ZERO TOLERANCE FOR SEXUAL ASSAULT: A safe admission for women

Victorian Mental Illness Awareness Council

Funded by The Helen Macpherson Smith Trust

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VICTORIAN MENTAL ILLNESS AWARENESS COUNCIL

Forward

As human beings, we are all "creatures of habit." If we do something often enough we do it without thinking. If we see something often enough we cease to see it. If we hear something often enough we stop listening and if we think something often enough we think it without question. This habitual way of seeing, listening, thinking and doing is in us all. It exists at a community, government, bureaucracy, management and employee level and affects not only the decisions we take, but also how we make them. Additionally, we usually only ever neglect or abuse the rights of those we see as having less power than we have and we tend not to get involved in trying to stop or prevent abusive or neglectful behavior unless it is happening to a loved one. Put simply, "habits of practice" allow good people to do not so good things. Sadly, it would seem that the "habits of practice" that have been developed in psychiatric in-patient units are having a profoundly negative impact on women who use them. Additionally, the "habits of practice" problem solving techniques that have been developed and used to resolve the issues for women have had little to no positive impact. It is now time to rethink the way we do things because our Duty of Care must be that we do no harm. Doing no harm and reducing the negative impact of "habits of practice" means always asking the question! If this happened to me or someone I loved what would I expect and want to happen?

For many years VMIAC has been listening to women with a lived experience of mental illness talk about their experiences as patients on psychiatric in-patient units. As a consequence of these conversations, VMIAC has major concerns about the degree to which women with a lived experience of mental illness are expected to endure sexual harassment and assaults without any major interventions. Indeed, the level of harassment and assault would not be tolerated in any other area of health. While attempts have been made to resolve the issue with the introduction of female only corridors and women's lounges, gender sensitive training, etc., these well intentioned strategies have had no real impact on improving the right of all women to not only feel safe, but to be safe on psychiatric in-patient units. It is for this reason that VMIAC is strongly recommending a zero tolerance approach to what should be regarded as an intolerable situation.

The nursing profession is one of the most privileged and finest professions a person can belong to. When a patient is unable to do for himself or herself, a nurse gets to do for their patient what only their parents have done for them before. Nursing is an independent profession to medicine with inter-dependent functions. Nurses spend more time with the patient than any other health profession. Their role is to look after the whole person, not just the illness. And, it is only nurses who can fix the problem of female harassment and

assault on the in-patient units. The fixing will require a change in "habits of practice". It will require nurses to get back to the basics of their professional role and responsibilities and it will require them to carry out their Duty of Care to protect their patients without fear or favour. It will require psychiatrists to learn more about the independent role of the nursing profession and to be respectful of their independent responsibilities.

Isabell Collins
Director

Preface

VMIAC's intention in undertaking this quality improvement project on women's safety in psychiatric in-patient units was to:

- ascertain through a survey the extent to which women experience harassment or assault in psychiatric in-patient units;
- determine whether nursing staff are complying with the National Competency Standards for the Registered Nurse in taking a nursing history from women on their admission to hospital and from the information gained, developing a nursing care plan that ensures an individualised and trauma-informed approach to nursing care activities;
- provide the women surveyed with an opportunity to have input into identifying interventions that may lessen their likelihood of experiencing harassment or assault;
- appraise women's views about what might be helpful strategies if they have experienced some form of harassment or assault;
- make recommendations based on the survey results; and
- facilitate an all-stakeholder discussion regarding the need to change clinical practice.

Executive Summary

The documented history of the sexual harassment and sexual assault of female in-patients in Victorian psychiatric wards prompted VMIAC to undertake a survey into current female in-patient experiences. This 12 month project included literature research, survey development and administration, focus groups, individual consultations, data analysis and Advisory Committee participation across the year. Data was gathered from 9 Area Mental Health Services (AMHS) across the State, providing a snapshot of current Victorian psychiatric admission experiences for women. Data analysis demonstrated that 85% of females felt unsafe during hospitalisation, 67% reported experiencing sexual or other forms of harassment during hospitalisation and almost half (45%) of respondents had experienced sexual assault during an in-patient admission: 61% reported the assault to nurses and indicated that nurses were 'slightly helpful' (18%) or 'not at all helpful' (82%). These current findings, together with Victoria's longstanding history of sexually unsafe psychiatric wards, highlight the lack of mandatory or uniform practice of safety in psychiatric wards. A number of recommendations are made, commencing with the establishment of internal women's safety officers and the implementation of independent, random auditing of safety practices and management accountability. The current data obtained in this survey shows that the effective provision of 'Zero tolerance for sexual assault: A safe admission for women' in Victorian psychiatric care is long overdue.

Acknowledgements

- The Helen Macpherson Smith Trust, whose generous financial contribution made this project possible
- The work orchestrated by Terri McNeilage, VMIAC Systemic Advocate
- Thank you to consumers for their invaluable contributions via survey participation, focus group attendance and individual consultations
- Project Advisory Committee: Isabell Collins, Julie Dempsey, Bronwyn Jackson, Cheryl Sullivan and Lana Woolf
- Relevant psychiatric support services in the metropolitan, regional and rural areas.
- VMIAC staff members

Introduction

'Nearly two-thirds of female patients surveyed in psychiatric wards in Victoria have been sexually abused or harassed by male patients…'

The Age newspaper published the above statistic in an article titled 'Women in mental wards face grave risk of abuse' on May 12, 2008. Concurrently, one third of female patients reported witnessing harassment or assault; in a 2008 VMIAC project 'Feeling Unsafe in a Sanctuary'.

Statistically speaking then, in 2008, the probability of experiencing or witnessing harassment or sexual assault as a female in-patient in a Victorian psychiatric ward is approaching 100%. To speak conservatively, such a probability remains unacceptably high. Would female in-patients describe different experiences in 2012? Has safety become a priority? Have guidelines and recommendations been implemented to ensure the prevention of and appropriate response to assault on the wards? Do Victorian psychiatric wards currently provide 'A Safe Admission for Women'?

In early 2013, a female consumer took to social media, using a photograph of her own face with the words of this statement: 'I was sexually harassed five times in (a Victorian) psychiatric unit. They told me the men were sick so it was okay. I didn't stay in the women's room so it was my own fault. I should have "remembered where I was." If I rang police, they said they would lock me into solitary confinement. Keep women safe in separate gender wards' (see appendix 1). The act of publicly identifying herself and the specific psychiatric ward speaks volumes – and echoes the data gathered in this report.

Incidences of sexual assault and harassment in Victorian psychiatric wards have remained at a consistently high level for decades, evidenced across consumer reports, research literature, media articles and government documents. These unacceptably high levels of sexual assault and harassment have been acknowledged and attempts have been made to reduce these levels – however, the undeniable fact remains: women do not experience a safe admission in Victorian psychiatric wards. Tolerance for sexual assault in Victorian psychiatric wards is significantly more than zero: female in-patients routinely describe minimisation and dismissal of sexual assault and harassment reports, feelings of vulnerability, helplessness and lack of support or assistance and the transference of responsibility from perpetrator to victim.

With an estimated 70 per cent of female in-patients reporting a history of sexual abuse (ABC News), incidences of sexual assault and harassment within Victorian psychiatric wards re-traumatise females and create fear and avoidance of psychiatric wards; as one respondent the project survey expressed it: 'I would rather die than be hospitalised again' (appendix 3).

With sentiments and findings echoing this statement, this document does not bode well for clinicians. Unless all of the issues regarding the safety of female in-patients are put squarely 'on the table', there will never be a resolution – and Victorian women will continue to experience what would be completely unacceptable for any other member of the community.

Literature Review

In 1993, Valerie Gerrand published 'The Patient Majority: Mental Health Policy and Services for Women'. Gerrand focussed her research and recommendations upon the State of Victoria, as the Australian State '…at the forefront of policy and service development in the mental health field' and detailed '…the issues which need to be taken into account to ensure that mental health policy is sensitive to the special needs of women.'
Gerrand reviewed Mental Health Policy in Australia and Victoria, and researched a wide range of issues experienced by female consumers, including patterns of psychiatric diagnosis, psychiatric treatment, interaction with clinicians, housing considerations and rehabilitation services.
In specific relation to sexual assault within psychiatric wards, Gerrand recommended that:

'Tackling the threat and actual experience by women of sexual harassment and abuse when using treatment services should be a high priority, and an imperative under equal opportunity legislation. Government departments with responsibility for public psychiatric services should be taking a lead role in such developments, especially given that their women clients include the most disabled and hence the most vulnerable to sexual exploitation. Creating hospital environments which are safe for women in-patients may mean physical re-arrangements in integrated wards. Policy which proscribes sexual harassment and abuse explicitly endorsed and well-publicised within each facility, and accompanied by reporting procedures which take account of women's difficulties in making such complaints. The current Burdekin Inquiry into the Rights of the Mentally Ill could well provide the impetus for changes, with submissions being made on the way women's rights to protection from sexual harassment and assault are abrogated in psychiatric institutions' (Gerrand: 1993).

'The Patient Majority' remains a foundational document in the field of gender-sensitive mental health care. Most of the recommendations made by Gerrand two decades ago remain as recommendations and have not been implemented into practice, however, subsequent government literature continually circle the 1993 'high priority' research findings of Gerrand.

In 1997, 'Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions' was published and became an additional foundational research report on this topic. A qualitative study of the experiences of women who were abused during in-patient admission was used to investigate the impact of sexual abuse within institutions, to explore staff responses to incidents of sexual abuse and to develop strategies for addressing sexual abuse within institutions, including identifying training needs for staff. The report also analysed the types of abuse reported, the characteristics of the perpetrators of abuse and the impact of sexual abuse on the victims. Further, disclosure of abuse was discussed, together with staff issues pertaining to training, policies and procedures and the impact of incidences of sexual abuse on staff members.
'Every Boundary Broken' suggested a number of significant recommendations which remain relevant today and particularly so in relation to the current document – despite the fact that 15 years have passed – most of the following recommendations have not been implemented:

- Comprehensive training on sexual abuse issues be undertaken on a regularly updated, systematic basis for all psychiatric staff, and included in educational institutions' curricula in mental health programs
- Consumers be provided with education about sexuality and sexual abuse issues
- Official Visitors and consumer consultants be provided with education and training on sexual abuse issues
- Staff of Sexual Assault Services receive regular training in mental health issues, and crises intervention with victims with a mental illness
- All facilities develop comprehensive and specific policies and procedures for the prevention of, and response to, sexual abuse, and hold regular training updates on the implementation and application of such policies and procedures
- All psychiatric facilities develop policies and procedures for the care and management of patients exhibiting sexually disinhibited behaviour
- Facilities review minimum staffing levels, in light of safety issues for patients
- Facilities develop clear guidelines for the management and removal of the perpetrator of an incident of sexual abuse
- There be an interagency and interdepartmental consultation to address the issue of criminal action against perpetrators of sexual abuse who have a mental illness
- Facilities provide patients with single-sex locked wards, and the option to access single-sex wards in less acute areas
- There be interagency review of the response to the sexual abuse of psychiatric patients by psychiatric staff
- All facilities implement programs which develop and maintain organisational cultures which are safe, boundaried, and respectful and knowledgeable about issues of sexual abuse

It is most unfortunate that the majority of the above recommendations were not implemented over the past decade and a half – and this begs the question: why?

'The Silence Imposed upon women who have been sexually abused whilst in psychiatric care' was submitted as a thesis paper by Vanessa Davies in 2001. The thesis investigated the ways in which '…the sexual assault of women in psychiatric care is often systematically denied', and also investigated staff responses to sexual assault on the wards. The lack of observation from staff was discussed as a contributing factor to instances of sexual assault and recommendations were made to shift policies and procedures from paper to practice. The thesis asked the question 'What kind of society are we if we cannot protect vulnerable people from being sexually assaulted in a place which purports to heal?'

Victorian Government Literature: 1997 to 2012

In 1997, Victoria's Mental Health Service released 'Tailoring Services to Meet the Needs of Women'. This document specifically focussed on the treatment of women in Victorian public mental health services and outlined ideas for improvements in service delivery, identified areas for change and provided strategies for change.
The document noted that approximately 50% of '…women using mental health services will have experienced some form of sexual assault or abuse' and also '…highlighted the need to

address particular issues faced by women with mental illness including risk of sexual assault and abuse.' Furthermore, Victoria's 'five-year period of reform to redevelop services for people with serious mental illness…particularly…services that are responsive to clients' needs' was discussed, and 1997 marked the midway point of this reform. Priorities identified at this midway point included 'delivering services responsive to the needs of women with experience of sexual assault' and 'developing in-patient and residential services that provide women with adequate safety and privacy.'

The identified priorities provided the basis for a number of 'Principles for Responsive Service.' These principles suggested that public mental health services 'recognise the importance of ensuring a safe and non-threatening service environment', followed by a number of other principles expressed as: recognising, ensuring, taking into account and preparing. The language employed is noteworthy, firmly setting the standard of optional, self-regulatory, variable and broad response to the safety of women within public mental health services. It is interesting to note that subsequent governmental documents on the topic of female in-patient safety have also employed a similar language of optionality.
Significantly, this 1997 document stated that 'It is also crucial that services have in place a clear process or mechanism for registering and responding to complaints about threats to or abuse of personal safety and privacy. Such a mechanism should be clearly communicated and exist in addition to general complaints processes.' Despite the crucial nature of this mechanism, there is no outline of or suggestion for investigation into the implementation of this mechanism, nor its efficacy in reducing assault or ensuring a safe service environment.
In concluding the 'Tailoring Services to Meet the Needs of Women' document, a summary is provided which outlines 'Practice Guidelines for Clinical Services' under the heading of 'Responding to the Challenges'. This summary does not include any information on, guidelines for or reference to the safety of women, nor the prevention of or response to sexual assault. Following this summary section, training of staff is briefly discussed, with a single reference to the possibility of 'In-service and education exchange with other specialist services; for example, sexual assault services…' however, once again, no compulsory action is directed and no follow-up is suggested.

Finally, 'Key Responsibilities' are outlined: safety is not a key responsibility. The prevention of sexual assault is not a key responsibility. Response to sexual assault is not a key responsibility.

The next significant document addressing the topic of female safety in psychiatric care was published in 2008. Entitled 'The gender sensitivity and safety in adult acute in-patient units project' and published by the Department of Human Services, this document zeroed in on 'improving the delivery of gender-sensitive and safe treatment', which had previously been touched upon in 'Tailoring Services to Meet the Needs of Women'.

This 2008 document acknowledged 'key gaps in policy and practice' reviewed policy and literature, conducted audits and reviews, analysed results, discussed findings and provided recommendations for the provision of sexual safety on in-patient units and for responding to allegations of sexual assault on in-patient units. Non-Victorian state policies are discussed and described as 'exemplary', in particular, the Department of Health 'Guidelines for the promotion of sexual safety in NSW mental health services' (2004), which include the principles: 'sexual assault and sexual harassment are always unacceptable', 'clear mechanisms for reporting and investigating allegations of sexual assault are essential and all

reports must be followed up immediately with an effective and caring response', and 'these areas should be supported with adequate monitoring and evaluation'. Despite highlighting the exemplary status of the NSW guidelines, Victoria does not include these principles, nor other important points such as 'education and training for consumers and mental health professionals in sexual assault issues' in its guidelines. However, it is recognised that 'Victorian policies need to be strengthened.'

The key stakeholders involved in this document 'reported that many women did not feel safe in in-patient units' and were concerned about the lack of uniformity regarding sexual assault complaints, responsiveness and timeliness of investigations. Furthermore, all stakeholders expressed the need for 'mandatory reporting of alleged sexual assault in mental health settings.'

The local mental health policy audit highlighted the 'inconsistency in service-level policies related to gender sensitivity and safety', along with related lack of knowledge regarding sexual assault, which was also echoed in the in-patient unit audit.

The stakeholder interviews together with the audit findings prompted a list of eight main recommendations which involved Mental Health Branch guideline development, trauma-informed care practices, reviewing key performance indicators in the area of gender-related care, the development of Chief Psychiatrist guidelines and the creation of single-sex in-patient treatment environments.

The 'Service guideline on gender sensitivity and safety' was published by the State of Victoria in 2011, and was inclusive of all Victorian clinical, psychiatric disability rehabilitation support and AOD services. This guideline '..provides an overview of what services should broadly consider in applying gender-sensitive practice to support people's health and wellbeing' and offers 'tips' to practitioners and organisations in regards to gender-sensitive care, trauma-informed care, family violence and childhood sexual abuse.

Specifically in relation to sexual harassment and assault with the 'service environment', practitioners are guided to 'encourage, support, respond, understand, provide, enquire, ensure' to incidents appropriately. Organisations are guided to 'develop local policies, offer debriefing, provide guidance, integrate reflective practice principles, address safety and traumatic events'.

The guideline states that a key principle is that 'Services uphold people's physical, sexual and emotional safety at all times'. However, no practical guidelines are provided and implementation of this key principle is unclear and without direction. Each key principle in this document is similar in presentation to this provided example: theory is given but practice is not described, alluded to or considered.

In June 2012, the Chief Psychiatrist's guideline 'Promoting sexual safety' was updated, making this particular guideline the most up-to-date government guideline on the topic of sexual assault in Victorian Psychiatric wards. Therefore, this document warrants careful consideration.

Commencing by situating patient safety in optional, variable terms: 'Mental health services should ensure that they provide a safe environment…Services should develop local policies

and procedures…Specialist mental health services have been expected to follow the Instructions…but may use clinical discretion…The Chief Psychiatrist's guideline…establishes minimum standards…' and provides no compulsory direction or language. Sexual activity in acute wards is described as 'incompatible with the acute treatment environment and...unacceptable', however, the opening key message does not define any mechanism to guarantee 'compatible' environments, nor any consequences for 'unacceptable' incidences.
It is particularly noteworthy that variations in response to sexual assault across State wards is recognised by the Chief Psychiatrist: 'The absence of a clear state-wide policy on…sexual assault in mental health services has led to variable practice', which suggests that female in-patients can expect an unknown range of both levels of sexual safety and response to sexual assault within acute psychiatric units, and that this absence, or lack, of clear state-wide policy, is known to the Chief Psychiatrist, and no reasons are provided for this lack of policy.

The purpose of the guideline is '…intended to assist mental health service managers, clinical directors and staff in their obligations to promote a therapeutic culture..', however, there are no mechanisms described to ensure that in-patients do experience a therapeutic culture, which has been 'intended', 'assisted', 'obligated' and 'promoted', but which has admittedly resulted in 'variable practice.' In labouring to highlight the use of language, terminology and tone within the Chief Psychiatrist's guideline, the optional, variable and un-regulated availability of 'A Safe Admission for Women' may be seen within a culture which conspicuously avoids terms such as 'compulsory', 'mandatory', 'uniform' and 'regulated'.
The guideline is also firmly situated as '…general information and not as legal advice', and outlines 'guiding principles', describes some characteristics of what a 'sexually safe environment' may contain and outlines a variety of 'general approaches' and 'general strategies' for responding to 'sexual activity.' Throughout the updated 36 page document, a uniform use of language is employed to maintain the optional nature of the guideline: psychiatric staff '..should ensure…where possible...acknowledge…consider...have a responsibility…actively discourage…'. Certainly, a wide range of information regarding sexual safety and sexual assault is contained within the guideline, however, the guideline does not define compulsory action for the prevention of, nor response to, sexual assault; despite the fact that a sexually safe environment is described; there is no indication of any consequences for failing to provide a sexually safe environment.

Consumer-Centred Literature

1998: 'Speaking out: women's experience of mental health service' The Victorian Women Mental Health Network (VWMHN) invited women to contribute to a collection of written accounts of experiences within Victorian psychiatric wards. Poetry and stories were received from both metropolitan and regional county areas, providing a wide variety of real-life experiences. The accounts varied in style and form; however each piece of writing included vivid, haunting detail of female in-patient experience. Overall, the collection highlighted the continuing vulnerability, danger and trauma within the Victorian psychiatric facilities and illustrated the ways in which women's needs were not being served.

2007: 'Nowhere to be safe: Women's experiences of mixed-sex psychiatric wards'. VWMHN conducted a series of listening events, encouraging women to share their personal experiences of psychiatric admissions, and from this information, produced a document

summarising the experiences shared. The document included consumer tips for improving in-patient safety, highlighted the history of the issue over the last five decades and provided consumer accounts of psychiatric ward admissions. The document also focussed on the incidences of intimidation, harassment and violence by male in-patients, both on the open ward and within the High Dependency Units.

'Nowhere to be safe' also provided a detailed account of sexual assault experienced by a female in-patient and emphasised the widespread lack of awareness about safety issues for women in psychiatric wards. The impact of staff responses to harassment and assault were noted and the tendency for staff to become desensitised was a concern. A number of improvements to staff-patient contact were listed, including patients to be treated with dignity, Codes of Conduct to identify acceptable and unacceptable behaviours and consistent responses to both male and female patients.

VWMHN utilises the information which consumers have shared to advocate for safety in wards across Victoria.

In the 2008 publication 'Outrage Becomes Determination: Advocating to Raise Awareness of Women's Experience in Mixed-Sex Psychiatric Wards', Clarke and Dempsey present an illustrated account of the introduction of mixed-sex wards in Victoria in the 1960's, through to 2008. The document outlines the ways in which consumer advocacy groups have raised awareness about abuse of female in-patients in psychiatric facilities, alongside government action and non-action in regards to the issue. In 2006, VWMHN surveyed female in-patients and the results demonstrated that 61% of respondents identified the experience of harassment during their admissions. The document explores further VWMHN findings, such as the way which 'disinhibited behaviour treated differently depending on gender', 'female in-patients expected to accommodate inappropriate male behaviour', 'sex on ward – no staff in HDU at night', and frequent assaults with devastating results. The document also highlights issues with visitor areas, new patients, lack of privacy and security and the trauma associated with seclusion practices.

In response to the findings, the Victorian government provides funding for gender-sensitive initiatives, and the VWMHN conducts focus groups with consumers in order to identify practical steps to tackle the safety issues on the wards. From this information, VWMHN developed a 5-point plan to put these issues in the spotlight. These points were: providing single-sex environments, including female-only bedrooms, bathrooms, corridors and outdoor spaces, providing funding for research and consulting in the area of female safety and establishing state-wide women's mental health co-ordinator positions. Further, training staff in the area of gender-sensitive practice was also included in the plan. VWMHN committed to continuing to raise awareness and lobby for government funding and change in ward practices across the state.

Method

Informed by consumer feedback, and in consultation with the Advisory Committee, a survey was constructed with the aim of capturing current (and some historical) female in-patient admission experiences. The survey sought both qualitative and quantitative data and therefore included multiple choice questions, short answer questions, and basic yes or no question choices (see appendix 2).

The survey became available online in April 2012 through 'Survey Monkey' and was promoted to consumers via VMIAC newsletters, Advisory Committee Members, VMIAC Advocates, email distributions and also at the annual VMIAC conference of May 2012. In addition to the online availability of the survey, the survey was also administered in focus groups in Melbourne, regional and rural areas encompassing 9 AMHS:

Consumers were encouraged to, and did, participate in one-on-one consultation regarding the survey and/or project discussion, either in person, via telephone or email, over the course of 2012.

Data Analysis

50 respondents completed the project survey.

Survey Questions 1 and 2 gathered data regarding the dates of hospital admissions (which year) and number of admissions. Up-to-date admission experiences were gathered: 86% of respondents indicated one or more hospital admissions during the last three years: 2010-2012.

Survey Question 3 asked respondents to list 3 positive experiences and 3 negative experiences during hospitalisation. This qualitative data gathered from Question 3 can be viewed in Appendix 3.

Quantitative Data is illustrated in the following charts:

Question 4: Upon admission, did a nurse enquire about and discuss your needs with you?

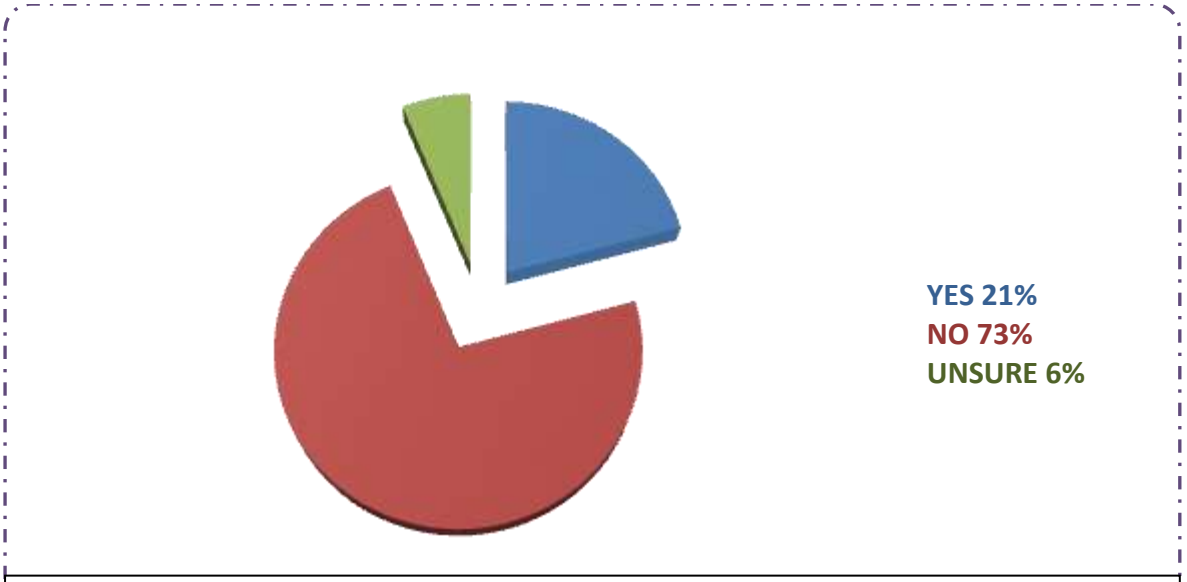
Respondents indicated that nurses generally did not enquire about and discuss in-patient needs upon admission.

Question 5 (a): Did the nurse ask you about past traumatic experiences when you were admitted?

This chart illustrates the response to question 5 of the survey, demonstrating that the majority of female in-patients are not questioned about their past traumatic experiences during the admission process.

If yes, Q5 (b) did the nurse discuss how past traumatic experiences may affect you during your hospitalisation?

Question 6: During the admission interview, did the nurse ask you whether you felt safe?



Approximately 70% of respondents were not asked whether they felt safe during the admission process.

Further, the chart below illustrates that strategies to help in-patients feel safe were not discussed by nurses during the admission interview.

Question 7: Did the nurse discuss strategies with you to help you feel safe?

YES 13%
NO 74%
UNSURE 13%

Question 8 (a): Did you feel unsafe during any of your hospitalisations?

YES 85 %
NO 12%
UNSURE 3%

This chart illustrates that the majority of respondents felt unsafe during their hospitalisations.

If yes, Q8 (b) did you report feeling unsafe to a nurse or doctor?

YES 56%
NO 32%
UNSURE 12%

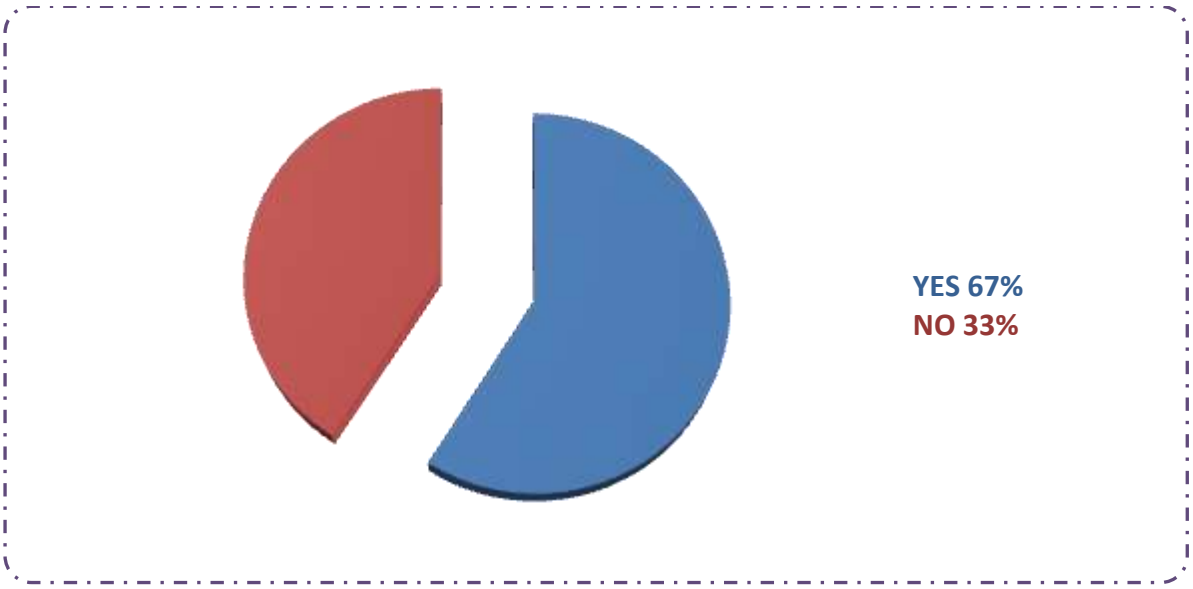
56% of the above 85% of respondents reported.

If yes, Q8 (C) was the nurse/doctor helpful and supportive when you reported feeling unsafe?)

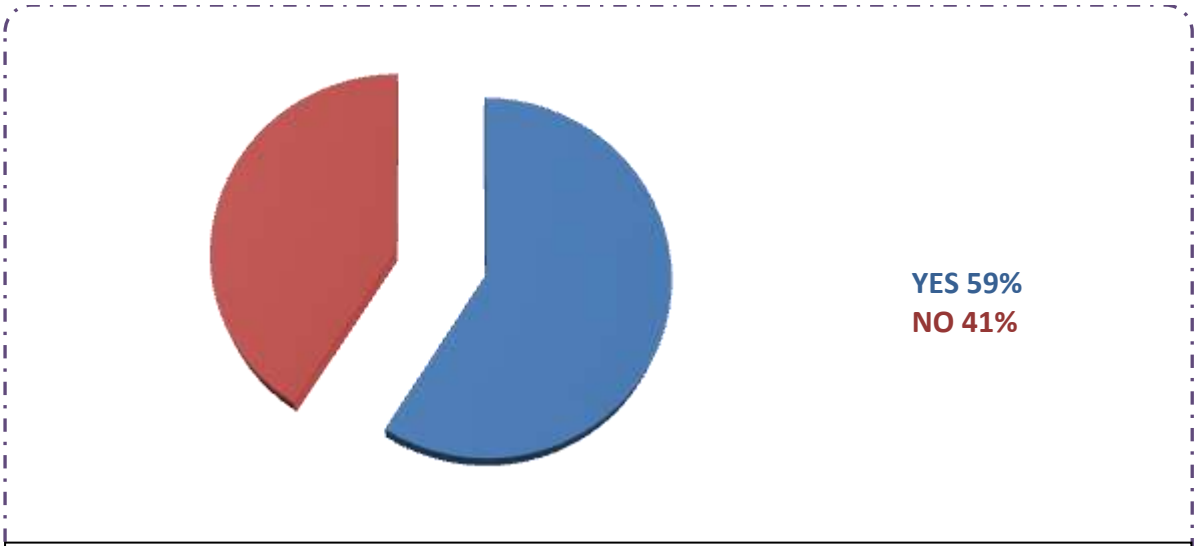
HELPFUL 14%
NOT HELPFUL 72%
UNSURE 14%

When this concern was reported to nurses and/or doctors, only 14% of respondents reported receiving support.

Question 9 (a): Did you experience sexual or other forms of harassment during your hospitalisations?

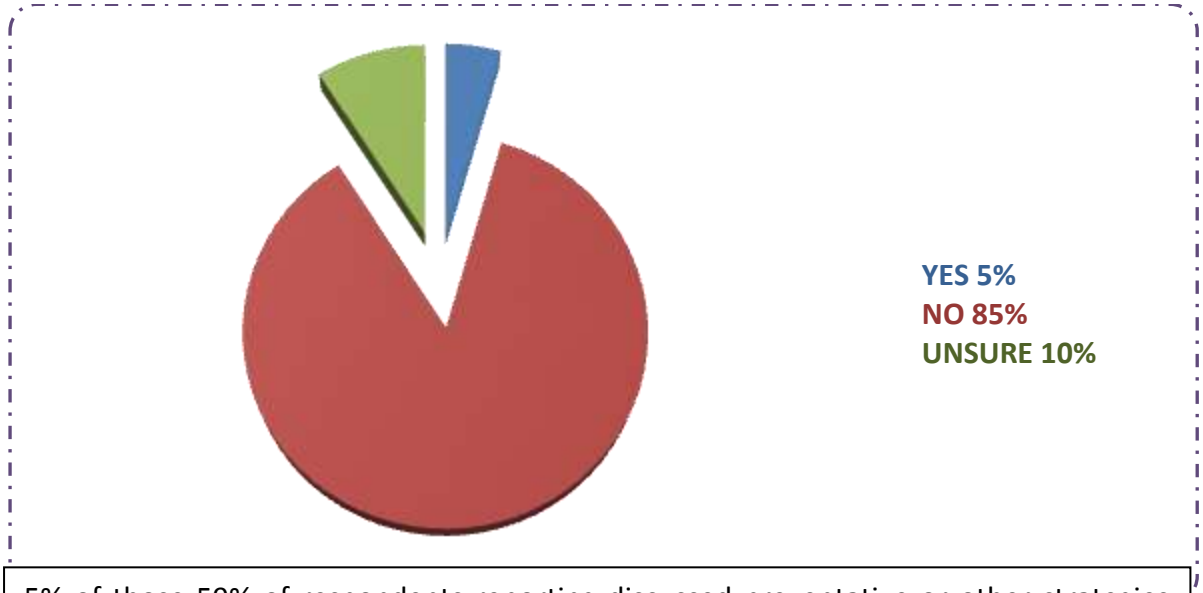


If yes, Q9 (b) did you report this to a nurse or doctor?



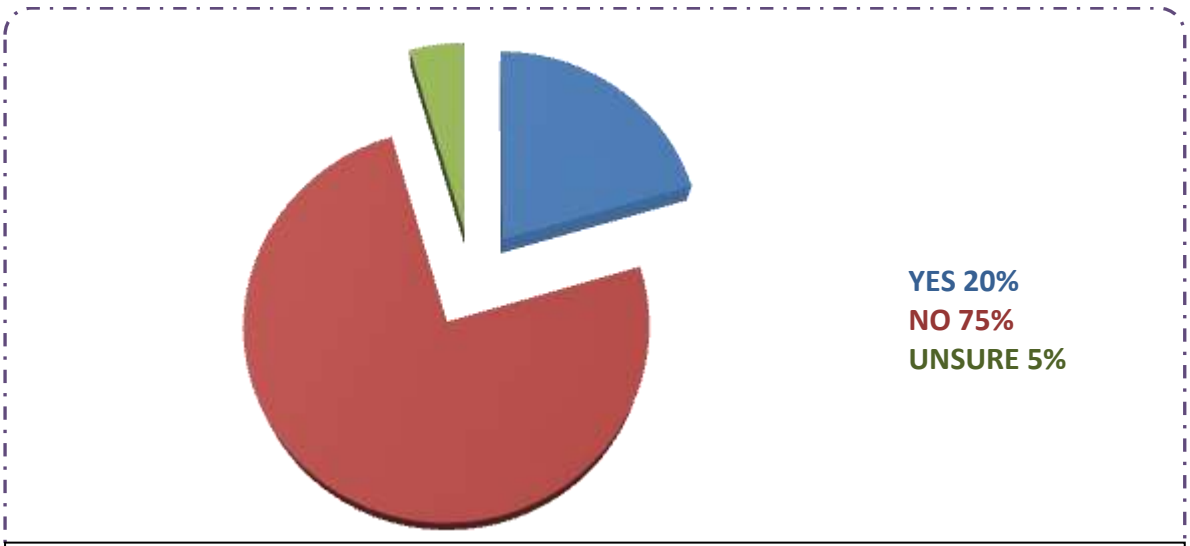
59% of those 67% of respondents reported.

If you did report harassment, Q9 (c) did a nurse/doctor discuss preventative or other strategies with you?



5% of those 59% of respondents reporting discussed preventative or other strategies with a nurse/doctor.

Question 10: Did a nurse encourage you to have input into your treatment plan and care?



Respondents indicated that they generally did not receive encouragement to have input into their treatment plan and care. One respondent who did not indicate either 'yes' or 'no' simply wrote "what treatment plan?" beside the question.
Qualitative responses to the treatment plan question (appendix 3) described confusion about treatment plans, believing that arts activities constituted treatment plans, nurses simply directing in-patients to join in activities as treatment plans and treatment plans being produced only upon discharge and without input from the in-patient.

Question 11: asked respondents to describe how they were encouraged to have input into their treatment plan and care. The qualitative data gathered in response to this question can be viewed in Appendix 3.

Question 12: Were nursing staff readily available for you to talk with during your hospitilisation?

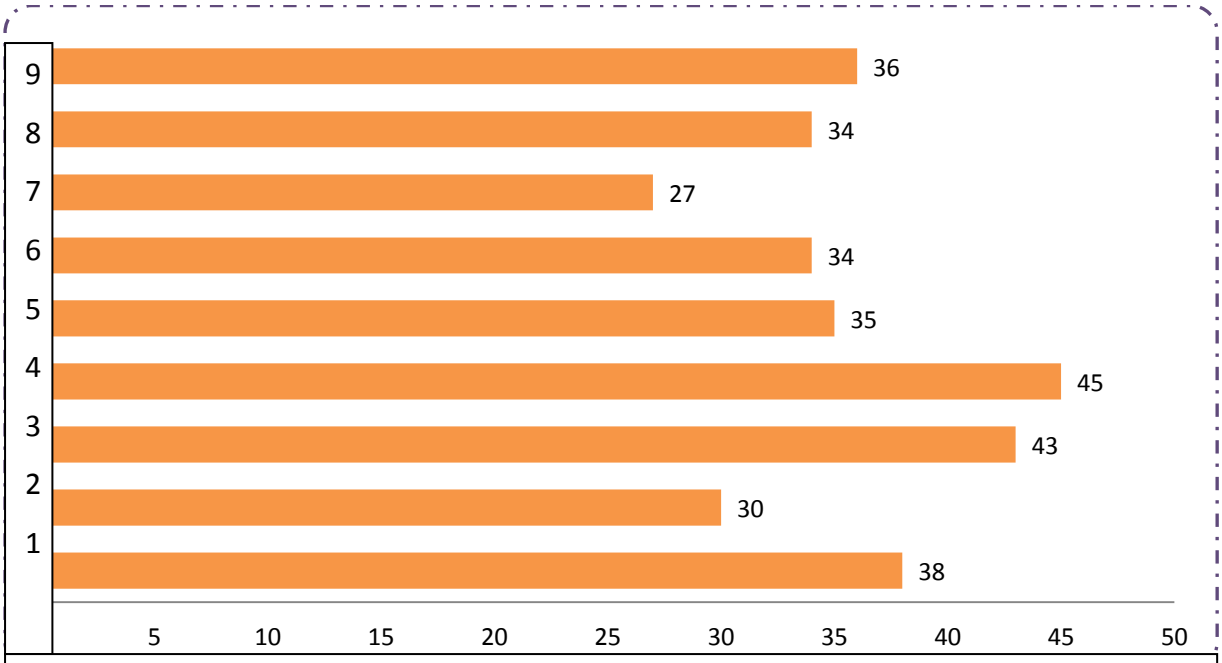
Respondents indicated that nurses were rarely available for contact with in-patients during their admissions, with some respondents interacting with nurses some of the time or never. A small percentage of nurses were available most of the time.

Question 13: Who provided you with emotional support while you were in hospital?

This chart illustrates that emotional support was provided by other in-patients/consumers and family and friends, while support from psychiatrists and nurses was minimal.

Question 14: Which of the following nursing interventions would be helpful in creating a feeling of safety and reducing harassment on in-patient units?

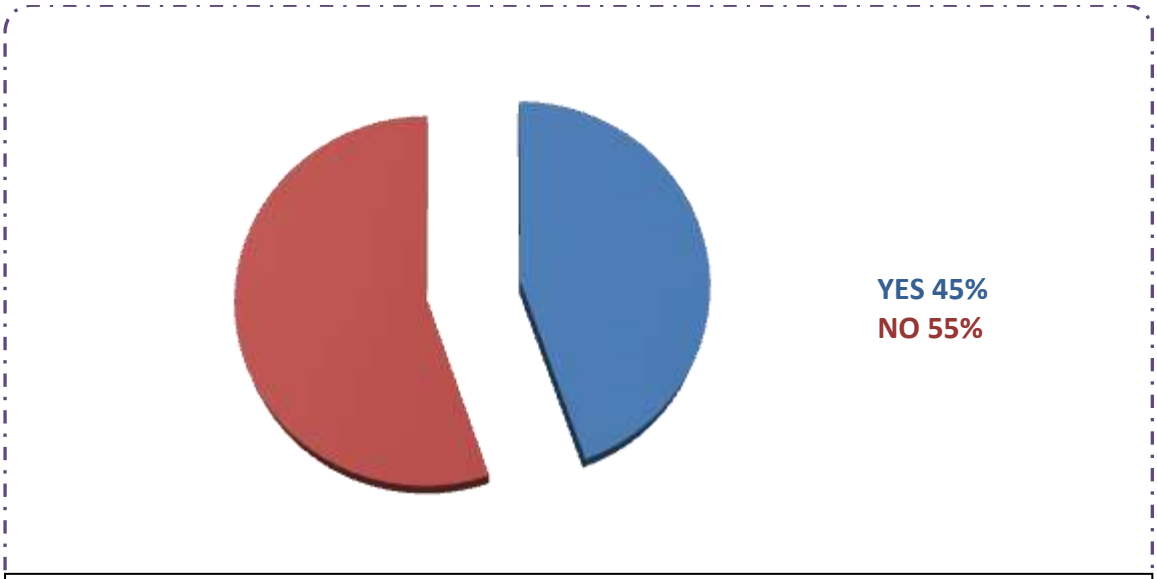
1. A nurse asking me about my safety when I'm admitted
2. A nurse asking me about my past traumatic experiences
3. At least two nurses present on ward at any one time
4. Nurses constantly monitoring the wards
5. A woman only area
6. The ability to lock my bedroom door
7. Developing a care plan with the nurse
8. Developing strategies with the nurse to keep me safe from harassment
9. Spending time with a nurse each shift to discuss how I'm feeling



Number of respondents in agreement

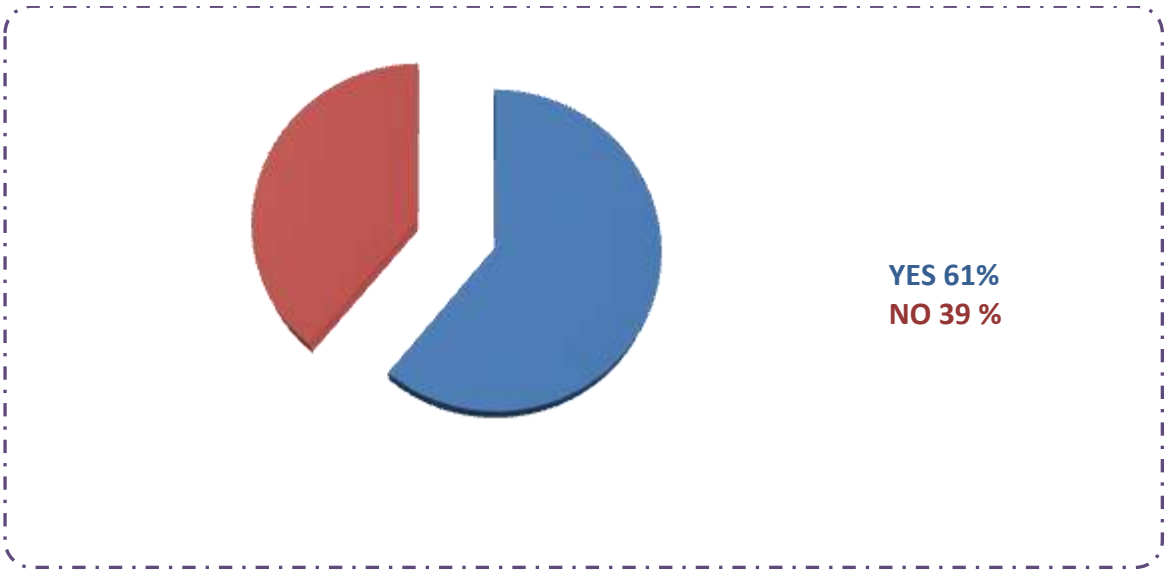
Respondents indicated that a feeling of safety together with a reduction of harassment on in-patient units could be created by nurses constantly monitoring the wards; this was the strongest preference indicated. Additionally, respondents indicated that at least 2 nurses present on the ward at any one time would create safety and reduce harassment, as would admission enquires regarding safety, developing strategies with nurses to keep in-patients safe from harassment and spending time with nurses to discuss how the in-patient is feeling.

Question 15 (a): Have you ever been sexually assaulted during hospitalisation?

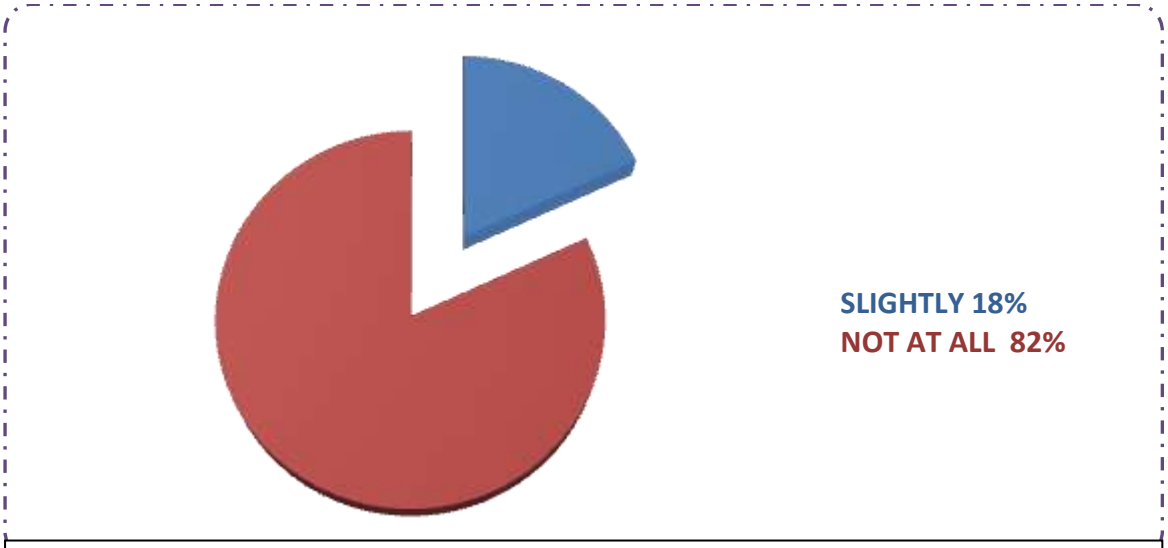


This chart demonstrates that approximately 45% of respondents have experienced sexual assault during admission.
Of this 45% experiencing sexual assault, 61% reported the sexual assault to a nurse or doctor as illustrated in Question 15 (b).

If yes, Q15 (b) did you report the sexual assault to the nurse or doctor?



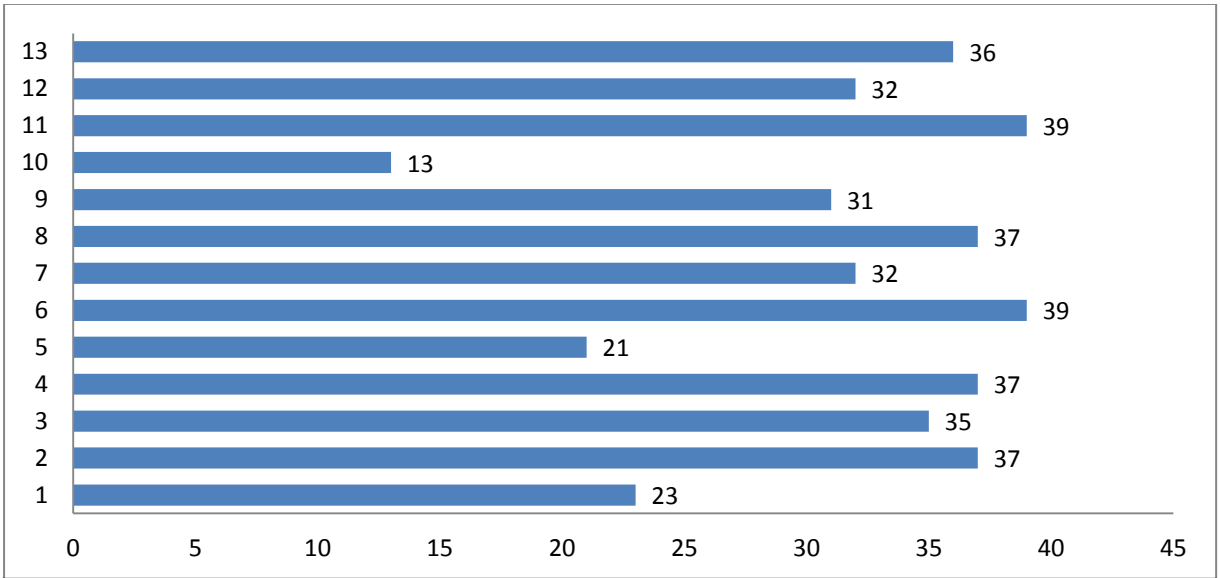
If yes, Q15 (c) was a nurse or doctor helpful to you when you reported the assault?



Only 18% of respondents that reported the assault to a nurse/doctor indicated the nurse/doctor was slightly helpful.

Question 16: In the event of you experiencing sexual harassment and/or sexual assault, which of the following would be helpful to you?

1. A family member or friend was notified
2. I was offered counselling from an external agency
3. A nurse spent time with me providing support and empathy
4. Centre Against Sexual Assault (CASA) was notified
5. Police were notified
6. An incident report written and I was provided with a copy
7. The Office of the Chief Psychiatrist was notified
8. The male who harassed was moved to another hospital
9. The male harassed me was placed in the High Dependency Unit
10. I was transferred to another hospital
11. I was offered an advocate
12. A community visitor was notified
13. Victorian Mental Illness Awareness Council (VMIAC) was notified



Number of respondents in agreement

The survey closed with 2 qualitative questions:

Question 17: 'If you have experienced sexual harassment or assault during hospitalisation, please describe which words or actions of nursing staff/doctors were not helpful?

Question 18: Are there any other comments you wish to make?

Data gathered from these final 2 survey questions can be viewed in appendix 3.

Qualitative Response Summary

The most common positive experiences listed in response to Question 3 included:

- Meeting other people with the same illness
- Having the opportunity to understand and recover from illness
- Having the opportunity to rest.

The most common negative experiences listed included:

- Experiencing fear, intimidation and threats by male in-patients
- Minimal time for nursing staff to interact with or listen to female in-patients
- The lack of staff intervention or support in the event of traumatic experiences during hospitalisation

Respondents provided a rich variety of both positive and negative experiences during hospitalisation, illustrating a vivid picture of current Victorian psychiatric wards from the female perspective (see appendix 3).

On the question regarding unhelpful staff actions in the event of sexual assault and harassment, responses included:

- Secluding the female in-patient
- Dismissive attitudes displayed by nurses and doctors
- Refusal to believe the in-patient report of sexual assault.

Helpful actions in the event of sexual assault or harassment included:

- Proactive communication with in-patients about sexual assault and harassment
- Simply asking the in-patient 'are you OK?'

The final question of the survey "Are there any other comments you wish to make?" also provided a detailed array of responses:

- The attitude conveyed to female in-patients by hospital staff that 'crazy women don't matter'
- Respondents described frustration, confusion and disappointment regarding the lack of support received from nursing staff
- Respondents expressed a desire for less pressure on nurses, in particular in the form of excessive paperwork, in order for there to be time for nurses to provide nursing care to in-patients during their shifts.
- Respondents questioned why sexual assault and harassment was a crime outside the psychiatric ward but not inside the psychiatric ward
- Respondents felt that they were less important as females with mental illnesses.

Consumers indicated that a feeling of safety, together with a reduction of harassment on in-patient units, could be created by:

- A nurse enquiring about safety and past traumatic experiences upon admission
- At least 2 nurses present on the ward at any one time
- A women only area
- The ability to lock bedroom doors
- Developing a Care Plan with a nurse
- Developing strategies with a nurse to keep in-patients safe from harassment

- Spending time with a nurse each shift to discuss how the patient is feeling.

Respondents indicated that the following options would be helpful in the event of sexual assault and/or harassment:

- A family member or friend was notified
- Counselling from an external agency was offered
- A nurse spent time with the patient, providing support and empathy
- The Centre Against Sexual Assault (CASA) was notified
- Police were notified
- An Incident Report was written and the patient was given a copy
- The Office of the Chief Psychiatrist was notified
- The male who harassed/assaulted the patient was moved to another hospital
- The male who harassed/assaulted the patient was moved to the High Dependency Unit (HDU)
- An advocate was offered to the patient
- A Community Visitor was notified
- The VMIAC was notified

Notably, respondents strongly disagreed with the option of being removed from the hospital themselves in the event of experiencing sexual assault and/or harassment, indicating a preference for the male perpetrator to be removed or moved into HDU.

RECOMMENDATIONS:

The following recommendations are made as a consequence of the survey data collected:

1. A zero tolerance approach to sexual assault and harassment to be adopted by all Victorian psychiatric services.

2. All AMHS be required to report all allegations of all forms of sexual assault and harassment and copies of mandatory Incident Reports be provided to the Office of the Chief Psychiatrist and Health Services Commission. Further, the Office of the Chief Psychiatrist be required to include data pertaining to sexual assault and harassment in their annual report.

3. All health services agreements which include psychiatric in-patient units be required to develop zero tolerance strategies to prevent sexual assault and harassment and provide bi-annual reports of progress in reducing the level of sexual assault and harassment to the Department of Health Mental Health Drugs and Regions Division.

4. Managers of Mental Health Services and Unit Managers of each psychiatric in-patient unit ensure that each patient has a Nursing History taken and a Care Plan developed, using a trauma-informed care approach (see appendix 4: An example of a Nursing History & Care Plan template).

5. The VMIAC supports continued funding for the education provided by the VWMHN on the prevention of and response to sexual assault and harassment within Victorian psychiatric wards.

6. Unit Managers ensure a minimum of two nurses on the ward, engaging with patients, at all times.

7. All clinicians to be required to undertake training on human sexuality.

8. CASA services are offered to in-patients in the event of sexual assault on the ward, and also to in-patients who disclose histories of sexual assault.

9. Consideration be given to the VMIAC to:

- Receive recurrent funding to work with the services to ensure safety is provided for female in-patients
- Receive funding to conduct an attitudinal survey of nurses regarding sexual assault and harassment within psychiatric wards
- Conduct a survey with male consumers on the topic of minimising sexual assault and harassment and encouraging positive behaviour

10. The role of the Office of the Chief Psychiatrist be expanded to include continual random spot-checks and audits of in-patient units to monitor safety strategies.

11. An all-stakeholder committee, to be formed through the Department, which is comprised of Health & Community Services Union members, the Australian Nursing Federation, senior departmental members and the VMIAC, in order to work through

any impediments to the implementation of these recommendations and to develop further strategies to ensure a zero tolerance approach towards sexual assault and harassment within psychiatric wards.

APPENDICIES

Appendix 1: Public posting on social media February 2013.

Appendix 2: Project Survey

VMIAC PROJECT SURVEY: A SAFE ADMISSION FOR WOMEN

This survey is the central part of a VMIAC (Victorian Mental Illness Awareness Council) project which aims to capture the experience of females in psychiatric hospitals and develop a practical guide to ensure the safety of women in in-patient units.

The survey is voluntary. You do not have to answer all the questions and can stop at any time.

Whatever contribution you make to this survey would be greatly appreciated and will be kept strictly confidential.

Should you wish to discuss any part of this survey and/or project, please feel free to speak with Terri McNeilage, Systemic Advocate for this project, or with VMIAC staff on 9380 3900.

The survey can be completed on-line, or alternatively, you can complete the survey with a VMIAC staff member.

Should you at any time feel distressed during or after completing the survey, please do not hesitate to contact the VMIAC for support.

1. When was the last time you were admitted to hospital?

2. How many hospitalisations have you had in the last 3 years?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ More than 3

3. What were 3 of your most positive and 3 of your most negative experiences during your hospitalisation(s)?

4. Upon admission, did a nurse enquire about and discuss your needs with you?

- ☐ Yes
- ☐ No
- ☐ Unsure

5. Did the nurse ask you about past traumatic experiences when you were admitted?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes, did the nurse discuss how past traumatic experiences may affect you during your hospitalisation?

- ☐ Yes
- ☐ No
- ☐ Unsure

6. During the admission interview, did the nurse ask you whether you felt safe?

- ☐ Yes
- ☐ No
- ☐ Unsure

7. Did the nurse discuss strategies with you to help you feel safe?

- ☐ Yes
- ☐ No
- ☐ Unsure

8. Did you feel unsafe during any of your hospitalisations?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes, did you report feeling unsafe to a nurse/doctor?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes, was the nurse/doctor helpful and supportive when you reported feeling unsafe?

- ☐ Helpful
- ☐ Not helpful
- ☐ Unsure

9. Did you experience sexual or other forms of harassment during your hospitalisations?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes, did you report this to a nurse/doctor?

- ☐ Yes
- ☐ No
- ☐ Unsure

If you did report harassment, did a nurse/doctor discuss preventative or other strategies with you?

- ☐ Yes
- ☐ No
- ☐ Unsure

10. Did a nurse encourage you to have input into your treatment plan and your care?

- ☐ Yes
- ☐ No
- ☐ Unsure

11. Please describe how you were encouraged to have input into your treatment plan and care:

12. Were nursing staff readily available for you to talk with during your hospitalisation?

- ☐ Most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Never

13. Who provided you with emotional support while you were in hospital?

- ☐ Other consumers
- ☐ Nurses
- ☐ Psychiatrist
- ☐ Family/friends
- ☐ All of the above
- ☐ None of the above

14. Which of the following nursing interventions would be helpful in creating a feeling of safety and reducing harassment on in-patient units?

	Yes	**No**	**Unsure**
A nurse asking me about my safety when I'm admitted	☐ A nurse asking me about my safety when I'm admitted	☐ A nurse asking me about my safety when I'm admitted	☐ A nurse asking me about my safety when I'm admitted
A nurse asking about my past traumatic experiences	☐ A nurse asking about my past traumatic experiences	☐ A nurse asking about my past traumatic experiences	☐ A nurse asking about my past traumatic experiences
At least 2 nurses present on the ward at any one time	☐ At least 2 nurses present on the ward at any one time	☐ At least 2 nurses present on the ward at any one time	☐ At least 2 nurses present on the ward at any one time

	Yes	No	Unsure
Nurses constantly monitoring the wards	☐ Nurses constantly monitoring the wards	☐ Nurses constantly monitoring the wards	☐ Nurses constantly monitoring the wards
A women only area	☐ A women only area	☐ A women only area	☐ A women only area
The ability to lock my bedroom door	☐ The ability to lock my bedroom door	☐ The ability to lock my bedroom door	☐ The ability to lock my bedroom door
Developing a care plan with the nurse	☐ Developing a care plan with the nurse	☐ Developing a care plan with the nurse	☐ Developing a care plan with the nurse
Developing strategies with the nurse to keep me safe from harassment	☐ Developing strategies with the nurse to keep me safe from harassment	☐ Developing strategies with the nurse to keep me safe from harassment	☐ Developing strategies with the nurse to keep me safe from harassment
Spending time with a nurse each shift to discuss how I'm feeling	☐ Spending time with a nurse each shift to discuss how I'm feeling	☐ Spending time with a nurse each shift to discuss how I'm feeling	☐ Spending time with a nurse each shift to discuss how I'm feeling

Other (please describe)

15. Have you ever been sexually assaulted during hospitalisation?

☐ Yes
☐ No

If yes, did you report the sexual assault to the nurse or doctor?

☐ Yes
☐ No

If yes, was a nurse or doctor helpful to you when you reported the assault?

- ☐ Extremely helpful
- ☐ Very helpful
- ☐ Moderately helpful
- ☐ Slightly helpful
- ☐ Not at all helpful

16. In the event of you experiencing sexual harassment and/or sexual assault, which of the following would be helpful to you?

	Yes	No
A family member or friend was notified	☐ A family member or friend was notified	☐ A family member or friend was notified
I was offered counselling from an external agency	☐ I was offered counselling from an external agency	☐ I was offered counselling from an external agency
A nurse spent time with me providing support and empathy	☐ A nurse spent time with me providing support and empathy	☐ A nurse spent time with me providing support and empathy
Centre Against Sexual Assault (CASA) were notified	☐ Centre Against Sexual Assault (CASA) were notified	☐ Centre Against Sexual Assault (CASA) were notified
Police were notified	☐ Police were notified	☐ Police were notified
An incident report written and I was provided with a copy	☐ An incident report written and I was provided with a copy	☐ An incident report written and I was provided with a copy
The Office of Chief Psychiatrist were notified	☐ The Office of Chief Psychiatrist were notified	☐ The Office of Chief Psychiatrist were notified
The male who harassed me was moved to another hospital	☐ The male who harassed me was moved to another hospital	☐ The male who harassed me was moved to another hospital
The male who harassed me was placed in the High Dependency Unit	☐ The male who harassed me was placed in the High Dependency Unit	☐ The male who harassed me was placed in the High Dependency Unit

I was transferred to another hospital	☐ I was transferred to another hospital	☐ I was transferred to another hospital
I was offered an advocate	☐ I was offered an advocate	☐ I was offered an advocate
A Community Visitor was notified	☐ A Community Visitor was notified	☐ A Community Visitor was notified
Victorian Mental Illness Awareness Council (VMIAC) were notified	☐ Victorian Mental Illness Awareness Council (VMIAC) were notified	☐ Victorian Mental Illness Awareness Council (VMIAC) were notified

Other (please specify)

17. If you have experienced sexual harassment or assault during hospitalisation, please describe which words or actions of nursing staff/doctors were not helpful?

18. Are there any other comments you wish to make?

Appendix 3: Qualitative Reponses to project survey

All qualitative responses are included within appendix 3, in order to respect the effort made by consumers in providing the feedback which shaped this report.

Question # 3: 'What were 3 of your most positive and 3 of your most negative experiences during your hospitalisation(s)?

Positive

"Meeting new people
ECT
Mental health Hearing"

Negative

"Meeting new people
ECT!
Unclear boundaries between myself and male patients, example: touching and sleazy looks and comments"

Positive

"Interacting with other patients and being able to focus on recovery"

Negative

"I was scared of some other patients and feeling rushed through meetings with doctors and nurses"

Positive

"It was good to speak with the other patients about their experiences.

Negative

"The negative was having no structure so you didn't really ever know what was happening, it was confusing"

Positive

"The staff were positive and the support was positive, and also visitors being allowed was good"

Negative

"The negative part was the aggressive patients"

Positive

"Helpful and caring staff"

Negative

"Lack of fun activities and the food"

Positive

"Friendly, helpful staff
Nurses and doctors, very caring and professional
Very safe "

Negatives

"Interacting with other sick people can be inappropriate
Boredom
Too many men"

Positive

"Getting rest

Negative

Being afraid of some other patients"

Positive

"Getting medication right
Talking to other patients"

Negative

"Not having things explained to me
Lots of things seemed really disorganised on the ward
Other patients doing illegal drugs"

Positives

"Finding out I wasn't the only one with mental problems
Sharing my experiences with other patients"

Negatives

"Feeling that the nurses didn't have time to care for me
Being rushed through time with nurses and doctors
Being afraid of some other patients"

Positive

"Meeting friends
Relating to people who share the same situation

Learning to help each other"

Negative

"Being restricted from going outside when I want
Only one area to be able to smoke without leave
Not knowing what day it is"

Positive

"Meeting people
Relating to others sharing the same situation"

Negative

"Not enough creativity (arts)
Some people don't know boundaries and this should be made clear to everyone"

Negative

"I don't think anything can be positive about hospitalisation
Being in a male dominated environment was a negative experience
Feeling threatened by males"

Positive

"The kitchen lady always had extra food
Chatting with other female patients
OT and friends keeping me supplied with art materials"

Negative

"An aggressive, offensive, sexist male whose attitudes and behaviour were sexist and unpleasant
Having painful constipation for ten days before the staff did anything about it. That was only after a friend advocated on my behalf that my physical health was as important as my mental health"

Positive

"Gathering my thoughts"

Negative

"Being showered by a male nurse
Being stripped of all clothing by male staff & security and put in seclusion for 13 hours, on a concrete floor with no blankets or water or anywhere to go to the toilet, and male nurses constantly looking through the window

A male patient entering my room with 2 other patients, they wouldn't let me leave and put on pornographic videos on their portable DVD player. When the nurse checked, she just smiled and left, even though she could see I was upset. There was much more negative than positive - this just touches the surface"

Negative

"Women need to be able to lock the bathroom door when showering. I did not like bad language"

Positive

"Being in hospital was less burden on my family
Being somewhere that I did not have to pretend as much
Time out from some responsibilities"

Negative

"Staff gathering in the staff room, often all together, and I felt intimidated and that it was very hard to approach them
We had to line up for medication like a cattle call
There were some patients in there that I felt scared around"

Negative

"I had no positive experiences"

Negative

"Effects of repeated changes in medication (mania)
Fear of staff who were physically intimidating
Psychiatrist unable to keep appropriate boundaries"

Positive

"Well fed.
Very clean
Good supports"

Negative

"Boredom
Not enough activates
Was not allowed to smoke"

Positive

"Finding friendships and understanding with other patients
Having space and time to think about my illness
Being similar to everyone around me for the first time"

Negative

"Medication seemed like it was killing me, could barely wake up or move
Some other patients were quite scary and it didn't seem that anything was being done for them or us in fear
Nurses extremely busy and often felt I could not ask them simple questions, let alone talk to them about bigger issues"

Positive

"Friendly staff who listened
Encouragement from other patients
Relaxed environment"

Negative

"Food was crap
Getting meds was not a private thing
Some nurses not understanding my illness"

Positive

"The most positive experience I had when I had my admission to …….. Centre was seeing my family & having me diagnosed with bipolar"

Negative

"The negative experiences I had was no activities
The ignorance of the nurses
The ignorance of reception"

Positive

"The assistance provided by the mental health nurses who offered relaxation therapy
Privacy of being in my own room
Being able to go outside and spend time in the garden"

Negative

"Being denied access from my children out of hours even though the day before the time had been cleared by the nurse unit manager

The way in which I was treated after I had tried to use a dressing gown cord to choke myself

Being dragged on my and knees whilst trying to stand up and walk in a dignified manner through the patient lounge to the High Dependency Unit was demeaning and offensive

Having very little, if any, contact from the treating psych

Because my admission was pretty dreadful, I have now taken out private insurance so I don't have to go back into the public system"

Negative

"I think patients need to be informed that Pica only holds 3 or 4 bed s and is only a small complex

When you see the rooms that confine patients, and plastic covering the TV.

I felt there were uncontrollable patients here

When you are in a state of anxiety seeing this heightens your stresses immensely. If I had known Pica was a small separate area it may have relieved my anxiety a bit"

Positive

"I felt safe and comfortable

I enjoyed the crossword and word games we did each morning

I also enjoyed the interaction with the other 'clients'. I must admit that I was so manic everything was positive and good"

Negative

"Sometimes some of the staff were not as sympathetic to my needs as I felt they should be, although I tried not to be troublesome, or so I believe

Didn't always like the state the bathrooms were left in, they were very messy

At night, when I couldn't get to sleep by about 1am I sometimes had great difficulty obtaining some sleep medication. I know it is not good to be dependent on it but it would only happen intermittently"

Positive

"Met some interesting & friendly patients

Had a rest

Had an art therapy session"

Negative

"I was not allowed to contact anyone on admission,

I was not spoken to respectfully or taken seriously by the doctor/professor whose care I was under

I was not provided with enough information and as it was my first visit to this sort of care unit I was very upset & distressed"

Positive

"My family were appeased I was getting the available treatment

Some of the staff were extremely insightful

Negative

"Not all staff were respectful of the fact that your symptoms created paranoid thoughts and so would play on this for their own egos

Being kept involuntarily in a clinical environment where there was with graffiti and shared facilities

Not being told the process of which my examination was being undertaken and what doctors were looking for me to do"

Negative

"The amount of young people; both sexes, on the ward with drug and alcohol induced psychosis

Biased attitudes of psychiatrists and mental health workers when the patient has the diagnosis &/or label of Borderline Personality Disorder

The amount of aggressive, irritating and agitating behaviour of in-patients that goes on without staff intervention"

Positive

"Meeting other people with the same illness

Getting my medication right

Being able to rest"

Negative

"Staff not being available when I needed them

Patients who were aggressive

Being afraid"

Positive

"Late art activity at end of intense therapy day, finishing 8:30pm

1 to 1 sympathetic nurse time each day when strategies/ideas discussed

Being with people who had same/similar diagnoses and working together without having to explain idiosyncrasies"

Negative

"Female Psychiatrist who turned out to be less than helpful

Nurses being too busy with admin paperwork to be actively engaged with people informally

Realising that other wards were run differently from the Trauma area

People in other wards were not offered any formal program to structure their day and focus on changes or symptom management"

Positive

"Meeting other patients

Good nurses

Recovering"

Negative

"Bad nurses who were cruel

Scary patients

Medication side-effects"

Positive

"Support from other patients, starting to recover and understand my illness.

Negative

Aggressive patients, no staff being around and too much medication".

Positive

"Interaction with other patients

Sorry, can't really say there is anything else positive"

Negative

"Being frightened by nurses. One in particular who would tell me not to drink water in bed because if I spill it I might get electrocuted. When I reported this (and other similar 'head games' with myself and others) I was simply told it was part of my psychosis. Being sexually assaulted by a wards man - I was too frightened to speak out even though I was left bleeding heavily as it was an anal assault

Having little or no say in my treatment particularly where medication is concerned. In my last hospitalisation I was scheduled under the mental health act and so was pretty much told to toe the line if I was to get out of there in a reasonable time frame. As soon as I left hospital another psychiatrist immediately stopped the medications I had been prescribed as it was clear they were making me worse"

Positive

"Regular meal times helped with routine"

Negative

"The room doors should have card lock system"

Positive

"A stable place to take time out Meeting other patients

Art therapy and group work"

Negatives

"Staff members treating me different to other patients because of my (mis)diagnosis

Being told I was being a child by a staff member when I was having a flashback

Having staff enter my bedroom against my consent"

Positive

"Taxpayer funded stay and so direct cost to me, which was good because I could not afford it at time

Staff contact (psych nurses, social workers, counsellors, psychologists). Effective medication"

Negative

"Being an involuntary patient.

Felt like a caged animal

Food sometimes was terrible

Had credit card stolen from me from my unlocked (mandatory) room by another female patient"

Positive

"Support from other patients was good

There were no other positives"

Negative

"Intense pressure to have abusive family members participates in my care. They tried to force it on me

One particular intern invading my space literally. He accosted me in the corridor, then when I stayed in my room to avoid him he tried to come into my room. This was after I told nursing staff I refused to see him

Being stalked by one of the male patients and also a male cleaner. Those two appeared to be friends"

Positive

"Staff took their time to speak with me
Safely getting better
Being alive and staring a journey of healing and forgiveness
Getting support"

Negative

"Worst experience was being alone and really scared
Not getting my property back
Not making contact with police
Being locked into the mental health system again and being denied access to sexual assault counsellors. Being rejected by CASA as in the too hard basket and not worthy of their time. Being homeless, losing everything, getting a reputation as someone who was dangerous, mad and bad to know. Getting kicked out of University and being called a lesbian and a drug addict by the nurse who admitted me at Royal Melbourne
Having to put up with the limited training of doctors, psychologists, social workers, housing workers and drug and alcohol workers, family violence workers and sexual assault workers."

Positive

"The GP who worked there was extremely kind to me and advocated strongly for me not to be sectioned (I was a voluntary patient in a private hospital). I was traumatised but the general reaction was to put me into a public psych ward, rather than support me in my trauma
On my first night, the nurse on duty let me sit in the nurse's station and read trashy magazines because I couldn't sleep
One worker was really great in supporting me after I received some unwanted sexual attention; she listened to me and supported me to work out what I wanted to say to the guy (another in-patient). I think she must have had a background in sexual assault training because she really knew how to support me"

Negative

"I had unwanted sexual attention and some of the staff basically told me off (and I'm a survivor of childhood incest and the whole thing triggered me)
The lack of time for anyone to actually listen to me
Boredom"

Qualitative Responses to Question # 11: "Please describe how you were encouraged to have input into your treatment plan and care"

"What treatment plan??"

"The nurses take care of you when your sickness arises and discuss finding a remedy to cure you"

"I was told it was best left to the professionals"

"Maybe being involved in the activities they offered, crafts I think, talking sessions (I think so from memory, I really don't remember much)"

"I wasn't I was offered various forms of occupational therapy and groups"

"Join in activities"

"I was encouraged to have ECTs to bring me out of my depression"

"A doctor would come into my room and ask how I felt. She nodded her head then said fine & she would see me tomorrow. So, with that in mind, I feel that I had no input into my care plan. To be honest, I didn't know I had a care plan until a few days before I was discharged"

"To follow through 'not allowing' unwanted behaviour"

"Cannot remember details but I do remember after I had been in about 10 days having discussions with various case nurses about going home and how I would manage"

"Medical staff talked to groups as well as individuals In the public hospital I asked for my room to be locked because twice I found a male in the bathroom, once having a shower, the other fully clothed just standing — this second man seemed as scared as me. I also found a male asleep in my bed at this public facility"

"I wasn't aware I had a treatment plan..."

"My input - that I didn't want abusive family members involved - was ignored repeatedly"

"I developed a Wellness Plan"

"The psychiatrist seemed to have a lot of power but I hardly ever saw him. That was really weird. I also had a therapist assigned to me and she was a power-tripper and didn't listen to what I said. She basically kept telling me off for my 'bad behaviour'. Because I was dissociating a lot, self-harming and running away, I was bought in to speak with the NUM and the head of the service. They wanted to kick me out unless we could come up with some strategies to stop myself self-harming. They were really trying and had lots of suggestions. But I think there's a difference between managing my self-harm and actually getting treatment. Oh, and they kept wanting to up my dosage of Seroquel. I didn't want to take it because it made me really sleepy and numbed me out. But I ended up taking some because I felt like they were going to section me if I didn't"

Qualitative Responses to Question # 17: 'If you have experienced sexual harassment or assault during hospitalisation, please describe which words or actions or nursing staff/doctors were not helpful'

"Basically just dismissing me and pretty much minimising what happened, as if it wasn't a big deal when it really was"

"I don't think they really believed me, like I was just a crazy woman and was making things up. It was terrible because I wouldn't make that up"

"Just treating me like I'm an annoyance to them and they just don't have time. I know they're busy and it's a big job to look after us patients, but if someone is hurt, they should give us some time, it's not our fault, we didn't ask to be sick and we didn't ask to be hurt when we are trying to get well. I don't mind if I have to wait a bit but they should explain what's going on and then I would be less agitated"

"In seclusion, the male nursing staff were constantly watching me, like I was a puppet struggling. Male staff member taunts or that particular nurse encouraging other patients or punishing the wrong person. Overdosing me, involuntary injections. The little nick-names they give patients"

"Why didn't you scream? You must have known he was disturbed."
"Why were you alone with him?"
"It wasn't like you were raped"

"Making me feel like I am making it up, like it's symptoms of my illness and not being believed"

"When the males were in my room, the female nurses were not at all sympathetic. This was very disconcerting as I wanted to talk with someone appropriate about my feelings at the time. The male nurse who was on the next shift was proactive, asking if I was ok, after the man was showering in my bathroom. After the male was evicted from my bed, I requested new sheets but was laughed at, which added to my distress"

"I didn't know what to do. There was no information on what to do"

"It's really hard to tell a male psychiatrist about a sexual assault. It would be better if there was a female psychiatrist or nurse to listen to what happened"

"You are not well and maybe you are a bit confused right now
In other words - denial of the event even though physical evidence - bleeding from the anus - was obvious. My underwear was soaked with blood".

"The nurse sympathised with the rapist, saying: ''He's lonely'' "

"I was told I was a risk to myself and it was my fault. I was called a lesbian and a drug addict. I was called violent and non-compliant. I was called paranoid. The police were called but I was not ready and did not have a perspective to talk to them. I was called sexually promiscuous. The harassment and assault was condoned as care. I was told it was related to my illness"

"They thought I was making it up and the patient was allowed to continue to be on the ward"
"Being treated like it was my fault/that I should have said/done something to stop it! Being treated badly and judged for going into a trauma response. During the rest of my stay, I was dissociating, self-harming and running away. This was all pathologised. Medicating me was also insulting. I didn't want it to all be squashed down with Seroquel! I wanted real support"

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Qualitative Responses to Question # 18: 'Are there any other comments you wish to make?'

"There should be clear rules about how to behave when you're in the psych ward, because people are not well but they can still understand that it's not OK to hurt or harass others"

"Some sort of timetable would be a good idea because it seems like most patients are just wandering around and then chased by a nurse to see a doctor or do something else"

"I think the nurses do their best most of the time but it seems like they are getting pressure from other people (not the patients, more from the doctors) and they have too much to do. I think the nurses should just mostly talk to the patients and that should be their main thing to do for their whole shift and all the other things should only be little things and not take up much time. The patients should have the nurses' time"

"So many times I've been in hospital and on many occasions, when I've left, I just want to die. I've had mental illness since I was ten and on one occasion, I was admitted to a hospital and they let my step dad have access to me. It was hell. They could see I was deeply upset but my step father just said I was missing home and the nursing staff just told me to grow up - crying wouldn't get me home any sooner. No other questions were asked. Staff had no respect for the gay, bi, trans-gender, queer community - that's been my experience. Thank you for doing this survey for people like me"

"When I was in my room at night, I was quite frightened and I saw shadows of a person/s that walked around at night and I could not see them completely because of the shape of my room and the doorway. I called the nurse in but I remember him being able to offer very little to help calm my fears. I witnessed sexual/other forms of harassment in the form of some other patients infringing on my visits with family/friends by chatting away with perhaps religious beliefs - very strongly. The incidents - I'm pretty sure that I reported them - was when a young male put his fist through the top of a glass door in a room where I was having a visit with my friend. Thank you for doing this work for all mental health consumers. I can have some trouble with filling forms in as there can be anxiety in how I want to word it. Because often, I do a lot of thinking that goes around and around to be clear and feel confident with surveys as my memory is often quite messy! I have had mental illness since I was 11 years old and this year, I'm 50, so there's a lot of doctors, counsellors, etc. I hope my information is of some help. Thanks again"

"If the assailant is not a patient but a nurse or doctor who can you trust or turn to for help?"

"Sometimes I just really think that crazy women don't matter. If the stuff that happened to us happened to non-crazy women, there would be a really big uproar"

"There needs to be more activities, rehab, more activities regarding diagnosis, medication, there also needs to be more understanding and education about diagnosis for family members"

"One of the most important things to remember about when you are admitted to hospital against your will is that you feel as though you are totally segregated from the community that you belong to and have no real human rights. Most importantly any access to legal assistance seemed to be denied & out of reach which was/is totally unfair. I can only hope that things have improved since 2007, as I would hate to experience the same feelings of frustration, powerlessness & alienation again. In between times, I try to keep well & like to keep up with what's happening in the mental health world"

"I was sexually assaulted by a woman in my hospitalisation and the staff did not give a shit. They don't care about women hurting women. This is the problem with the push for women only wards - distressed and ill women are as capable of sexual and other violence as men but nobody gives a damn, including your organisation. If men came near me as women had, then there would have been staff on them, but women have harmed me much more. Women only wards are NOT SAFE, it is a fantasy and completely, utterly sexist and WRONG"

"Offenders can be any sex, age or race, mentally ill or sane but no-one deserves to be abused and no-one has the right to abuse. The legal system and the punishment for offending should be a deterrent for abusers so all offenders need to be made accountable for their actions. All of society has the right to know those who have abused in the past and who could abuse again"

"The staff in the wards should believe what women tell them instead of thinking women are imagining things or making them up. It's like 'innocent until proven guilty', it should be 'there is a reason for being afraid' first before 'there is no reason to be afraid"

"It is not only females who are at risk when an in-patient - young males are also at risk of abusive behaviour from either gender. Having single, lockable bedrooms would assist people's safety. Also, having staff knock on doors, even when the door is ajar would demonstrate respect for individual's dignity. Forcing eating in only the dining-room from the first meal is not a good idea, as being in a group with so many new people compromises feeling safe. A small area with just one table would reduce alarm for me as a transition from being solitary (I live alone) to being with a large group. Having nursing and other staff in dining areas can be off-putting for some, but very reassuring for others"

"Mostly, it's scary to be in a psych ward, so there should be more ways to make women feel safe"

"I would rather die than be hospitalised again"

"All patients should have a G.P available to see about other medical issues. Not just mental health while an in-patient"

"Sexual assault is a crime"

"There are times when I still feel the effects of this. I am only realising now how I was so needy and just wanted to be loved and I let a violent man into my life and I did not have a good perspective on things. And that he sexually assaulted, he raped me and after I was discharged, also subjected me to domestic violence. I still haven't had counselling for this. I am only now starting to love myself and accept myself. I had to walk out on everything I knew and had and to nearly lose my life. But now I have a home where I am safe for the first time in my life - and friends who accept me"

"Thank you. I really appreciated someone listening to this. No one really wants to listen to crazy women and the awful things that happen in hospitals. They seem to assume that hospitals are safe, or that we're too crazy to be believed. What happened to me makes me scared to go back into hospital again"

Appendix 4: Example template: In-patient Nursing History & Care Plan

In-Patient Nursing History & Care Plan		
Name: **Address:**	**Interpreter required:**	**Support person(s) & contact details** **Name:** **Phone:** **Name:** **Phone:**
Mental Health Issues	**Physical Health Issues**	
History of Trauma:		
Consumer concerns regarding current admission:		
Vulnerabilities regarding current admission:		

Nursing History & Care Plan Cont.				
Issues causing distress:				
Strategies helpful in reducing distress:				
Any other concerns:				
Referral Requirements				
Social Worker:	**Psychologist:**	**Physician:**	**Occupational Therapist:**	**Other:**
Advanced Statement sighted & relevant aspects included in Care Plan?		**Signatures** **Consumer:** **Nurse:**		**Date:**

Nursing Care Plan

Decision Making Orientation Checklist

Duty of care explained?	**Yes** ☐	**No** ☐
Mental health status explained?	☐	☐
Informed Consent explained?	☐	☐
Clinicians responsibilities explained	☐	☐
Support person involvement discussed?	☐	☐
Advocacy organisations explained	☐	☐

Ward Orientation Check List

Introductions?	**Yes** ☐	**No** ☐	**Shown around ward?**	**Yes** ☐	**No** ☐
Explanation of rights?	☐	☐	**What to do if feeling unsafe?**	☐	☐
Visiting hours?	☐	☐	**Meal times**	☐	☐
Ward meetings	☐	☐	**Doctors rounds**	☐	☐
Smoking policy	☐	☐	**Medication times**	☐	☐

Observations	**Frequency**	
Distress Level (includes ascertaining how the person is feeling, feelings of suicide, etc., and deciding emotional supports required)		
Vulnerabilities (includes risk of being harassed, or harassing & strategies to reduce risks)		
Visitor Supports (includes who should be contacted if patient becomes distressed)		
Dietary Intake (includes special diet, food & fluid intake monitoring)		

Nursing Care Plan Cont.			
Observations	**Frequency**	**Nursing Interventions**	
Physical health issues (includes monitoring, & referral requirements to physician, wound dressing requirements, etc.)			
Sleep Patterns (includes quality & quantity of sleep patterns)			
Social Issues (includes Centrelink, housing, employment, PDRS sector issues)			**Actioned**
Allied Health Section (includes needs pertaining to allied health and/or allied health contributions to the nursing care plan)			**Actioned**
Discharge Plan (includes actions necessary to ensure holistic approach to discharge, encompassing accommodation, follow up appointments, support services needed, etc.)			**Actioned**
RN Signature: Date:	Consumer Signature: Date:	Copy of Care plan provided to: consumer Yes □ No □ Support Person □ □	

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