clearly conveyed.

Strategies reported by services included the use of codes of conduct and signage and posters in bedrooms to reinforce the message, regular reviews of capacity to ensure that consumers have the opportunity to fully understand the information provided, a checklist item on the sexual safety risk assessment form to prompt discussion on admission, and co-producing orientation booklets and DVDs with consumers. Coproduction of resources is a particularly positive development that should help staff to more easily have discussions about expectations while an inpatient with consumers, given these resources provide staff with accessible, coproduced key messages about why sexual activity is prohibited on an inpatient unit.

Few services outlined how they develop individualised safety plans with each consumer, with some services indicating that existing individual treatment and/or safety planning protocols will be reviewed or expanded to include collaboration with consumers, in particular allowing consumers to explore and communicate strategies that both assist and hinder their ability to feel safe. This is an area for continuing development across services.

Area of recommendation 7: create a common framework to ensure risk assessments identify and respond to environmental, perpetrator and vulnerability factors, and work with people accessing inpatient treatment to identify and manage risk

Specific recommendations made to services in relation to this area were:

- Ensuring that sexual safety risk assessments encompass perpetrator and vulnerability risk factors, and risk factors relating to the physical and dynamic/relational environment
- Reviewing processes to ensure that risk assessments and plans are part of handovers
- Considering ways in which sexual safety risk assessments can be undertaken jointly with people accessing treatment
- Using existing systems to identify and respond to known perpetrator risks.

Some services confirmed that they had risk assessment processes in place, others noted that they were reviewing these; some services advised that they undertake specific sexual safety risk assessments. The risk factors considered as part of these assessments were often not described but included perpetrator risks and vulnerability factors. Most services confirmed that risk assessments and plans are a standard part of handovers.

Only some services confirmed that sexual safety risk assessments were undertaken jointly with consumers, including seeking consumer and family/carer perceptions of risk as well as consumers' lived history to collaboratively develop strategies to mitigate risk and ensure safety.

As they continue to implement the recommendations, some services noted that they will seek input from their lived experience workforce in the review of sexual safety risk assessment processes. Most services indicated that they used existing systems, including risk assessments, handover processes and alerts and flags systems to identify and respond to perpetrator risks.

Tertiary interventions

Area of recommendation 8: Ensuring that responses to sexual safety breaches are trauma-informed, and that pathways to trauma-specific care are clear and available

Specific recommendations made to services in relation to this area were:

- Developing approaches to ensure that initial responses to breaches of sexual safety are led by persons able to provide a trauma-informed response
- Ensuring systems are in place to enable medical reviews to be conducted
- Ensuring systems are in place for the transfer of information about trauma history and sexual safety breaches between inpatient staff and community teams
- Developing or enhancing protocols to improve consumers' access to services such as CASA following an alleged or suspected assault, through development or enhancement of partnerships with these services.

Some services outlined processes for escalation of sexual safety breaches to senior or on-call staff. Many services reiterated that training in trauma-informed care was available to all staff, but it was unclear for most services whether responses to sexual safety breaches were led by staff with specific expertise in trauma-informed care. Most services confirmed the availability of senior clinical mental health staff to conduct medical reviews, but only some services noted that policies and procedures were in place to ensure that these reviews occur.

Increasing numbers of services have implemented electronic medical record systems that can be accessed by all clinicians involved in a consumer's care. Such systems may include information on a consumer's trauma history or sexual safety breaches. Only some services described specific handover processes such as intra-service referral forms that ensured relevant information is shared between community and inpatient services, especially with community services following an inpatient admission, to enable community teams to provide follow up care and support to the consumer. Positively, some services have clear expectations that community clinicians for case-managed consumers would have regular contact with consumers and staff during inpatient admissions, to better enable continuity of care. This also supports consumer involvement in discussions about what information they agree can be shared and what supports they might like to access once discharged.

Most services have policies and procedures in place following a breach of sexual safety for referral to CASA or similar services. However, some services are taking specific steps to enhance their relationships with these services, including the development of joint protocols, regular meetings and seeking support and training from CASA in improving responses to sexual safety breaches.

Area of recommendation 9: Developing specific guidance and approaches for managing open disclosure in relation to sexual safety breaches

Specific recommendations made to services in relation to this area were:

- Reviewing the service culture and training provided to staff related to open disclosure

- Ensuring that supports are in place for staff participating in open disclosure, including from staff members with relevant training and experience
- Reviewing support mechanisms for individuals, carers and families participating in open disclosure processes to ensure responsiveness to their cultural, religious or communication needs
- Ensuring that individuals who experience breaches of sexual safety, and their families and carers, have the opportunity to express their views about the breach
- Ensuring that the views of individuals, carers and families are considered in relation to quality improvement activities as well as individual sexual safety breaches as part of open disclosure processes.

Most services confirmed that open disclosure policies were in place and that relevant training was available, although sometimes only to senior staff. However, services did not report reviewing their open disclosure policies or training to ensure that they include a focus on open disclosure as a right of people accessing mental health treatment, as well as representing good clinical practice and being of benefit to the mental health service. While some services noted that only senior staff with relevant training led open disclosures, few services were able to articulate processes for ensuring that other staff were supported during the process, such as through formal debriefing and the use of checklists and plans.

Services confirmed the existence of general policies to ensure responsiveness to the cultural, religious or communication needs of individuals, carers and families, but are yet to review open disclosure processes to explicitly incorporate these. However, some services noted that open disclosure checklists or plans were in place to support consideration of patient and family needs, as well as the involvement of carer and consumer consultants.

Services outlined complaints processes, meetings with senior staff and other supports such as consumer liaison officers to give consumers, carers and families the opportunity to express their views about sexual safety breaches, with some services able to articulate how this was embedded in their open disclosure policies and procedures. This included seeking input from consumers, carers and families on how the sexual safety incident should be managed. Services did not confirm that consumers, carers and families' views about quality improvement activities were routinely considered as part of open disclosure processes. However, a number of services outlined mechanisms to otherwise obtain input from consumers, carers and families to support quality improvement activities, such as consumer committees and thematic analysis of complaints data.

Area of recommendation 10: Developing clear guidance about services' duty to report suspected or alleged assaults to Victoria Police and supporting people to make decisions about contacting police

Specific recommendations made to services in relation to this area were:

- Ensuring that local policies and procedures are updated to reflect guidance provided by the department about reporting obligations
- Reviewing policies and procedures to ensure people are supported to make informed decisions about contacting police following a suspected or alleged sexual assault.

As updated guidance about reporting obligations is yet to be provided by the department, the MHCC did not seek a response from services in relation to this recommendation.

Most services have policies in place in relation to reporting suspected or alleged sexual assaults to police, with some services requiring that all suspected or alleged assaults be reported to police.

Some services were able to clearly articulate that their policies outline how staff can support consumers to make informed decisions about contacting police, including providing access to CASA information, counselling to understand their wish not to report, and information about the benefits of reporting.

The MHCC is not aware of work being undertaken by the department and Victoria Police to clarify reporting protocols and provide specific guidance for mental health services. We continue to be of the view that clear guidance needs to be developed for services to ensure consistent approaches across mental health services, that ensure services are upholding their responsibility to report suspected or alleged crimes that occur on their premises. This guidance must outline how to support consumers to make informed decisions about making a formal complaint to police.

Area of recommendation 11: Developing clear guidance for staff about working with Victoria Police to respond to sexual safety breaches

Specific recommendations made to services in relation to this area were:

- Reviewing policies and procedures to ensure that staff are aware of their responsibilities in preserving evidence, documenting accounts or observations of suspected or alleged assaults and requesting or responding to queries about the need for Independent Third Persons
- Continuing to work with Victoria Police through Emergency Services Liaison Committees to clarify local roles and responsibilities
- Working to develop local pathways and protocols to respond to revised guidance from the department in relation to the above.

As above, most services confirmed that policies are in place regarding contact with police following alleged or suspected sexual assaults, but only some services were able to articulate how these policies ensured that staff were aware of their responsibilities in preserving evidence, documenting accounts or observations and requesting and responding to queries about Independent Third Persons.

Most services confirmed that regular Emergency Services Liaison Committee meetings took place, where roles and responsibilities could potentially be discussed. Most services noted that once the revised guidance from the department about reporting obligations was received, it would be actioned through existing systems to review and update policies and protocols or through Emergency Services Liaison Committee meetings.

Area of recommendation 12: Reviewing investigation processes for suspected or alleged sexual assault to ensure they are consistent with the requirements of other service settings

Specific recommendations made to services in relation to this area were:

- Reviewing investigative procedures to ensure that alleged breaches of sexual safety are investigated by appropriately qualified staff external to the unit in which the alleged breach occurred

- Reviewing investigative procedures to include advice from Victoria Police on the timing and scope of the service's investigation
- Reviewing investigative procedures to include a review of the records of any co-consumers alleged to be involved in a sexual safety breach, as well as staff on duty at the time of the breach
- Reviewing investigative procedures to ensure that they include the account and perspective of the alleged victim/person at the centre of the concerns, and/or person raising the concerns
- Considering opportunities for involving the consumer and carer workforce in investigations.

Some services described procedures for the review of serious incidents that involve senior personnel from outside the affected unit or external experts, such as root cause analyses or in-depth case reviews. However, as noted above, not all services routinely classify sexual safety breaches as ISR2 or above, so that at the time that services provided these reports, these investigative procedures were not necessarily triggered for every sexual safety breach.

Other services reported that incidents were only reviewed by the nurse unit manager or consultant psychiatrist within the unit. Some services confirmed that they have received advice and input on investigation procedures from the police, including on scope and timing, while other services indicated that they would seek this input. Some services confirmed that investigation processes included a review of the records of relevant co-consumers and consultation with staff on duty at the time of the alleged incident.

Most services provided basic confirmation that the perspective of the consumer or person raising the concerns is routinely sought as part of an investigation, without outlining how it happens. While this appears to be a basic minimum requirement of any investigation, the MHCC's experience is that this does not universally occur. More detailed responses noted that the service has policies, protocols, guidelines and checklists for investigations to ensure these perspectives are accounted for as part of any investigation.

Several services have either implemented or are planning to implement lived experience workforce involvement in incident reviews and investigations. These services outlined their approach to ensuring adequate training and supervision for the lived experience workforce, including providing support and supervision with a trauma-informed approach. Other services noted that the lived experience workforce was involved only in the resolution of complaints and feedback or providing support to consumers and carers through the investigation process.

Area of recommendation 13: Ensuring that sexual safety breaches are escalated for review and oversight of responses

Specific recommendations made to services in relation to this area were:

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

Most services confirmed that they had disseminated reporting requirements to the Chief Psychiatrist through a range of mechanisms, including team meetings, formal training and integration into broader procedures and guidelines for responding to sexual safety breaches; however, some services reported that only senior staff were informed. We understand that all services are now reporting sexual safety breaches to the Chief Psychiatrist.

Area of recommendation 14: Ensuring that observations or reports are clearly, accurately and contemporaneously reported using factually accurate terms to describe the nature of any sexual safety breaches

Specific recommendations made to services in relation to this area were:

- Reviewing documentation practices to identify vague or unclear practices and providing training where required
- Ensuring that nursing observations are recorded at the time of completion rather than pre-recorded and signed.

Services generally described clinical file audit processes in response to this recommendation that did not relate specifically to the recording of information relating to sexual safety breaches. However, one service noted that their policies, procedures and guidelines for responding to sexual safety breaches provide clear guidance on terminology and documentation requirements, which have led to significant cultural change in terminology used, demonstrated through auditing and investigations. Another service's policy likewise addressed the appropriate documentation of incidents and noted that a documentation audit focusing on breaches of sexual safety was underway.

Most services provided assurances that it is standard practice for nursing observations to be recorded at the time of completion and are not pre-recorded. However, only some services were able to specify what systems and strategies were in place for ensuring that this occurs. These included formal training, ongoing audits, observing staff practice and addressing individual practice issues with the staff involved, and using time stamps on electronic medical records. We note the importance of services implementing checks and balances to ensure that nursing observations are not pre-recorded, given it was unexpected to find such a deviation from standard practice when investigating complaints to our office.

Area of recommendation 15: Ensuring that discharge planning clearly identifies the nature of any breach experienced, as well as planning for future admissions and any supports/referrals required for families or carers

Specific recommendations made to services in relation to this area were:

- Ensuring that discharge planning and documentation accurately reflects any sexual safety breaches and steps required to respond to identified needs
- Ensuring that discharge planning processes consider advance statements or other plans about future admissions, including plans to admit the person to a different unit if admission is required in the future
- Considering the needs of families and carers, including referrals to carer support services or psychological or counselling supports.

Some services noted that discharge summaries are prepared that include an account of any incident that occurred during the admission and specific referrals are made to sexual assault counselling or health screening services, with community clinicians able to follow up with the consumer to facilitate re-referral if necessary if the consumer does not want to accept the referrals at the time. Some services were reviewing their policies and procedures with a view to ensuring that any breaches are documented in discharge summaries to allow community staff to offer ongoing support and referrals to specialist services. Other services noted the existence of discharge policies and procedures, including the distribution of discharge summaries to community clinicians, but it was not clear whether these specifically address

any sexual safety breaches and the follow-up required. We note the importance for discharge planning to occur in collaboration with the consumer, their family and carers.

As noted above, most services facilitate and encourage the use of advance statements but are yet to consider their role in the specific context of sexual safety, or in discharge planning. Only two services reported that they had policies in place for their discharge planning to consider implications of sexual safety breaches for future admissions, including the need to admit to another facility. Most services confirmed mechanisms for family and carer involvement in discharge planning in general, with support available from peer workers. Some services highlighted this as an area for further development, including exploring opportunities to enhance partnerships between CASAs and families, and reviewing professional development for peer workers to better provide support to families following sexual safety breaches.

MHCC approach to sexual safety complaints and next steps

The information provided by individual services is considered regularly by the MHCC as part of our assessment and resolution of individual complaints. We also discuss service responses to the recommendations at our regular meetings with services.

The MHCC has discussed the above themes in the responses to the recommendations of the sexual safety project with the department, the Chief Psychiatrist and services in our regular meetings. As noted above, when we receive complaints about sexual safety we assess services' actions and response in the light of their responses to the recommendations, and use these complaints as an opportunity to work with specific services to improve their approach.

From the nature of services' responses to the recommendations, as well as complaints received and feedback from consumers, services may be more likely to take decisive action to prevent sexual safety breaches once a serious breach has occurred within their service. It is clear, however, that much can still be done at some services, even within existing constraints to better ensure people's safety. Services should not wait for a serious breach to occur before taking action.

We encourage all services to consider what further action they could take to implement the prevention strategies and targeted interventions outlined in the sexual safety project report to address risks.