Preventing gender-based violence in mental health inpatient units

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Preventing gender-based violence in mental health inpatient units

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ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include: 1800 RESPECT – 1800 737 732 and Lifeline – 13 11 14.

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Executive summary

This report outlines the findings of the *Preventing gender-based violence in mental health inpatient units* project. The project aimed to investigate and document experiences of gender-based violence occurring in adult mental health inpatient units and perpetrated against those identifying as women, in order to inform how policy and practice can be improved to make these environments safe for women. The project aims were explored through the following two research questions:

1. What are the experiences of gender-based violence for women staying in adult inpatient mental health units?
2. How can these experiences inform and improve policy and service delivery?

The project involved researchers from RMIT University in Victoria and Charles Sturt University in New South Wales. Partner organisations included NorthWestern Mental Health, Mental Health Legal Centre and Victoria Legal Aid.

Terminology

In this report, the term "consumer" is used to refer to any people who elect to use or who are forced to use mental health services. People who work in mental health services are referred to as "staff", "service providers" or "professionals". The term "women" in this report refers to any person who identifies as a woman, this includes trans women.

Methodology

A review of the existing Australian and international literature pertaining to gender-based violence in mental health inpatient units was conducted in 2018. This was supplemented by a policy review conducted in 2019 that mapped and analysed relevant Australian documents produced by state and territory health departments and mental health services.

The research design and analysis were informed by a feminist approach. This means that the study is grounded in the feminist belief that women experience multiple oppressions due to existing power structures. Feminist thinking also contests the idea that male experiences represent the norm. In line with this, the study puts women's experiences and voices at the centre of the project.

The research was conducted with guidance and support from a project advisory group consisting of consumers, academics, advocates and service providers. The team also consulted with Victoria Legal Aid's "Speaking from experience" mental health consumer advisory group.

Qualitative data collection for the project was conducted in two stages:

1. Interviews: 11 in-depth interviews were conducted (July 2018–May 2019) with women who had experienced gender-based violence during or due to a stay in a mental health inpatient unit in Victoria in the past 5 years.
2. Workshops: The first four workshops were held in May and June 2019 with 42 service providers from NorthWestern Mental Health in Melbourne to present the findings from the interviews and receive feedback. The workshop groups included:
    a. Safety and Quality Committee
    b. Nurse unit managers
    c. Senior nurse advisors
    d. Senior allied health workers, including:
        i. Social workers
        ii Occupational therapists
        iii Psychologists.

Two further workshops were conducted in August 2019 with 21 nurses and allied health workers to garner feedback on the draft guidelines that were developed as part of this research project.

Key findings

The key findings from the interviews and the workshops represent critical issues raised by consumers and practitioners. There was general consistency of opinion across the participants on a number of issues as described in the findings below.

Nevertheless, individuals did express different viewpoints and experiences at times and these are noted throughout the report. We were unable to interview consumers who identified as Aboriginal or Torres Strait Islander, or as non-binary, which limited the scope of experiences that were captured in the research.

Interview findings

The interview findings were consistent with previous studies in that women reported experiences of gender-based violence in mental inpatient health units. The key emerging themes discussed in detail in this report are: the diversity of women's experiences of gender-based violence, gender-based violence in the course of treatment, built environments and resourcing that contribute to women's vulnerability, poor service responses that leave women to take responsibility for their own protection and a lack of trauma-informed care. Women also shared their solutions to address the issues raised.

The study found that women were exposed to a range of behaviours including: threats, harassment and sexual and physical violence. Perpetrators of gender-based violence were mostly male consumers but also included male staff members and other men known to the women, such as partners/ex-partners. Gender-based violence in the course of treatment included practices employed by staff, such as restraint and seclusion. Women noted that gender-based violence can heighten over the period of a stay, whereby, if incidents are not addressed adequately, the violence can escalate.

Male violence reduced women's access to, and ownership of, space in mental health settings. This was exacerbated by limitations of the built environment such as the way mixed-gender spaces, including lounges, dining rooms and bathrooms, contributed to women's exposure to gender-based violence. Furthermore, resourcing issues, such as pressure on bed availability, resulted in women being placed in men's sections and vice versa, increasing women's vulnerability in those spaces.

Women received a range of responses when they approached staff about being victimised; however, most were unhappy with how they had been treated. This was compounded by a lack of trauma-informed care, including a failure to respond to past trauma, poor responses to traumatic events and a failure to address ongoing trauma. Consequently, women reported feeling responsible for protecting themselves against gender-based violence due to inadequate institutional responses. For example, women may leave mental health inpatient units prematurely as a form of protection from gender-based violence and avoid future mental health care due to fear of gender-based violence occurring again.

Women's solutions included changes to the built environment, gender-segregated inpatient units, changes to staffing and staff training, and the further inclusion of peer support and consumer advocacy.

Workshop findings

The workshop findings largely confirmed the women's experiences, with service providers further asserting that mental health inpatient units are dynamic and "fast-paced" environments that make it difficult to monitor all consumers and thus provide universal safety.

Service providers also acknowledged that gender-sensitivity and sexual safety policies and procedures are increasingly prevalent in mental health settings; however, structural limitations such as the built environment and adequate resourcing prevent their full implementation. This included inadequate staff levels to offer sufficient support for women with regard to gender-based violence.

The lack of trauma-informed care identified by women was also confirmed by the workshop groups. For example, when seeking information about a woman's mental health history, men who have perpetrated family violence, such as partners/ex-partners, may be erroneously or deliberately contacted by service providers for their perspective on the woman's mental health, which would inform their treatment and care planning. Mandatory reporting of incidents of gender-based violence was perceived as a positive measure, despite the way in which this limited women's control of reporting processes.

Service providers specified that they would value having specialist sexual assault workers employed to support consumers and mental health service providers in response to situations of gender-based violence; this would complement, not replace, the responsibility of mental health service providers to manage such situations and maintain safety.

Implications and recommendations

Beyond establishing a clear imperative for reforming inpatient treatment and care, the findings of this study must be seen in the broader societal context of women's experiences of gender-based violence and in how women's experiences of mental health can be overlooked in the mental health system. Rectifying the specific issues of women's safety in mental health inpatient units is part of the larger societal problems of women's inequality and oppression.

The study's implications and recommendations for policy and practice within mental health inpatient units are detailed in our "Guidelines for ensuring women's safety in mental health inpatient units" (hereafter referred to as the Guidelines—see Appendix A). These guidelines were generated through consultations with the project advisory group, consumers, advocates and service providers. The purpose of the Guidelines is to provide a coherent and uniform method to improve safety for women in mental health inpatient units through better clarity and new approaches to eliminate gender-based violence. The Guidelines are intended to increase service provider confidence in their capacity to prevent and respond to gender-based violence. The eradication of gender-based violence will allow units to better operate as safe and therapeutic environments for improvement in mental health and wellbeing.

The Guidelines draw on the principles of safety, recovery, gender sensitivity, dignity, autonomy and choice. These principles must be embedded throughout the process of a stay in a mental health inpatient unit. Promotion of gender safety should ensure that gender-based violence never occurs. Prevention of gender-based violence requires that:

- Women are never required to share spaces with men.
- Early intervention when gender-based violence does occur requires trauma-informed and person-centred intervention.
- Incident response must be led by women and conform to best practice in sexual assault response.
- Incident reporting and recording must also be led by women and result in appropriate continuing care.
- Data which is collected must protect women's privacy while ensuring that services are transparent and accountable. This data must inform oversight and monitoring mechanisms to ensure that the required changes are embedded in the mental health system.

Introduction

Mental health inpatient units are settings, typically located in hospitals, which offer both compulsory and voluntary treatment for individuals experiencing an acute period of mental illness. Consumers are admitted for psychiatric assessment, management and treatment. Although mental health inpatient units are intended to offer consumers individualised care, support and treatment in safe environments; for women, this does not always occur. This is because, as existing research demonstrates, mental health inpatient units are sites where women are exposed to gender-based violence (e.g. Clarke & Dempsey, 2008; Frueh et al., 2005; Kulkarni & Gavrilidis et al., 2014; Office of the Public Advocate [OPA], 2017). Gender-based violence is not unique to mental health inpatient units. Victims/survivors of sexual violence in Australia, for example, are predominantly women, with one in five having been sexually assaulted and/or threatened (Australian Institute of Health and Welfare [AIHW], 2018A). Gender-based violence in mental health inpatient units, therefore, needs to be appraised within this broader societal context. Nevertheless, women need to be able to depend on mental health inpatient units to be places that ensure their safety, with systems in place that provide zero-exposure to gender-based violence.

Current policy approaches to eliminating gender-based violence indicate substantial variance between Australian states and territories. This inevitably creates inconsistencies in service provision, compromising women's safety and wellbeing. As such, there is clearly a need to examine women's experiences and review current policies and practices to understand why existing gender-safety measures are not working. Crucially, this needs to be directed by the experiences of consumers. Unfortunately, women's mental health is often neglected (Kulkarni, 2014), with little attention paid to how mental health is experienced and treated according to gender. This must be rectified if inpatient settings are to eliminate gender-based violence.

This report documents the findings of a research project that explored women's experiences of gender-based violence occurring in mental health inpatient units. The report includes a State of knowledge review of Australian and international literature, as well as Australian policy pertaining to gender-based violence in mental health inpatient units. This is followed by the presentation of qualitative data from a series of interviews with women who had experienced gender-based violence in inpatient settings as well as from workshops conducted with mental health professionals. These findings provided the foundation for the development of the Guidelines (see Appendix A).

The aim of this project was to investigate and document experiences of gender-based violence occurring in adult mental health inpatient units in order to inform how policy and practice responses could be improved to make these environments safe for women. This aim was informed by two research questions:

1. What are the experiences of gender-based violence for women staying in adult inpatient mental health units?
2. How can these experiences inform and improve policy and service delivery?

Project rationale

Within the context discussed above, the rationale for this project is premised on three main understandings:

- The safety of mental health inpatient units for women: the provision of safe environments is paramount for people to receive effective and timely mental health treatment. Inadequate, and/or lack of consistency in, responses to gender-based violence in mental health inpatient units means that these spaces cannot guarantee women protection from male violence. This project seeks to provide evidence that institutional action is needed in these settings for change to occur.
- The features of the built environment are essential in eliminating gender-based violence: mental health inpatient units differ in design for a range of reasons such as location (urban or rural), capacity, jurisdiction and age of the facility. This means there is variance in how women and men are accommodated. This project documents how the built environment protects and/or endangers women.

- The need to centre women's voices in relation to their experiences in inpatient units: a crucial aspect of any institutional strategy to eradicate gender-based violence from mental health inpatient units is incorporating, and being led by, the experiences of women. This project puts women's voices at the centre. Not only does this project document women's experiences, it is unique because consumers have been involved during every stage of the project, from the design through to the development of the Guidelines.

The location of the research focus is Victoria because, while gender-based violence in mental health inpatient units is a national problem, Victoria is leading the way in implementing processes and measures that attempt to improve women's safety in inpatient mental health units. An example of such measures is the Victorian Chief Psychiatrist's guideline, *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* (Victorian Department of Health, 2012), first released in 2009, and later updated in 2012. Correspondingly, the Victorian Department of Health released the *Service guideline on gender sensitivity and safety* (Victorian Department of Health, 2011) that included a focus on mental health services. Even so, Victoria has been unsuccessful in eliminating gender-based violence in mental health inpatient units to date.

Other Australian jurisdictions have approached the issue with varying levels of interest, as discussed in the policy review below, but Victoria has given it the most attention in recent history. Some other jurisdictions, such as New South Wales, have also developed responses to the issue. In other jurisdictions, the situation is significantly worse, with old asylum-style accommodation still being utilised, with shared bedrooms and bathrooms without locks and/or no women-only areas or corridors.[1] Moreover, existing guidelines, such as outlined in the "Safewards" initiative (Victorian Department of Health and Human Services, 2016), are sporadically implemented, respond to outdated and narrow assumptions of gender and sexuality and are not wholly grounded in the experience of women who have been subjected to gender-based violence.

Women entering mental health inpatient units should expect these spaces to be free from gender-based violence. Yet, existing studies demonstrate that women are not safe, indicating it is imperative that research is undertaken to understand why gender-based violence continues to occur. It is necessary to explore why, despite reforms and policy changes, gender-based violence has not been eliminated in mental health inpatient units. Our research involved assessing the policy requirements of different jurisdictions and environments to interpret the discrepancies that exist, and exploring how policy is implemented in practice including barriers that prevent zero-tolerance of gender-based violence. This project takes the position that the experiences of women need to underpin the research, recommendations that are produced and systemic changes that may result because it is their wellbeing that is at stake.

Terminology and identity

In both mental health and gender-based violence discourse, language is contested and can be used in problematic ways. In writing this report we understand that no single approach to terminology will satisfy all stakeholders. We, therefore, clarify our use of the following terms in this report:

- Women: when we refer to women in this report, we include any person who identifies as a woman. This includes trans women. We also understand that many people do not identify as male or female (e.g. gender non-binary, genderqueer and gender fluid). We, therefore, have chosen "women" to refer to both (those who identify as) women who participated in the interviews and (those who identify as) women who are in mental health inpatient units.
- Consumer: acknowledging that the terms "patient", "service user" and "consumer" are all contested, we have used "consumer" to describe people of any gender who elect to use or who are forced to use mental health services.
- Victim/survivor: the term "victim/survivor" is also employed at times to refer to women who have experienced gender-based violence.

1 For example, Western Australia's acute forensic inpatient unit (The Frankland Centre) is a 30-bed facility with three units for both men and women in the criminal justice system. This means that in a 12-bed unit there may be one woman in a setting with eleven men, all of whom have been referred there due to mental health concerns and contact with the criminal justice system.

- In referring to people who work in mental health services we have used "staff", "service provider" or "professional", understanding that these terms also include peer workers and consumer advocates.

We also acknowledge that men, people who identify as non-binary, trans people, mental health professionals and many other groups also experience violence in mental health inpatient settings. Even so, this study is about gender-based violence as experienced by those who identify as women.

State of knowledge

Women's vulnerability to gender-based violence in mental health inpatient units is a longstanding issue (Ashmore, Spangaro, & McNamara, 2015; Bartlett & Hassell, 2001; Kulkarni, 2014; Kulkarni & Galletly, 2017). There is no single definition of gender-based violence that covers all possible circumstances. Definitions are adapted to suit different contexts and purposes. Gender-based violence and violence against women are terms that (though different) are typically used to describe acts of violence against women and girls. The most commonly applied definition can be found in the United Nations General Assembly (1993) *Declaration on the Elimination of Violence against Women*, where violence against women is:

> … any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Understandings of gender-based violence also need to extend conceptualisations of gender beyond normative binaries to include gender identity regardless of biological sex. This means that gender needs to be inclusive of LGBTIQ identities, for example, diverse sexual orientation and gender diversity. As such, gender-based violence can include the perpetration of homophobic violence. Gender-based violence takes many forms and, according to "The Istanbul Convention" (Council of Europe, 2014), has four main categories: physical, sexual, psychological and economic. Gender-based violence can be perpetrated by men or women who are known or unknown to the victim/survivor. Moreover, gender-based violence takes place within the broader context of gender inequality, structural disadvantage and oppression.

The gendered experiences of women under psychiatric care have been an issue of contention since the first days of modern psychiatry, when Philippe Pinel removed the iron shackles from the women at the infamous Paris asylum, L'Hôpital Salpêtrière, in 1795 (Carrez, 2008). Over time, women in psychiatric institutions and mental health inpatient units have been subjected to similar problematic practices to men, but women's experiences have been compounded by additional indignities conferred by their gender. As psychiatric treatment and care have progressed, the experiences of women have no doubt improved, although much work remains to be done.

The ongoing prevalence of violence against women in mental health inpatient units should not be seen as an indication that mental illness or maleness necessarily means that men in these spaces are more dangerous to women. Rather, the mental health system's process of determining who is involuntarily treated specifically selects those who are perceived as most threatening and those who are perceived as most likely to be harmed and places them together. Not all people in mental health inpatient units are involuntary, but for the more than half who are there is, in all states, an explicit legal requirement that they are at risk of harm or pose a risk of harm to others (AIHW, 2018b). In Victoria, one of the treatment criteria for involuntary treatment and detention is:

> … because the person has mental illness, the person needs immediate treatment to prevent … serious harm to the person or to another person (*Mental Health Act 2014* (Vic), s. 5)

This means that if there are two people who both have a diagnosis of mental illness, both of whom have been assessed as requiring treatment, the one more likely to commit harm will be selected for inpatient treatment, while the other may be treated in the community. This explains that while people who have a diagnosis of mental illness are much more likely to be victims/survivors of violence than perpetrators (Baumann & Teasdale, 2018; Bonner & Wellman, 2010; Daley, Beresford, & Costa, 2019), those men who are most likely to cause harm are often those who are selected for inpatient treatment. It is not necessarily the presence of mental illness which contributes to the increased potential of violence, rather, that risk of violence is specifically selected for. The same applies for people who are likely to be harmed in these spaces, that is, women—those women who are assessed as more likely to be harmed will be prioritised for inpatient treatment. The kind of harm is not specified in the legislation, but certainly includes women who are assessed as being at risk of being harmed in the community due to sexual "disinhibition" or any other consideration. Furthermore, the process of involuntary treatment can be dehumanising, oppressive and traumatic (Trotter, 2015), leading to increased lateral violence. This is compounded because ordinary coping strategies such as taking a walk or being alone are often prohibited, forcing people to use alternative coping strategies which may be harmful to others or increase susceptibility to harm. Without

minimising the responsibility of men for their behaviour, this provides some context for why mental health inpatient units are unsafe spaces for women.

This State of knowledge section is in two parts. The first part, a review of Australian and international literature, describes the shifting and competing understandings of women's experiences of gender-based violence in mental health inpatient settings. The second part, an analysis of the relevant policies from across the country, highlights both the variation in approaches and the absence of a coherent strategy to ensure that women are safe. No jurisdiction releases data on this issue, but even in Victoria, the state which has given the most attention to the issue, gender-based violence and sexual safety remains an issue acknowledged both by consumer advocates and statutory oversight bodies (Mental Health Complaints Commissioner [MHCC], 2018; OPA, 2017; Victorian Mental Illness Awareness Council [VMIAC], 2013).

This State of knowledge overview contextualises gender-based violence in mental health inpatient units within the broader context of gender inequality and violence against women that exists in Australia and globally. In this study, we do not take a binary view of gender and consider women to include anyone who identifies as such. This is combined with the understanding that gender needs to be conceptualised through "intersectionality"; gender does not shape people's experiences and identities in isolation, but through complex and dynamic interactions related to structural factors such as race, sexuality, class, ability, religion and place (Carastathis, 2014; Crenshaw, 1989). In addition, illuminating how and why women experience violence in mental health inpatient units brings attention to the intersection of gender and mental health.

In Australia, according to the 2016 Personal Safety Survey (Australian Bureau of Statistics [ABS], 2016), one in five women have experienced sexual violence since the age of 15; one in four women have experienced violence perpetrated by an intimate partner; and one in two women have experienced sexual harassment since the age of 18. Although men also experience gender-based violence (as perpetrated by women), the rates are far higher for women. Furthermore, women and men are far more likely to be victims/survivors of male violence than female violence (ABS, 2016). Violence against women is unavoidably connected to entrenched power imbalances that are underpinned by existing gender norms.

Historical background

The experiences of women receiving psychiatric care, in general, are historically under-researched; although, women have been singled out as having specific "women's maladies" since ancient times. These conceptualisations of women's "diseases" serve as an example of the way psychiatric care used gender-based violence to confine women into "women's roles" throughout history. Many of these ideas, such as the ancient Greek conceptualisation of the womb described by Plato (2015) in 360 B.C.E as a wild beast which would wander the body causing hysteria and other diseases if not regularly engaged in procreation, persisted until relatively recently. "Hysteria" was only removed from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980) in 1980, and is a clear example of the way that "mental disorder, especially in women, so often misunderstood and misinterpreted, generates scientific and/or moral bias, defined as a pseudo-scientific prejudice" (Tasca, Rapetti, Carta, & Fadda, 2012, p. 110).

This theme of psychiatric sexism is also historically dominant in inpatient and institutional settings, with female asylums historically grouping, othering and detaining women with a disability, "madwomen" and "the debauched"—sex workers and street beggars (Carrez, 2008). This grouping of all women who did not follow social norms was explicit; for example, the Salpêtrière employed an inspector *la police des mœurs* responsible for addressing the immoral behaviour of this group of women (Carrez, 2008).

From the early 1800s, through the period of "moral treatment", the short-lived "mental hygiene" movement and the rise of institutionalisation, women were consistently—although not always—housed separately from men. This largely limited the gender-based violence they would have experienced (from male consumers) to violence perpetrated by staff and institutions. From the 1960s onwards, in line with broader moves towards

deinstitutionalisation, psychiatric care began to move towards mixed-gender wards (Henderson & Reveley, 1996). This was intended to better reflect the general community, and women were thought to have a calming and civilising effect on men (Copperman & Knowles, 2006). This attitude can be seen as a form of gender-based violence in itself, in that it prioritises the experience of men over women's safety.

In the United Kingdom (UK), where we have the most comprehensive data, as early as 1963, staff raised concerns about "permissiveness and licence" (Jones in Henderson & Reveley, 1996, p. 513), and reports of sexual harassment and rape are documented from the 1980s onwards (Copperman & Knowles, 2006). Despite this, the trend of gender mixing continued both in the UK and internationally, in attempts to promote a more normal, less institutionalised and more therapeutic environment (Brunt, 2008; Krumm, Kilian, & Becker, 2006; Kulkarni & Gavrilidis et al., 2014).

In the 1990s, some countries such as the UK began to transition back to single-sex wards (Brunt, 2008), while others, such as Germany, continued the transition to mixed-sex wards (Krumm et al., 2006). In Australia, there has mainly been an attempt to create women-only spaces in mixed settings, with varying success (Kulkarni & Gavrilidis et al., 2014). This difference in approach between the UK and Australia is not limited to mental health but reflects an overall approach in hospital service delivery (Williams, Cross, & Darbyshire, 2017). In both jurisdictions, debates in the literature and changes in practice reflect a growing concern for women's safety in an inpatient setting, albeit with little consensus as to how to address it. This has occurred in the context of women's mental health being overlooked more generally (Kulkarni, 2014). More recently, we have seen improvement in the reporting systems implemented in mental health services and better management of violence against consumers, with some shift in the culture of inpatient units, but it is still not sufficient (Kulkarni, 2013).

Literature review

This literature review outlines the two main ways in which gender-based violence is perpetuated: by interpersonal violence from other consumers and by the structural factors which both allow gender-based violence to occur and that perpetuate it.

This review uses a hermeneutic-phenomenological methodology (Efron & Ravid, 2018). A hermeneutic-phenomenological literature review is not an assertion of truth, but a process of engaging in the conversation between scholars on the topic, finding new meanings and contrasts in the literature. This acknowledges the varying viewpoints on the topic and immersion in various sources, extending the literature. This approach has been chosen as the literature on this topic is a limited mix of activist research, program evaluation, theoretical analyses and empirical studies from a range of practice settings. Navigating this literature requires an appreciation of the value of subjective texts and the way that personal experiences—both of consumer-led research and clinical-led research—gives rise to a variety of ways of understanding gender and violence. A hermeneutic-phenomenological methodology allows for a selection of literature that reflects the variety of discourses which consider this topic, valuing the contribution of each.

This process is circular and recursive, drawing on links between texts as well as using database keyword searches. These databases include all those included in the RMIT University library search function and those included in Google Scholar. Search terms included variations of "gendered violence", "gender-based violence", "women", "female", "mental health", "inpatient unit", "sexual assault", "safety", "trauma", "sexual safety" and "sexual harassment". A hand search was also conducted. This entailed searching the reference lists of recent documents which covered similar topics (e.g. Maylea, 2019; MHCC, 2018; VMIAC, 2008;) and the publication history of key authors on the topic (e.g. Kulkarni) for other relevant papers. This process became circular as related issues began to coalesce; for example, service responses to family violence were not initially included, but were clearly within the adopted definition of gender-based violence and so were also searched for. Ultimately, 117 papers of varying relevance were reviewed.

There is very limited scholarship on women's experiences of gender-based violence in mental health inpatient settings. Most

work has come from the United Kingdom and Australia—particularly Victoria, where debate with regard to mixed-sex wards is ongoing (Kulkarni, 2014; Maylea, 2019; MHCC, 2018). The contemporary literature which does examine this topic can be grouped into two main areas discussed below: literature on interpersonal violence perpetrated by other consumers and violence perpetuated by systems and institutions.

The majority of literature that examines the experiences of people within mental health inpatient units or mental health services more broadly has not adopted a gendered analysis. For example, recent studies by Donald, Duff, Lee, Kroschel and Kulkarni (2015) and Brophy, Roper, Hamilton, Tellez and McSherry (2016), which documented consumer experiences, did not identify gender-based violence as an issue. Similarly, the NSW Chief Psychiatrist's report into seclusion and restraint, triggered by the 2014 death of a woman in an inpatient unit, makes no reference or recommendations regarding gender (Wright, 2017). The "Safewards" project, an international approach to reducing violence in mental health inpatient units adopted by a number of Australian jurisdictions including Victoria, Tasmania and Queensland, does not make gender a focal point. Notwithstanding multiple studies reflecting its success, there has been little interrogation of the nature of gender-based violence in these settings, despite noting that men are more likely to harm others and women are more likely to harm themselves (Fletcher, Buchanan-Hagen, Brophy, Kinner, & Hamilton, 2019; Fletcher, Hamilton, Kinner, & Brophy, 2019; Fletcher et al., 2017; Hamilton, Fletcher, Sands, Roper, & Elsom, 2016). Occasionally, gender-based violence appears in research which does not explicitly seek it out, such as emerging as a reason why one woman felt unsafe and sought to leave an inpatient unit in a study examining "absconding" (Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013).

Conversely, when researchers have taken an explicitly gendered view, such as Fish and Hatton's (2017) study of intellectually disabled women in a forensic inpatient ward, participants have been quick to identify the gendered nature of coercion. Wood and Pistrang (2004) noted that up to the time of their study, most studies of violence in mental health inpatient units focused on violence against staff—not violence against consumers. This has shifted in recent years, with a small number of studies examining gender-based violence perpetrated by consumers against other consumers, (E.g. MHCC, 2018; Quinn & Happell, 2015), and others examining the experiences of women in restrictive settings, including seclusion and restraint (Fish & Hatton, 2017; Xiao, Gavrilidis, Lee, & Kulkarni, 2016). The combination of an emerging gendered lens, and a developing focus on the experience of people using services, means that there is only limited literature which engages with this topic, and that which does, tends to be more recent. There is a particular tendency to action research focused on policy change, rather than widespread large scale systematic research.

Prevalence of violence by other consumers

While estimates and findings vary considerably, the literature which examines violence perpetrated by other consumers consistently paints a picture of inpatient experiences as being very unsafe for women. A significant number of the studies and other literature reviewed from Australia, the UK, the United States (US) and other jurisdictions, show consistently high rates of violence in inpatient settings (Garling & New South Wales Government, 2008; Owen, Tarantello, Jones, & Tennant, 1998; Wood & Pistrang, 2004; Wright, 2017), with many identifying sexual violence against women in particular (Clarke & Dempsey, 2008; Frueh et al., 2005; Kulkarni & Gavrilidis et al., 2014; Leavey, Papageorgiou, & Papadopoulos, 2006; Lucas & Stevenson, 2006; Mezey, Hassell, & Bartlett, 2005; Motz, 2009; Nibert, Cooper, & Crossmaker, 1989; OPA, 2017, p. 201; Wood & Pistrang, 2004). Debate about the ability of services to provide safe environments for women has particularly been sparked by the shift to single-sex wards in the UK (Bonner & Wellman, 2010; Cutting & Henderson, 2002; Fish & Hatton, 2017; Hawley, Palmer, Jefferies, Gale, & Vincent, 2013; Henderson & Reveley, 1996; Krumm et al., 2006; Leavey et al., 2006; Mezey et al., 2005; Motz, 2009; Noble & Rodger, 1989; Thomas, Hutton, Allen, & Olajide, 2009; Wood & Pistrang, 2004). Even with the shift to single-sex wards, there are reports of sexual assaults increasing (Williams, 2015) and of resourcing and cultural resistance to change limiting the ability of women to choose to stay on single-sex wards (Copperman & Knowles, 2006). Literature from the US (Frueh et al., 2005), Canada (Nicholls, Brink, Greaves, Lussier, & Verdun-Jones, 2009; Nicholls,

Ogloff, & Douglas, 2004), Switzerland (Soliman & Reza, 2001), South Africa (Lucas & Stevenson, 2006) and other Australian jurisdictions (Cleary & Warren, 1998; Davidson, 1997; Owen et al., 1998; Wright, 2017) indicate that issues with safety in mental health inpatient units are not limited to Victoria or the UK.

Attempts to gain a clear understanding of the experiences of women in the current context are made difficult by the limitations of the available literature. Studies which explicitly seek to highlight the risk of gender-based violence in mental health inpatient units tend to go looking for evidence to support this risk—and are successful in finding it. This does mean that while incidence has been identified, it is difficult to make any reliable claims regarding the prevalence of gender-based violence and to generate policy and practice responses to address it. Studies that interviewed women tended to rely on self-reporting and did little to account for selection bias, whereas studies that considered violence overall tended to review incident reports or reports from staff. Given the potential for underreporting of gender-based violence in this environment, this may go some way to explaining the disparity between studies which present gender-based violence as widespread, and those which do not. Even studies that sought to objectively assess the issue using staff observation queried the gendered nature of staff reporting, with staff having different expectations for men's and women's behaviour (Krumm et al., 2006).

At one end of the scale, a Victorian Mental Illness Council (VMIAC) report, extrapolating from limited available data, found that "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%" (VMIAC, 2008, p. 6). That same study used purposive sampling through an online survey to determine participants' experiences of safety. Of 50 participants, 67 percent reported sexual or other harassment, and 45 percent reported being sexually assaulted.

A 2006 survey by the Victorian Women and Mental Health Network (VWMHN), using a similarly purposive recruitment technique, noted that 61 percent of 75 women surveyed reported experiencing harassment or abuse as inpatients (Clarke & Dempsey, 2008). The same study reported that 70 percent of 42 staff who participated in the study acknowledged that harassment and abuse occur, and 30 percent estimated these occur "frequently or very frequently". Other VWMHN (2008, 2009) qualitative and quantitative data support these findings. Another qualitative Victorian study with six women who were inpatients at the time of the study found similar issues but presented a less dire perspective, with two women expressing fear of physical harm from men who were also inpatients at the time (Kennedy & Fortune, 2014). That study found that the built environment of the inpatient setting contributed to negative experiences for women but did not reflect the same widespread lack of safety identified in the VMIAC and VWMHN studies. While the recruitment method for these three studies makes the statistical findings less than reliable due to the selective nature of the sampling, they generally support the need to make mental health inpatient units safe for women.

In addition, a number of studies reviewed indicate that within a mental health inpatient setting, women perpetrate violence as much as men (Nicholls et al., 2009, 2004; Noble & Rodger, 1989; Soliman & Reza, 2001), although men were more likely to commit sexual assault (Bowers, Ross, Cutting, & Stewart, 2014). One study did find that violence between consumers was predominantly aimed at women (Lucas & Stevenson, 2006). Studies that do not emphasise the gendered nature of violence should not be discounted, but they do not correlate with literature that prioritises the experience of women rather than externally assessed prevalence of violence. One potential explanation for this discrepancy is that women in mental health services were consistently identified as likely to experience more harm from an act of violence due to the very high likelihood that they had previously experienced sexual assault (Clarke & Dempsey, 2008; Craine, Henson, Colliver, & MacLean, 1988; Frueh et al., 2005; Hegarty, Tarzia, Rees et al., 2017; Krumm et al., 2006). This shows the opaque nature of the issue, with many studies only measuring the prevalence of violence, not the actual impact of violence.

The general lack of safety for women illustrated in these studies has led to support for single-sex wards, or for women-only corridors and recreation spaces (Clarke & Dempsey, 2008; Garling & New South Wales Government, 2008; Kennedy & Fortune, 2014; Kohen, 1999; Kohen, McNicholas & Beaumont, 2013; Kulkarni & Gavrilidis et al., 2014). Cutting and Henderson (2002) take this a step further to argue that due to the high rates of violence experienced by women in single-sex wards, simply separating men and women would not be in itself sufficient to make these places safe for women. Mezey et al. (2005, p. 159) support this, finding that women in single-sex units still "reported intimidation, threats and abuse by other women patients, although they were less vulnerable to sexual abuse and exploitation and serious physical assault". They wrote that "single-sex secure units for women may not be justified on the grounds of safety issues alone" (Mezey et al., 2005, p. 579). This is supported by Mills and Hamer (2015, p. 83), who found that there "are no compelling results to support or refute transition to single-sex environments". Kennedy and Fortune also argue that single-sex wards is an important step but would be in itself insufficient:

> … for the inpatient service to be safer and more sensitive to women's needs, a focus on gender segregation alone is inadequate. It is felt that the physical environment can be utilized more effectively to improve safety [and] reduce chaos … (Kennedy & Fortune, 2014, p. 302)

Other studies are even less clear in their recommendations, with Hingley and Goodwin (1994), Cleary and Warren (1998) and Felton and Abu-Kmeil (2012) finding that though women did experience gender-based violence, they still expressed a preference for mixed-sex wards. Those studies all had mixed results, and other studies indicate a clear preference for single-sex wards from women (e.g. Leavey et al., 2006). This is further complicated by the number of studies that emphasise the negative impact of single-sex wards on men (Cutting & Henderson, 2002; Hawley et al., 2013; Krumm et al., 2006; Thomas et al., 2009). This highlights one clear theme in the literature—women, and women's safety and wellbeing, tends to suffer in mixed wards, while men benefit; but even this narrative is not consistently upheld. Cutting and Henderson (2002, p. 705) write that "attempts to 'normalize' institutional care by desegregating wards appear rather to have compounded problems faced by women". The presence of men is one part of the picture with concern for women's safety, but there is more to consider.

Overall, the literature paints a picture of an environment that is unsafe for women; although, the complexity of the issue, variations over time and jurisdiction and the lack of consistent data make clear assertions difficult to draw. Even within a single jurisdiction, as a number of studies point out, there can be significant variation in the practices and approaches which would be expected to protect women from gender-based violence (OPA, 2017; VWMHN, 2009). Furthermore, existing research highlights how gender and mental health intersect, yet is limited in highlighting how experiences of gender-based violence in mental health inpatient units are shaped by factors such as race, class, ability, sexuality, place and religion. The focus on violence perpetrated by other consumers, in particular, male consumers, belies another way in which gender-based violence is perpetrated in inpatient units—by the systems and institutions themselves.

Systemic and institutional violence

While much has been done in recent years to uphold and maintain the rights of people engaged in mental health services, it remains the case that many women who are detained in mental health inpatient units are treated against their will. Clear and consistent national data is not available, however, roughly half of inpatient admissions in some jurisdictions are formally involuntary (AIHW, 2018c; DHHS, 2017). This means that the experience of being an inpatient cannot be clearly separated from the experience of being detained, involuntarily treated and subject to other coercive practices such as seclusion and restraint. This has attracted the attention of human rights scholars. Weller (2019, p. 11) argues that a failure to prevent sexual assault in care settings could constitute torture under international law:

> Sexual assault of women and girls (and others) who have been placed in the care of the state (or in private facilities) demonstrates a failure to acknowledge and respond to the special vulnerabilities of these groups.

Failing to prevent sexual assault where it is possible to do so is in breach of the United Nations *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1984). Even if the legal threshold for torture is not met, Weller (2019, p. 11) writes that "sexual assault in the context of care clearly constitutes an instance of cruel, inhuman or degrading treatment or punishment".

Providing a safe treatment environment is not limited to ensuring that traumatic incidents do not occur; it extends to the prevention of re-traumatisation. When understood in the context of the high proportion of women who use mental health services who have experienced past trauma, the simple action of disempowerment and coercion can be viewed as a gendered issue. Fish and Hatton's (2017) study, drawing on feminist disability studies, illustrates the gendered nature of restraint in an inpatient setting, even when not explicitly sexual. The women in their study recounted experiencing restraint as gender-based violence, because it was perpetrated by men, because it would expose their bodies, and because they had experienced sexual abuse in their past—the trauma of which was triggered by the experience of being restrained. Mohr, Petti and Mohr write:

> Women having histories of childhood sexual abuse recalled the experience of being physically restrained as representing a reenactment of their original trauma. The restraint experienced years later was associated with traumatic emotional reactions, (for example, fear, rage and anxiety). (2003, p. 334)

Mental health inpatient units also contribute to gender-based violence by failing to respond adequately to violence perpetrated by other consumers. The studies above often cast men's violence against women as being the fault of male consumers; however, when the state detains a person, that person is in the care of the state who is thus responsible for her safety. The Office of the Public Advocate (OPA) (2017), for example, highlighted the way resourcing constraints perpetuated gender-based violence, where bed shortages meant men who had sexually assaulted women on the ward were not removed or "female only" corridors were used to house men. Similarly, the OPA described staffing shortages leading to a lack of appropriate supervision. In the VMIAC study described above, only 61 percent of women who experienced sexual assault on the ward reported their experience to staff, and 82 percent of those who did report found the service's response "not at all helpful". Wood and Pistrang (2004, p. 27) also commented on the need for appropriate responses, writing that: "it is not just the presence of threatening behaviour which makes service users feel unsafe, but also the absence of protective behaviours on the part of staff".

The potential for services to inflict gender-based violence is not limited to perpetrating violent acts. The failure to provide services that respond to a person's gender in a way that makes them unsafe or experience a lack of safety is also gender-based violence. The high rates of women in mental health services with trauma histories is not a recent discovery (Brown & Anderson, 1991) and is a common link for women in countries across the globe (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008) but remains a largely unaddressed issue in Australian mental health services (Hegarty, Tarzia, Fooks, & Rees, 2017). This can include childhood sexual abuse, family violence and other forms of sexual assault (Clark & Fileborn, 2011; Ellsberg et al., 2008; Friedman & Loue, 2007; González Cases et al., 2014; Khalifeh, Oram, Trevillion, Johnson, & Howard, 2015; Oram, Trevillion, Feder, & Howard, 2013; Riecher-Rössler & García-Moreno, 2013). The symptomology associated with this past trauma, such as dissociation, makes women particularly vulnerable to gender-based violence in institutional settings (Clarke & Dempsey, 2008; Craine et al., 1988; Frueh et al., 2005; Hegarty, Tarzia, Rees et al., 2017; Krumm et al., 2006).

A failure to provide trauma-informed care, therefore, constitutes gender-based violence. Xiao, Gavrilidis, Lee and Kulkarni (2016) highlight a need for service providers to be better trained in understanding and responding to women with a history of abuse. The ANROWS-funded Women's Input to a Trauma-informed systems model of care in Health settings (WITH*)* study (Hegarty, Tarzia, Rees et al., 2017) specifically emphasised the importance of implementing trauma-informed care in the mental health sector due to the significant and complex relationship between sexual victimisation and mental illness. The WITH study (Hegarty, Tarzia, Fooks et al., 2017, Hegarty, Tarzia, Rees et al., 2017) noted a number of ways in which a history of sexual violence could receive poor responses:

- the absence of a trusted person to whom they could disclose sexual violence;
- disclosure of sexual violence being ignored or minimised; and
- sexual abuse being blamed on the victim/survivor.

Each of these can lead to further isolation, fear, anxiety, self-harm and suicidal ideation. The WITH study also noted that childhood sexual abuse heightens the risk of sexual violence later in life, indicating a role for services to identify and support women with this experience to minimise this risk.

In addition, services can perpetuate gender-based violence through failing to respond appropriately to intersectionality—the structural, cultural and political dynamics of privilege and oppression that occur through the interaction between multiple identities (Crenshaw, 1989, 1991). Cutting and Henderson (2002) note that mixed wards are even less appropriate for women from cultures where gender segregation is more common, and Kohen et al. (2013) raise the importance of reflecting local cultural diversity in staffing choices. In the UK, Motz, writing on women in inpatient units generally, states:

> There is a loss of particular racial identity and a sense of blending into a homogenous group of 'patients' who are without individual features. For many black women, this type of merging into white culture may feel profoundly uncomfortable and evoke a deep sense of betrayal and loss. (2009, pp. 38–39)

This hints at further layers of intersectional violence experienced by women of colour, which requires further exploration. By way of explanation, Crenshaw's (1991) examination of African-American women's encounters with women's shelters due to gender-based violence highlights that violence may be the most recent manifestation of oppression in the context of multiple other oppressions that African-American women experience. Hence, in order to support African-American women effectively, Crenshaw argues, services cannot address the violence only, but must also "confront the other multi-layered and routinized forms of domination that often converge in these women's lives" such as the interweaving of racism and poverty (1991, p. 1245). Likewise, for women of colour, the lack of culturally appropriate mental health services has impacts beyond gender-based violence; however, it can be assumed that culturally inappropriate service responses exacerbate these negative experiences (Motz, 2009).

Gaps in the literature

In terms of scholarly output, there is very little available on this topic that explores the experiences of women of diverse sexualities, ability, religion or ethnicity. In particular, gender diverse—including non-binary and transgender—women's experiences of gender-based violence in inpatient mental health units is not well-documented (Walton & Baker, 2017). This is a group that has historically been highly stigmatised within psychiatry, as well as having been vulnerable to transphobia and gender-based violence more broadly (Stotzer, 2009). The research that does exist highlights the need for further understanding and sensitivity to the needs of this group (Klotzbaugh & Glover, 2016).

The literature reviewed rarely considered sexual assaults of women perpetrated by staff, which Melville-Wiseman (2011, p. 26) describes as "endemic but hidden by ineffective management responses". There is limited scholarly evidence to support this claim—although Nibert et al. (1989) found that 27 percent of residents in their study reported being sexually assaulted by staff; anecdotal evidence points to limited contemporary examples (e.g. Bucci, 2016; Offer, 2015; UK Government, 2005). Clark and Fileborn (2011) suggest that the power imbalances inherent in mental health inpatient settings minimise the likelihood of reporting, however, increases in transparency and accountability may have reduced the institutional tolerance for such behaviour.

This literature review has not considered another linked issue—that of consensual sex between people in inpatient units. This has been excluded from this review, as a thorough consideration of capacity, consent and the right to sex and intimacy is beyond the scope of this study. It should be noted, however, that such interactions are common (Bowers, Ross et al., 2014).

Policy review

In order to understand what needs to be done to eliminate gender-based violence in mental health inpatient units in Australia, it is vital to understand what has already been attempted. To this end, the second half of this review outlines current policy responses to this issue. As discussed above, the literature reflects a growing but limited understanding that sexual assault occurs in environments which are unsafe for women, and that a lack of gender safety is a contributing factor towards sexual assault. This understanding is only reflected in limited ways in the diversity of policy frameworks. Policies rarely link women's experiences of trauma, gendered safety and gender-based violence. Instead, they are dealt with as discrete issues, with many key policies on safety being silent on gender.

The location and form of policies, guidelines, procedures and other documents that reference gender-based violence vary markedly across Australian states and territories. For example, New South Wales (NSW), Queensland (Qld), Victoria (Vic) and South Australia (SA), have specific guidelines on sexual safety (NSW Health, 2013; Queensland Health, 2016; SA Health, 2017; Victorian Department of Health, 2012). In Western Australia (WA), the current Chief Psychiatrist has set up a reference group to produce sexual safety guidelines, which is meeting in 2019. The Australian Capital Territory (ACT) and Victoria are the only jurisdictions that have specific guidelines outlining gender-sensitive practice (Canberra Hospital and Health Services, ACT Health, 2017; Victorian Department of Health, 2011).

References to sexual safety and gender sensitivity are found in a broad range of documents, including those that reference critical incidents, the use of searches, seclusion and restraint, same-gender accommodation, and staffing requirements amongst others. Each jurisdiction requires that individual services must develop sexual safety policies and standards that facilitate an environment that supports sexual safety, and promotes a culture that encourages the disclosure and reporting of incidents. Three themes were identified across the policy documents: incident response, prevention of sexual assault and responding to gendered trauma.

Policy review methodology

The search for relevant policies was conducted iteratively using a combination of approaches to identify relevant documents developed by state and territory health departments, mental health services and Chief Psychiatrists governing gender-based violence in adult mental health inpatient units. A Google search was conducted to identify and locate policies, guidelines and procedures that referenced gender in each state and territory for the analysis. Primary criteria for inclusion was any use of the term "gender" and any reference to "sex" and any variations on the term or related phrases such as "sexual safety", "sexual harassment" or "sexuality". Secondary Google searches were also undertaken for any terms that may be used to describe a critical incident, such as "aggression", "seclusion", any form of "restraint", "threat", "violence", "harassment", "safety", "assault", "consent" and "trauma".

Finally, a Google search was undertaken for any guidelines, policies or strategies that may involve contact or interactions that could be perceived as potentially traumatic or triggering, such as security searches, policies around privacy and security of wards and shared spaces and which mentioned the term "gender" or the term "sex". Search terms included "gender sensitivity", "sexual safety", "gender", "violence", "trauma", "mental health services", "inpatient units" ("in-patient units"), "policies", "guidelines" and "procedures". An initial list of relevant policies was compiled and subsequently complemented by cross-referencing against other publications which covered similar issues (e.g. MHCC, 2018) and in discussion with the project advisory group and other specialists in the field.

After the initial search, a more targeted approach was adopted to identify further policies, procedures and guidelines in each state and territory based on the documents identified in the first search. Where references were found to specific policies, guidelines or procedures that were not located in the initial search, attempts were made to find the relevant documents. When we were unable to find a particular document online, the relevant health department or Office of Chief Psychiatrist was contacted by telephone and/or email to request the policy, procedure or guidelines. We were denied access to the Central Australian Health Service (CAHS) documents, but we were sent the Top End Health Service (TEHS) documents.

Published reports on gender-based violence and sexual safety in adult mental health inpatient units were also used to inform the identification of relevant material to include in the policy analysis.

Contained in the final analysis were policies, guidelines, directives and procedures that referenced gender sensitivity and sexual safety, with 40 documents included. These primarily include:

- Chief Psychiatrist guidelines;
- health or mental health department guidelines; and
- mental health service guidelines.

A full list of documents is included in Appendix B. Many of these are some years old, which often means they do not reflect changes in legislation or that they conflict with more recent policies. For example, Victoria introduced its *Mental Health Act 2014* (Vic) in 2014, but the *Victorian Service guideline on gender sensitivity and safety* dates from 2011, despite being marked for annual review. Similarly, the Victorian *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* was written in 2009 and was last updated in 2012, although this document is currently under review.

The analysed documents were diverse and were focused on sexual safety and gender sensitivity, chemical and mechanical restraint, seclusion, searches, observation, same-gender accommodation and staffing requirements, amongst others. Within the analysis, specific attention was given to the management of incidents and prevention of sexual assault, including the designation and management of risk and the physical environment and trauma-informed practices relating to gender sensitivity. Documents that did not reference gender-based violence were not included in the final analysis.

Key areas

The policy frameworks relating to gender-based violence are too diverse to make useful generalisations or to summarise in a coherent fashion; however, they tended to cover three key areas:

- prevention of sexual assault;
- incident management; and
- gendered trauma.

Most policies covered all three areas, while some focused on a specific aspect of responding to gender-based violence. Across these three areas, policies reflected a general assumption that women in mental health inpatient units lacked the capacity to make their own decisions and that services should make decisions for them. Nearly all policies focused on sexual assault or sexual safety rather than the broader conceptualisation of gender-based violence adopted by this study. Where related issues were taken into account, such as domestic and family violence, these were mainly understood as being related to preventing further trauma, not as being useful to prevention or incident response.

Prevention of sexual assault

Policies commonly included references to screening, de-escalation, risk management and the importance of prevention by identifying and managing potential perpetrators of violence (e.g. Northern Territory. Top End Mental Health Services, 2017; SA Health, 2017). This commonly included the requirement to manage sexual disinhibition and identifying which women would be more vulnerable to sexual assault. While rarely explicit, the implication is that people who are sexually disinhibited lack the capacity to make decisions about sex and should be prevented from doing so. Where consensual sex was raised, it was only to indicate that it was not permitted or should be discouraged as being counter-therapeutic. This also reflected a general assumption that people in mental health inpatient units lacked capacity to consent to sex and therefore any sexual contact would be unlawful and constitute sexual assault. At times, policies imposed a highly normative view of "correct" sexual behaviour. For example, the NSW *Sexual Safety of Mental Health Consumers Guidelines* defines sexual disinhibition in terms of "wrongness":

> Poorly controlled behaviour of a sexual nature, where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations; at the wrong time; or with the wrong person. (NSW Health, 2013, p. 4)

In general, policies made implicit assumptions about capacity, wrongness and the rights of women to control their bodies, but these were not interrogated in explicit or critical ways.

The importance of having a safe environment, such as lockable doors, women-only spaces, nurse call buttons and other safety features, was consistently highlighted.

Incident management and response

Many policies required mandatory reporting, either of sexual assaults or of any sexual incidents, through standard incident reporting processes (e.g. Victorian Department of Health, 2012; NSW Health, 2013). Reporting was generally internal to the relevant health department, but in some cases included mandatory reporting to the police. For sexual interactions that were not obviously sexual assault, mandatory reporting was not required in most jurisdictions. No policies gave total control of the response to the victim/survivor, with at least internal reporting and recording requiring documentation. Even policies which gave control over reporting to the police to women required full documentation by the clinician with or without the consent of the woman. For example, the Queensland Health *Sexual Health and Safety Guidelines* require that "clinicians should document the alleged sexual assault in the clinical incident reporting system as soon as possible after caring for the client" (Queensland Health, 2016, p. 15).

The information which is required to be reported is extremely specific, including personal information about all involved as well as explicit detail of the incident. Even where policies made a clear distinction between the capacity of people to make decisions, such as their capacity to make decisions about reporting to police, some policies overrode this by requiring mandatory reporting to the police (e.g. Victorian Department of Health, 2012). In all jurisdictions, allegations of sexual misconduct by health practitioners must be reported to the Australian Health Practitioner Regulation Agency by law (for example, see s. 140 of the Health Practitioner Regulation Law Act 2009 (Vic)).

Many policies reinforced the importance of including women in the process, such as through providing information and updates about the process, while others sought to involve carers.

No policies included in the review prioritised the importance of victims/survivors of sexual assault having control over the process, and many explicitly or implicitly allowed for service providers to deny access to police reporting. For example, the *Responding to an Allegation of Sexual Assault Disclosed Within a Public Mental Health Service* report states:

> Repeated allegations of sexual assault may occur in the context of ongoing psychosis, severe borderline or other personality disorder and intellectual disability. In these cases the possibility of a false allegation needs to be balanced against the understanding that people with a mental illness can be highly vulnerable to sexual assault. Suspected repeat allegations without adequate basis need to be referred to a senior clinician/team for a documented case discussion. (Western Australia. Department of Health, 2012, p. 23)

These policies clearly locate the control of the response to the incident with the service providers, although to varying degrees.

Gendered trauma

Consideration of gendered trauma was mainly limited to a preference or requirement for same gender or gender of preference staff for searches, observations or other sensitive interactions (e.g. Queensland Chief Psychiatrist, 2017). This only occasionally extended to situations of restraint or use of force. Many policies included a reference to the importance of trauma-informed care, but this was often not related to issues of gender (e.g. Victorian Department of Health and Human Services, 2016). When considerations of gendered trauma were raised, policies tended not to specifically outline a response, instead requiring the development of a care plan. These appear to assume that the person responsible for developing the care plan would have an understanding of gender-based violence and gendered trauma; however, that understanding was not reflected in the policies and processes themselves.

There are some highly developed trauma response policies, such as the Victorian *Service guideline on gender sensitivity and safety*, arguably the most developed across the jurisdictions, which states:

> Trauma can be understood to be gendered, both in terms of the prevalence of particular types of trauma as well

> as in the effects. For example, the incidence of sexual assault is higher among women than men and family violence is predominantly reported as perpetrated by men against women, particularly intimate partner violence … the effects of childhood sexual abuse tend to manifest differently in men and women. (Victorian Department of Health, 2011, p. 6)

This guideline also states that staff must "accept the person's experience without judging, devaluing or making discrediting statements" (p. 8). Despite this, the Victorian *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* (Victoria. Department of Health, 2012) takes the decision about reporting to the police away from the woman, regardless of her assessed capacity, and allows the psychiatrists to deny access to police reporting:

> All allegations of sexual assault should be reported to police where an assault is known or suspected to have occurred. However, in an acute mental health setting there may be some occasions where clinical judgement will need to be exercised. For example, where a patient does not consent to police involvement, or where an allegation appears related to a person's mental state or condition. It is the authorised psychiatrist's role to determine reporting in these instances, on a case-by-case basis. (Victoria. Department of Health, 2012, p. 25)

This approach implicitly conflates capacity with a validity of experience, assuming that if a person lacks capacity it is appropriate to treat them differently. A trauma-informed approach would not require the service provider to make a decision about the validity of a complaint of sexual assault, instead, affirming and supporting them in developing their response. In addition, both reporting without the person's consent and denying their access to the police to make a report have the potential to re-traumatise or delay recovery. This example, from the jurisdiction that has done the most work on the issue of women's safety, highlights the lack of integration of trauma-informed practices in mental health services.

This is just one area in which trauma-informed responses are not foregrounded in mental health inpatient unit policy, with a lack of specialist trauma counselling and a general lack of focus on women's experience of trauma. Even when these are addressed, such as in guidelines for a person of the same gender to conduct searches, these are usually only "preferred" not "required". Additionally, they do not reflect the individuality of trauma experiences, which may mean that invasive or restrictive actions of persons of any gender would be traumatising.

Conclusion

This State of knowledge review highlights two main themes. One is that when the question is asked, it is widely acknowledged that women are not safe in mental health inpatient units, but that many studies are not asking this question. The second is that while there are some jurisdictions in which women's safety has received more attention, this attention has been sporadic and inconsistently applied. There is no clear consensus on what should be done; however, there has been a strong push for women-only units in the literature with an acknowledgement that more would need to be done alongside segregation. More nuanced responses, including person-centred and trauma-informed care, sensitivity to domestic and family violence and tackling intersectional discrimination are all also necessary. Despite this, gender segregation is not a policy priority in most jurisdictions, and the more considered responses are only rarely and sporadically present in policies at all. The totality of women's experiences of violence are not reflected, instead, piecemeal approaches of dealing with limited aspects of gender-based violence are evident. Based on this analysis, this research project has taken a holistic view of women's safety as it is experienced by women, viewing gender-based violence as including:

- sexual assault;
- failure to address past trauma and domestic and family violence; and
- any other ways in which women are made unsafe in mental health inpatient units due to gender.

It is hoped that this understanding, viewing services in the way they are received by women rather than as how they are delivered, can provide a clear direction for ensuring women's safety in these settings.

Methodology

Theoretical framework for the methodology

A feminist approach

This study is framed through a feminist lens. This approach makes gender a category of inquiry. It contests non-gendered methods of research which commonly equate the male experience with gender-neutrality whereby diversity can be missed or ignored. Instead, our study disputes the idea that male experiences represent the norm by focusing on issues of importance to women. In applying a feminist lens, we recognise that feminism is not a homogeneous movement, but rather is a dynamic and contested site. Indeed, there is a multiplicity of feminisms that represent the diversity of theoretical and practical positions (Tong, 2009). Taking a feminist position requires continual reassessment of what this means in the context of evolving ideologies (Whelehan, 1995). The feminist approach applied to this research acknowledges how feminist activism and scholarship have been central in framing gender-based violence explicitly as a manifestation of gendered power imbalances and inequality (Theobald, Murray, & Smart, 2017).

The application of a feminist research lens puts women's experiences and knowledge at the forefront and recognises that patriarchy is central to power structures that create vulnerabilities faced by women. At the same time, we recognise that gendered oppression operates in conjunction with other forms of oppression. Hence our study also takes the feminist stance that many experiences and systems of oppression are mediated through gender. For example, we follow Crenshaw's (1989) analysis of the intersection of racism and sexism to demonstrate how oppression does not occur along a single axis framework to understand the interaction between multiple structures that create complex inequalities. An intersectional approach contests existing relationships between inequality and structural processes by refusing to privilege prevailing power dynamics (Cooper, 2008). This provides a framework for explaining how multiple power structures (for example, mental health, legal and family structures) affect groups differently, with unequal distributions of oppression and privilege.

The primary intersectional focus of this project was women living with mental illness, thus putting the dual identity signifiers of gender and mental health at the forefront of methodological concerns. In this context, this means respecting the lived experience of women regardless of their diagnosis, mental state or decision-making capacity. The structures that create inequalities, such as the mental health system, mean that people take on, or embody, these inequalities through their identities because this is how they are externally perceived. It is these identities (mental illness and gender) that are sites through which oppression is systematically imposed by legislation, policies and practices. This research, therefore, questions limited representations of people living with mental illness and advances a fuller picture of women's experiences to identify and challenge systemic inequality.

Project aim and research questions

The project was driven by the aim to investigate and document experiences of gender-based violence occurring in adult mental health inpatient units, to inform how policy and practice can be improved to make these environments safe for women. This aim was explored through the following two research questions:

1. What are the experiences of gender-based violence for women staying in adult inpatient mental health units?
2. How can these experiences inform and improve policy and service delivery?

The project employed qualitative research methods to answer these questions and consisted of a State of knowledge and policy review (see previous sections) and two stages of data collection, which then informed the development of the Guidelines (see Appendix A).

In line with the study's feminist lens, feminist qualitative research methods were the most effective way to answer the research questions and were also appropriate for exploring sensitive material in a safe environment. There is no single method that typifies feminist qualitative research, but the strategies used commonly seek to remove power imbalances

and employ processes that recognise women as holding expert knowledge rather than as objects of study. This study engaged a range of feminist qualitative research methods techniques, for example, getting consumer feedback on interview questions (including from participants following the interviews), putting the consumers' narratives at the centre of the research and analysing them through a feminist framework and enlisting researchers with a feminist understanding of gender-based violence. Feminist qualitative research methods allow for an in-depth exploration of complex lives through the gathering of rich, empirical data on women's experiences and views, making their worlds visible. Accordingly, this study is underpinned by Reinharz's (1992, p. 51) principles of feminist ethnography, which are:

1. to document the lives and activities of women;
2. to understand the experiences of women from their own point of view; and
3. to conceptualize women's behavior as an expression of social contexts.

Although this is not an ethnographic study, these principles are pertinent because, as Reinharz (1992) states:

> By listening to women speak, understanding women's membership in particular social systems, and establishing the distribution of phenomena accessible only through sensitive interviewing, feminist interview researchers have uncovered previously neglected or misunderstood worlds of experience. (p. 44)

The examination of experience allows for a relational analysis of interactions between individuals and institutions. Understanding how women and staff experience these relationships is crucial to creating safe mental health inpatient environments.

Consultations

A project advisory panel was established to provide expert advice and feedback on recruitment, consumer participation, the Guidelines and for advocacy and assistance with the dissemination of the research findings. Panel members were selected through collaboration with our research partners and with the consideration of having multi-state representation to ensure the findings of the research have impact across multiple states and territories. The panel had representatives from academia, mental health services, consumers, advocates and government. Consumer involvement on the panel was vital to the ethos of this study, and three consumer advocates agreed to be involved. The panel members included:

- Sue Armstrong—Consumer advocate, Mixed Nuts Media Inc (Victoria)
- Professor Lisa Brophy—University of Melbourne/ LaTrobe University/Principal Research Fellow, Mind Australia (Victoria)
- Lyn English—Consumer advocate, National Mental Health Consumer Carer Forum (South Australia)
- Dr Sabin Ferbacher—Mental Health Consultant, Western Victoria Primary Health Network (Victoria)
- Professor Kim Foster—NorthWestern Mental Health/ Australian Catholic University (Victoria)
- Professor Jayashri Kulkarni—Alfred Psychiatry Research Centre/Monash University (Victoria)
- Rebecca Randall—Consumer advocate, Consumers Health Forum/Health Advisor to Senator Richard Di Natale (ACT)

In the preliminary stage of the project, the researchers consulted with the panel members individually to seek their expertise in the design of the project. Once the project received ethics approval from RMIT University, the panel met in order to finalise the plan for proceeding with the research. Panel members also provided suggestions for assisting with the recruitment of participants. The panel was provided with a copy of the draft literature review for feedback. Following the data collection and analysis, the panel was consulted on the draft Guidelines.

In addition to the project advisory panel, Victoria Legal Aid's Speaking from Experience consumer advisory group gave feedback on the project design, recruitment strategies and the Guidelines.

Data collection methods

Interview recruitment

This project employed purposive sampling, which involves the selection of participants for research based on the aims of the study and the characteristics of the population (Etikan, Musa, & Alkassim, 2016). This was the preferred method because it particularly suits qualitative research (Etikan et al., 2016) and because the study required participants with the following characteristics and experiences:

- Who identify as women—we took an inclusive and non-binary position on gender and recognised women to be anyone who identified as such.
- Who had experienced gender-based violence—in order to account for changes in contemporary legislation and practice guidelines, the participants must have experienced gender-based violence during or due to a stay in an adult mental health inpatient unit in Victoria in the previous 5 years.
- Age—participants needed to be aged 18 years and over.
- Who were not current inpatients—in order to protect their safety and emotional wellbeing, women who were currently staying in an inpatient mental health unit or who were otherwise in crisis were ineligible to participate.

Recruitment was conducted through our partner organisations—NorthWestern Mental Health (NWMH), the Mental Health Legal Centre (MHLC) and Victoria Legal Aid (VLA)—and through community organisations suggested by our project advisory panel, for example:

- Victorian Mental Illness Awareness Council (VMIAC);
- Australian Association of Social Workers', Victorian Mental Health Social Work Practice Group;
- Centres Against Sexual Assault;
- Women's Legal Service Victoria;
- Our Consumer Place;
- Speaking from Experience;
- This is My Reality; and
- Women's Mental Health Network.

They were provided with project flyers, the plain language statement (see Appendix C), consent forms and the link to the project website to pass on to potential participants. The researchers met with key workers from the organisations to discuss recruitment criteria, including presenting at nine team meetings with various partners. The key workers used their discretion to identify and contact potential participants with the understanding that women would only be approached if the worker assessed that the research would not be burdensome.

Recruitment proved to be difficult for a range of factors. We were particularly hampered by the time it took to secure ethics and governance approval from Melbourne Health to recruit from NWMH. This process took a year, with final approval being given in December 2018. Furthermore, this project researched a sensitive issue for the organisation, and the research team spent much time engaging at various levels to ensure a solid partnership. This included meeting with the consumer advisor, the Safety and Inclusion Committee and mental health inpatient teams to plan for recruitment once governance was approved. The Safety and Inclusion Committee indicated that they would be able to recruit sufficient numbers for the project. Following ethics and governance approval, NWMH identified women who had experienced gender-based violence through their risk management system, through which incidents are recorded. Where considered appropriate by the key clinicians, they contacted women involved in incidents and informed them about the research. The project, already limited in available time to recruit through NWMH, was further hindered by the risk management system, which did not have up-to-date information on key clinicians, causing further delays in being able to make contact with potential participants. Some key clinicians fed back that they were uncomfortable raising the issue with women who had experienced gender-based violence, as they were professionally responsible for admitting them, most often against their will, into those environments. This barrier was not anticipated but may have contributed to the low engagement rates via clinical services. Unfortunately, we were unable to recruit any participants through NWMH, something that had not been anticipated.

Due to the delays that were experienced in receiving ethics and governance approval from NWMH, we decided to form

a new partnership with Victoria Legal Aid (VLA) through their Mental Health and Disability Advocacy Team. VLA agreed to provide us with access to their consumer advisory group, "Speaking from Experience", which has members and is in contact with others who have experienced mental health inpatient treatment. This approach also failed to generate any referrals. This appeared to be due to the crisis-driven nature of the work that these teams undertake, which preclude the kinds of relationships that might generate referrals.

The research team met with clinicians, advocates, lawyers and peer workers to promote the project. Social media was also extensively utilised and peer-to-peer networks were used to distribute invitations to participate from people whom potential participants would trust. Approaching the peer-to-peer networks was ultimately the most successful method, generating most of the participants who participated.

In addition to the difficulty in making contact with women who would be eligible, a number of women expressed interest and later decided not to proceed or assured their workers that they would proceed and then did not. This reflects the challenging nature of the topic and that, for consumers, their trauma recovery journeys and potentially chaotic lives preclude non-critical tasks such as participating in research studies.

Interview process

Stage 1 of the project used in-depth, semi-structured interviews with participants. This project positioned the participants as co-researchers because they were contributing their expertise through a "social process, an interaction or cooperative venture" (Bauer & Gaskell, 2000, p. 45). This meant that we looked to the participants not only to offer their experiences but also for their expertise and guidance on how to improve mental health inpatient units for women. As such, semi-structured interviews provided participants with the opportunity and time to reflect on their experiences at their own pace, and by offering leeway for elucidation of matters that were raised but were not covered in the interview schedule. This format allowed the participants to engage in sustained dialogue, making the interview an "exchange of ideas and meanings" (Bauer & Gaskell, 2000, p. 45). Crucially, the participants offered suggestions, based on their experiences, of how to improve the conditions of mental health inpatient units so that women are not subjected to gender-based violence.

Interviews with the participants took place in private rooms at RMIT University or over the telephone from July 2018–May 2019. Initially we planned to offer telephone interviews only to those living in rural or regional areas; however, once recruitment commenced it became apparent that many women preferred the telephone option, so this was offered to all participants. In total, seven women chose to be interviewed by telephone.

Participant information (see Appendix D) and consent forms (see Appendix E) were provided by the researcher at the time of the interview in person or via email, depending on whether the interview was face-to-face or via telephone. The Participant Information Form explained the purpose and requirements of the research. This was further reiterated by the researcher prior to the commencement of the interview. Particular emphasis was placed on the participant having control over the interview process and that her involvement in the study was voluntary. All interviews were conducted by female researchers.

Participants were provided with the opportunity to ask questions before giving their consent to be interviewed. All participants were provided with gift vouchers worth $40 to recognise their expertise and contribution. The interview schedule focused on:

- their experiences of gender-based violence in mental health inpatient units;
- if and how the participant was supported; and
- suggestions for making inpatient mental health units safe for women.

Interview sample

As the project progressed, and in discussion with ANROWS, we reduced our sample size from 30 to 20 participants, with the anticipation that we would reach this number when ethics and governance approval was received to recruit through NWMH. As discussed above, this did not occur and our final sample size was 11 women. Despite the small sample size,

the participants represented diversity through country of birth, location, age and physical disability, and the interviews revealed rich qualitative data. As will be discussed in the findings, the interviews provided a variety of perspectives and experiences while producing consistent suggestions for developing the guidelines.

The participants were aged from their 20s to 50s and all were located in Victoria. Of the 11 participants, two were born overseas with one having a CALD (culturally and linguistically diverse) background, and three were from rural areas. Three participants disclosed having experienced homelessness, ranging from "couch surfing" (e.g. staying with friends or family) to "rough sleeping" (such as staying on the streets, in parks and in cars). Four participants identified as having a physical disability and/or chronic illness. Five women were parents. One participant aligned herself as Christian, with no others identifying religious affiliation. None of the participants identified as LGBTIQ or as Aboriginal and Torres Strait Islander. The underrepresentation of Aboriginal and Torres Strait Islanders in mental health research is a common issue. The implications for this study due to underrepresentation of particular groups is addressed in the conclusion of the report (see p. 65).

Workshops

Stage 2 comprised two sets of workshops (six in total), run by the research team. The first set of workshops (four in total) were held with 42 mental health providers from NWMH. These workshops were framed by a national review of gender-based violence and sexual safety mental health policy and guidelines that were undertaken by the research team. Building on this framework, composite case studies based on the experiences described by participants in Stage 1 of the project were presented to workshop participants. These were intended to highlight to the workshop participants the issues faced by women in mental health inpatient units and, alongside the suggestions made by the women to improve safety, formed the basis for the development of the "Guidelines" to prevent gender-based violence in mental health units. These workshops were initially conducted according to professional roles and included:

- Safety and Quality Committee;
- Nurse unit managers;
- Senior nurse advisors; and
- Senior allied health, including:
  a. social workers;
  b. occupational therapists; and
  c. psychologists.

These groups were suggested as the key stakeholders by the NWMH Safety and Inclusion Committee.

The workshop process for these four workshops was developed to address the key issues identified from stakeholder consultation to date, that existing guidelines were either inadequate or were failing to be implemented. This process was limited from its initial scope due to organisation-based limitations in getting the groups together. The research team asked for 2-hour sessions and was offered, instead, 1-hour or 30-minute sessions. It did not prove possible to run a group with consultant psychiatrists due to organisation restrictions and resourcing implications.

Participants for this first set of workshops were provided—in advance—with a copy of the scenarios, the recommendations from the women's interviews and a list of questions for discussion. The format of the workshop consisted of discussing the individual scenarios and asking further probing questions to determine participants' views on a range of relevant issues. The workshop facilitator guided the discussion to focus on areas reflected as contentious in the literature and participants were asked to share their perspectives openly and frankly. Each workshop was facilitated by a member of the research team with another writing notes and documenting the key recommendations.

Following the development of the Guidelines, another set of workshops (two in total) were further conducted with 21 nurses and allied health workers. These participants were provided with the draft guidelines in advance. The workshops consisted of the researchers facilitating feedback on the Guidelines. This feedback is documented in this report and was used to further refine the Guidelines.

Data analysis

The data were analysed following each stage of the study. The interviews with women were transcribed and then coded thematically according to established qualitative research conventions that are guided by the research questions (Denzin & Lincoln, 2011; Ezzy, 2002). These conventions involved an open coding approach, whereby themes were allowed to emerge, and then labels were applied (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The themes were further informed by findings from previous studies that have examined gender-based violence in mental health inpatient units and the feminist methodology outlined above. The themes that surfaced were then compared across interviews to corroborate and refine the findings. Further examination of the data assisted in the coding of themes, guided by the direct quotations from the participants. These are outlined in the findings section of this report.

This material provided the foundation for the composite case studies that were presented to the workshops held with mental health service providers (i.e. the first four workshops). The responses collected from these workshops were thematically analysed and compiled by the members of the research team who had conducted the workshops. The notes collected from the workshops highlighted points of consensus, disagreement and recommendations of solutions.

Feedback from the workshops was then incorporated with the interview findings, alongside consideration of existing state and territory policies, to provide the foundation for the Guidelines. The development of the Guidelines was an iterative process. It began with the experiences of women being presented and explored in workshops. The suggestions from both the women and service providers were then collated to inform the Guidelines. The Guidelines were then sent out for review to key consumers, service providers and the program advisory group. They were also reviewed in the final two workshops. In total, 28 consumers, policy-makers, academics and clinicians provided feedback on the guidelines, which was incorporated into the final copy (Appendix A).

Ethical considerations

Ethics approval was gained from the Human Research Ethics Committees for Melbourne Health (reference code: HREC/17/MH/431) to undertake research through NWMH and for RMIT University (reference code: 21237) to undertake research with other organisations.

Due to the sensitive nature of the research, the design of the project required careful deliberation to provide a safe and supportive experience for the participants. A key component of the study was exploring traumatic incidents through the participants' experiences of gender-based violence. It was therefore essential that involvement in the research did not compound pre-existing trauma. The following measures were put in place to manage the participants' safety.

We had initially intended to present the interview schedule to the NWMH consumer group. We hoped to seek their input on the suitability of the questions with regard to the potential to cause distress. However, when we approached the NWMH consumer advisor, we learnt that at that point in time the group members solely consisted of men, so we decided this was not appropriate. Instead, we consulted with VLA's Speaking from Experience group and the project advisory panel for feedback on the questions and recruitment strategies. Further changes were made based on suggestions from the ethics committees to which the project was submitted.

All efforts were made to create a safe interview space, whether it was conducted face-to-face or by telephone. Telephone interviews did not offer verbal cues from participants to the researchers (and vice versa), but they did allow for more interviews to be conducted with women who would have been unable to do so because of distance or discomfort with the face-to-face process. Prior to the interviews, participants were given the option to see a copy of the interview schedule (see Appendix F). They were advised that the interview was semi-structured so questions could arise from the material during the interview. The interview schedule was sent via email to participants who wished to see it in advance. This allowed the participants to prepare for the interview if desired but was not required. This has the potential to inadvertently increase the risk of social desirability bias, however, this risk

was considered justified in the context of ensuring women felt as safe as possible to share their experiences. All interviews were preceded by telephone contact from the researcher to discuss the research and answer questions, after which a time was made to conduct the interview if the participant wanted to proceed. Participants were advised that they could stop the interview or take a break at any time, and the researchers made a point of checking this with the participants throughout the interviews. The participants were given the option to not answer any questions that made them uncomfortable.

As discussed above, time was taken to ensure that the participants understood the nature of the research and what their involvement would entail. Confidentiality was explained, and the participants were advised that information that could potentially make them identifiable would not be disclosed. Information such as age, location, sexuality, ability, race/ethnicity and religion was not included in the report except where it was relevant and agreed to by the participant. For example, it is useful to know that a participant had a physical disability if this in any way contributed to her vulnerability. Similarly, if women in rural mental health inpatient units have different experiences from those in urban locations, then this is important information to document. The participants were provided with pseudonyms to further protect their anonymity.

The interviews were conducted by female researchers who were also social workers with extensive experience working in the fields of sexual assault and/or family violence. This ensured that the researchers were thoroughly cognisant of the impacts of gender-based violence, including how to identify indicators of distress and how to implement strategies to de-escalate this if it occurred. The researchers were also familiar with how the sexual assault and family violence service systems operate and were able to provide advice about seeking support if required, although this was never necessary.

We sought permission from the first four participants we interviewed to make further contact so they could provide feedback on their experience of the interviews. This was to allow us to make any necessary changes to the interview schedule in order to avoid causing distress. The response to the interviews was positive and we did not need to make any changes to the interview schedule.

All participants were required to have existing support networks to ensure they had follow-up support if needed. Support was made available through case managers from the referring services. Where this was unavailable or unsuitable, the researchers were able to provide details for 1800RESPECT, the 24-hour sexual assault and family violence counselling service or Lifeline, the 24-hour anonymous phone counselling service. Participants were advised in the interviews that they could contact the researchers if they had any concerns. Participants were also contacted within a week of the interview to check if they required support as a result of the interview. We did not need to link any participants with existing or new support services.

The interviews were digitally recorded and transcribed for analysis. The digital files and transcriptions were kept on password-protected computers and were only accessible to members of the research team. The transcripts were only made available to the members of the research team who conducted the interviews, who de-identified and thematically analysed this data before presenting it to the other team members. This approach was taken to ensure minimising the number of people who had access to this sensitive information.

De-identified data from the interviews were incorporated into composite case studies and subsequently presented at the first set of workshops in Stage 2 of the study. The composite case studies combined aspects of different participants' experiences to highlight the issues without aligning them with a single participant. The workshop attendees were told at the outset that the case studies were made up of blended experiences.

Limitations of the research

As already discussed, the study was limited in its capacity to recruit participants for Stage 1. Although the sampling was never intended to be exhaustive, the reduced number of participants put restrictions on the diversity of experiences that are represented in the report. For example, while participants' diversity is represented through physical disability,

country of birth, cultural background and location, other subjectivities such as Indigeneity and sexual and gender diversity—that could inform a critical intersectional feminist analysis—are missing.

Mental health legislation is a state- and territory-based domain. Victoria is the jurisdiction that, to date, has undertaken the most research and policy development addressing women's safety in mental health inpatient units. As a result, the project team decided that Victoria could provide leadership in this area. However, because the data for the study were collected in Victoria, this means they are state-specific, and there are limitations on their applicability across a national context.

Key findings

The clear and consistent finding of this study is that women in mental health inpatient units are experiencing gender-based violence, including sexual assault, and that the current approach to ensuring women's safety is not working. This study makes no specific claims to prevalence; however, both women and service providers acknowledged that the issue was both serious and widespread. This is consistent with other studies conducted in Australia and internationally (e.g. Clarke & Dempsey, 2008; Garling et al., 2008; Kulkarni & Gavrilidis et al., 2014; Leavey et al., 2006; Owen et al., 1998; Wood & Pistrang, 2004; Wright, 2017).

The interviews revealed that the participants had experienced different and multiple types of gender-based violence including incidents of sexual assault, physical assault, harassment and/or threats of sexual and physical violence. Perpetrators of gender-based violence were identified mostly as male consumers. Also identified were male workers and other men known to the participants such as a partner or ex-partner. No instances of violence perpetrated by female workers were disclosed.

This section presents the key findings from this study based on thematic analysis in two parts: first, the interviews from women; and second, six workshops conducted with mental health service providers. The data from the women are grouped into four themes:

1. women's experiences of gender-based violence;
2. how women protected themselves from violence;
3. the failure of services to respond to women's histories of trauma; and
4. suggestions from women as to what would address these issues.

The findings from the workshops with staff have been grouped into five themes.

- administrative;
- ethical;
- resources;
- environmental; and
- workplace culture.

In general, the findings from women and the service providers concur in acknowledging the seriousness and prevalence of gender-based violence and the inability of the existing policies and procedures to ensure women's safety in mental health inpatient units. Further, the implementation of policies and procedures are constrained by limited resources and circumstances.

Participant interviews

Women who participated in this study did so in order to share their experiences of gender-based violence; however, it is noted that these will not reflect the diversity of all women's experiences (as discussed in the previous chapter). Despite this, these experiences are genuine and recent. To give most weight to the women who shared their experiences, this section intentionally prioritises their voices using quotes from the interviews, with only minimal structure and framing by the authors.

Women's experiences of gender-based violence

Women consistently recounted that mental health inpatient units were not safe places and that they were exposed to various forms of gender-based violence: "It's somewhere that you're meant to be safe but there is a real risk of not being safe and to be exposed to violence" (Megan).

Forms of violence included verbal abuse and threats, exposure to sexual imagery and sexual and physical assault. Violence was perpetrated by male consumers, male staff members and men known to the women such as partners/ex-partners. Two themes run through these experiences:

1. the staff did not always act to ensure women's safety; and
2. in many instances, they are not able to do so.

These themes are evident in the way the women spoke of the types of gender-based violence that they experienced, as discussed in the sections below.

Verbal abuse and threats

Six participants disclosed being verbally abused and/or threatened. For Megan, threats of gender-based violence were common.

> It's honestly been quite a constant throughout in one way or another. Particularly like emotional stress like emotional violence or like threats of physical violence and threats of sexual violence. Definitely more threats than anything … [A male patient] would tell female staff, but also female patients if he was upset with them, that he was going to grab their arse or that he would come into your room and rape you.

For Amanda, the threats came from male workers:

> [The] security guards … were just standing over me and glaring at me and saying abusive things to me at the doorway … They were saying that you're so mentally unwell like no-one will believe you.

Jen described the comments of a male consumer who had watched her do some yoga in a communal space:

> One morning—there was nowhere to really do any exercise in there, I normally like try and do some yoga and stuff like that … [A male consumer] came up to me afterwards and said 'oh it's really difficult eating breakfast watching you do your stretching cause you're really distracting and I'd love to like help you with your … ' or something disgusting along those lines … It definitely didn't make me feel comfortable.

Jen's comment links the environment, where there is nowhere to do exercise, to the impossibility of ensuring her safety. In a mixed-gender environment there is virtually nothing staff could have done to prevent comments such as those that made Jen feel unsafe. Catherine talked about sexualised comments becoming normalised:

> There were a lot of men that would say sexual things to me. I think just little sexual comments—it became so common … before that I would think if someone said something inappropriate, sexual thing to me I'd—'oh my goodness', you know? But then it just became 'oh yeah, that happens all the time'.

Jen equated the environment with a bar, and that the imbalanced ratio of men to women in the unit placed more sexual attention on the women.

> Some people treat it like it's a bar, like somewhere to pick up or make a relationship … How can I say it without sounding conceited? I'm reasonably attractive, objectively speaking. So, when there's only five women on the ward and—like I got told by one bloke, he's like 'oh yeah, we've rated you all so you're like a 9 out of 10 and pretty hot for 40'.

Jen's description of an imbalanced ratio is not reflected in the demographics of people in mental health inpatient units, who are very slightly more likely to be women than men (AIHW, 2019; DHHS, 2017). Jen's comment likely reflects the gender ratio during her specific time in the mental health inpatient unit. Or, that even when there is no gender imbalance, men's tendency to occupy the public spaces may give the impression of a male-dominated environment.

Exposure to sexual imagery

One participant described how she and other women were made to feel uncomfortable by being exposed to sexual imagery by a male patient in the mental health inpatient unit:

> There was this one bloke who was always looking at soft porn on the ward … he was really yucky. I wasn't the only female who could feel he was just sexually yucky … Just sitting there and checking out video clips of complete—or almost—naked music clips of almost naked women. (Olivia)

Unwanted exposure to sexual imagery is clearly, in itself, an act of gender-based violence, however, Olivia's comment that he was "sexually yucky" highlights the way in which the presence of men can make women feel unsafe. Even if that consumer was prevented from exposing others to sexual imagery, it is unlikely that Oliva would feel safe around him.

Sexual assault

Five participants were sexually assaulted during a stay (or stays) in a mental health unit. This ranged from sexual touching to rape. Olivia's experience articulates how easy it was for this to occur.

> Then we had some other dick come in and I think he was just fresh out of jail and as soon as he came in he was sleazy, sat down next to me and put his hand on my thigh and in between my legs.

This experience, caused by a man transitioning from an all-male prison environment into a mixed-gender mental health inpatient unit, highlights a challenge for service providers in keeping women safe. Without minimising the man's responsibility, it seems that moving men from prisons into mental health inpatient units will inevitably result in women being made to feel unsafe. As with Olivia's comment above, it is difficult to see how staff could have prevented this kind of sexual assault in a mixed-gender environment.

In other circumstances, women described how the staff failed to intervene and as a result they were sexually assaulted. Participants described being exposed to multiple incidents of violence perpetrated by the same man, which when unchecked by staff could lead to increased severity of violence. For example, Zoe experienced several incidents of harassment that culminated in sexual assault by a male patient. This occurred while Zoe was staying on a locked women-only section at the unit. The male consumer was continually able to gain access to the secure area by following other people into the space when they used their secure swipe cards for access:

> I was actually staying in the locked women's ward but the rest of the facility was mixed gender but I was staying in the women's only corridor. There was a male inpatient who was harassing me quite badly while I was there and he kept on breaking into the locked ward into the women's corridor and coming into my bedroom and harassing me and then one day he sexually assaulted me while I was in my room.

Elizabeth was stalked and sexually assaulted by a male consumer while placed as the only woman on a corridor in the unit designated for men. She spoke to a nurse about this but no action was taken. A few days later Elizabeth was moved to a high dependency unit where the same male patient had also been relocated. The sexual assaults, which involved sexual touching, continued on the high-dependency unit, where she was raped:

> There was another incident. We were outside and there was a little courtyard and he touched me inappropriately on the buttocks … The next time he tried to put my hand in his pants. He grabbed my hand and went to put it in his pants 'cause he had an erection.

Later, she said:

> Then he touched me again … He stroked me down the sides of my face, hair and he said these things about me, he had an erection right in front of me. I was freezing … I didn't know what to do … Then a bit later … I had to go to the bathroom so he followed me to the bathroom. I forgot to lock the door of my bathroom and he came in and he forced me to have oral sex with him. This was the worst part of it. 'Cause he pushed me forward and forced his genitalia in my mouth.

Zoe's and Elizabeth's experiences highlight the importance of the built environment in ensuring women's safety, but also underline the ineffective nature of some of the existing protections. Even when gender-specific corridors exist, they are not sufficient to ensure women's safety, and high dependency units, bathrooms and bedrooms are sites of sexual assault.

Physical assault

One participant was physically assaulted. Zoe, perhaps minimising what occurred, described the assault as not being serious, yet it involved her being shaken and hit:

> There was actually another male patient when I was in there that was harassing me and he did physically assault me at one stage. Not seriously, he just grabbed me and shook me and kind of hit me.

Jen also described how a male consumer's behaviour intensified during her stay in a mental health inpatient unit. At first, she thought the behaviour was harmless, if inappropriate. However, the behaviour escalated, with another male consumer being physically assaulted because he was keeping Jen company:

> He took a little bit of a shining to me and used to want to shake everybody's hand so not just mine … and I was comfortable with that and he would do it to other people. Then one day we were sitting outside on a bench in the

> yard … and he sat down next to me and he shook my hand like he normally would and then he said 'oh can I give you a hug?' and I said something like 'we're not really supposed to touch when we're in hospital' but I think I kind of let it fly because of the fact that I just thought he was intellectually disabled … I said 'yeah, okay but only once'. So, I let him put his arm around my back and give me a pat on the back type of thing and there were other people present so it didn't make me feel uncomfortable. Then a bit later on he asked me would I give him a hug and I said 'no, I don't really feel comfortable doing that' but I think I might have consented … Then he started asking me do I have a boyfriend. I said 'yes' … I just wanted him to basically go okay, she has a boyfriend so leave her alone … Then he asked again, 'can I put my arm around you?' and at this point I said 'no'.

Later, Jen said:

> Out of nowhere this guy comes … looks to the side to make sure no-one is watching, walks over and pushes [male consumer] straight off the bench.

Failure to intervene

As described above, there are many examples where the conditions of the mental health inpatient unit meant staff could have done little to prevent gender-based violence from occurring. There are other examples, though, of a failure to intervene when doing so would have prevented further assaults. Several women highlighted the way in which responses to gender-based violence or threats appeared to reflect the culture of the setting more generally. One of the most consistent ways this was reflected was in the degree to which women felt that their concerns or experiences were taken seriously or believed. As shown above in Elizabeth's experience, the failure to intervene not only exposed her to being raped, it also compounded and added to the trauma. When asked what could be changed to better support women who have experienced gender-based violence, Marie said, "I think it needs to be taken more seriously, that's for sure".

When asked whether she could tell the staff about the gender-based violence she had experienced on the ward, Amanda replied that she experienced the staff as abusers, too:

> No, I couldn't because I felt that the staff were abusive so I couldn't tell them because why would you tell your abuser that you—you're worried about or that the other men are trying to rape you?

Zoe, when comparing her experience in a mental health inpatient unit with a community-based treatment facility, identified differences in the attitudes of staff in each setting. In the community setting, Zoe said that:

> The staff are just wonderful, they're all very passionate about what they do and they've all been there for quite a while because they love their jobs. I had—last time I was there I had another incident with a male patient who was harassing me and touching me and just being very inappropriate and I brought it up with them and they did all the right things and took care of it and they discharged him and they really made me feel safer and like I was being listened to.

Zoe contrasted this with her experience in a mental health inpatient unit where she decided not to report a sexual assault to staff:

> I wasn't really able to talk about stuff … The staff were a big factor. They didn't want to have one bar of you and they just would lock themselves up in their office and yeah not speak to anyone.

And later:

> Yeah, it was just kind of—the culture of this inpatient unit was just—yeah, they put the quite dangerous patients in with the less risk patients, yeah which I just think was very unsafe.

Consistently, when women described who the "quite dangerous patients" were, they were men. Not all men were identified as violent, and as discussed below, occasionally a woman was also identified as being violent, but the overall consensus was that the perpetrators of the vast majority of violence were men. The incidents described above were perpetrated by strangers who were also in the unit, however, some women identified violence perpetrated by men they already knew.

Violence by other known men

Three participants identified gender-based violence perpetrated by men already known to them. Previous studies indicate that gender-based violence is significantly associated with mental illness, emotional distress, suicidal ideation and suicide attempts (Ellsberg et al., 2008; Hegarty, Tarzia, Fooks et al., 2017; Khalifeh et al., 2015; Riecher-Rössler & García-Moreno, 2013) and that women with mental illnesses are at increased risk of victimisation by their partners (Friedman & Loue, 2007; Khalifeh et al., 2015).

Olivia, for example, noted that no attention was given to the situation to which she would return on exiting the mental health inpatient unit, which was living with a violent partner. Vanessa was separated from her abusive husband when she self-admitted to a mental health inpatient unit. He was listed on Vanessa's record as her emergency contact person, so he was contacted about her admission:

> When I was admitted I went in consensually, I took myself in. When I explained the circumstances of what happened they contacted my ex-husband as he was my emergency contact, I didn't realise at the time … and from my understanding when they spoke to him he gave his version of events … he basically told them that I was extremely manic, I was not of sound mind, I was acting irrationally and irresponsibly. I was a risk to my children … I tried to explain to them at the time that he was my ex-husband, we're going through a separation and I was asking them to speak to my private psychiatrist, I was asking them to speak to my mother, I was asking them to speak to my brother and sister-in-law who I'd stayed with previously, they knew what was going on, they knew my behaviour.

These other people were not contacted, and the information given by Vanessa's husband contributed to her being detained involuntarily in the unit the next day.

Men who are known to women in other ways can also pose a threat to safety in mental health inpatient units. Amanda, who had experienced homelessness, was visited at the unit by a man she feared from that sphere. She was particularly troubled by how easy it was to be located in the unit:

> If you're in hospital anyone can call up and give them your name and ask if you're admitted and where you are. Then they can physically just walk in off the street and find you. So, I would like that to be changed because I've had perpetrators come in the past, like come to the hospital … Word can spread within the street community like if one person knows that you're in hospital then soon everyone can know.

This highlights the links between environmental protection and staffing practices. The doors to the unit would ordinarily be locked, but are opened for any person who comes to visit the unit. This reinforces the need for responses to this issue to tackle both physical spaces and staffing practices.

Taking responsibility for protection

The participants' experiences of gender-based violence in the mental health inpatient units, the enduring nature of the violence and insufficient responses from staff were contributing factors in the women assuming responsibility for their own safety. Olivia described a sense of having "to put up with it":

> He was just horrifically, psychically, sexually revolting not only to me but to my friends as well—and you just have to put up with it, you know?

Some participants described how they tried to evade any areas where men were located in order to feel safe. Megan, in particular, explained how the onus was on women to protect themselves because men's behaviour was not addressed and managed by the mental health inpatient unit:

> I guess the thing that strikes me is that when you're uncomfortable you have to isolate yourself, like it's not the person who is doing the harassment who is taken somewhere else if that makes sense … I have to make the adjustments for their not so friendly behaviour rather than the adjustments being made to them.

Zoe managed a perpetrator's behaviour by not seeking support because she was fearful this would incite the perpetrator to more violence:

> I was very scared of this one man and like you didn't want to get him into trouble because I was scared that he would hurt me more. 'Cause he was very verbally abusive to me the whole time I was there and I just didn't want to upset him and get him into trouble.

Zoe's comment about not wanting to cause trouble for a male consumer over his behaviour demonstrates how women are put in a position where they are responsible for the consequences of men's behaviour. Jen, for example, specifically decided not to pursue a matter because she did not want to be the cause of further problems for a male consumer. After receiving sexualised comments from a male consumer, Jen was asked by a nurse if she wanted "to press charges". Jen's response was:

> The guy was a recovering meth addict, like do I want to ruin his life further because he made an inappropriate comment to me in a psych ward and he doesn't even know he shouldn't be doing that type of thing? So I just said no. But [his behaviour] definitely didn't make me feel comfortable.

Another strategy employed by two participants to manage the circumstances was to leave the mental health inpatient unit prematurely. Zoe indicated that doing so was detrimental to her mental health:

> Well at the time I discharged myself from the hospital even though I was no-where near ready … 'Cause I've got a very complex trauma background, it kind of compounded it.

Three participants declared that they would never return to a specific mental health inpatient unit where they had received treatment:

> It's on my file to never send me back to that inpatient unit because I will not put my feet there, it's just horrendous, which makes it hard 'cause it's the only one in the area … When I've been very unwell and needed to be in an inpatient unit I just haven't been able to go so instead, yeah, I've just had to suffer at home by myself. (Zoe)

Experiences of gender-based violence led Vanessa to take out private health insurance to protect against returning to the same public inpatient environment. Similarly, Marie was considering moving to another state to avoid the possibility of being exposed to gender-based violence in a Victorian mental health inpatient unit in the future.

Other men as a source of protection

Two participants spoke of relying on male consumers with whom they felt safe to provide protection from those who were violent. The presence of gender-based violence speaks to the greater entitlement that men have to the space within the units, so it makes sense that men would be called upon to manage these circumstances. Jen indicated that having men around provided her with a sense of safety:

> I'm comfortable in male company and … I often feel the good ones that aren't trying to crack onto you are quite protective over you in these places 'cause they can sense when you're not feeling safe and they will try and protect you. So, I tend to get protected by decent blokes in these places.

Olivia described how she was protected by a male consumer from another who was about to physically assault her:

> [A male patient] just kept wanting me to do some prayer of his and it was just ooky, yuck … I just said 'no, I don't feel comfortable with that so I'm not doing it'. He just got really, really pissed off with me in the end with that. He went to go me but I had an army bloke in there who I was friends with so he just stood in between the two of us.

This occurred more than once for this participant. Following threats of violence to Olivia from another male patient over cigarettes:

> Two mates came and just stood in front of me which was the best—actually one of the best feelings I've ever had in my life because I've had so many men be violent to me … No other woman would have the guts to stand in between a guy like that and me right at that moment.

Not only does this strategy rely on men to be available to women and be able to provide support if violent situations arise, but it also puts undue pressure on male consumers to control other men's behaviours in the units.

Transactional sex

The transaction of sex for material support such as accommodation and money, and for non-material support such as physical protection is more commonly associated with homelessness (Watson, 2018) rather than in mental health settings. Yet, this study found that transactional sex does occur in mental health inpatient units. For Catherine, this was prompted by having to share a room with a woman whose behaviour continually disrupted her sleep. To avoid unwanted touching by the room-mate, Catherine self-managed the situation by relocating to a shared space. This exposed her to gender-based violence whereby she was expected to transact sex for access to the space:

> I think it was about 5 days and I just could not sleep. I felt sick and one night the nurse in charge said I could sleep in the family room that had a couch and I felt so happy 'cause I was just desperate for sleep. Then I went in and another patient was setting up his bed 'cause he couldn't sleep 'cause his roommate was manic and I just—honestly I just felt like killing myself then and there, that I was going to have another night of this woman—and she'd touch me. Then I ended up talking to him and he said 'I'll give it to you if you do something for me' and I ended up performing oral sex on him for—in exchange for being able to sleep on the couch … A few days later I was also complaining that there weren't enough blankets in the ward … and I ended up doing it again for him, performing oral sex so that he'd give me some blankets.

Megan described how the banning of smoking at a unit where she stayed had led to some consumers trading sex for cigarettes:

> I've been around people that were trading like sexual acts for cigarettes. That was really worrying … That was something that was really quite—I don't know, confronting, I guess that something that is supposed to be imposed for a level of safety is then in another aspect essentially compromising.

These strategies for managing the environment of mental health inpatient units illustrate the lengths that women go to in order to feel comfortable and to protect their wellbeing. Unfortunately, the failure to ensure safety was not limited to protecting women from other men in the unit; services were also identified as perpetrating gender-based violence.

Gender-based violence in the course of treatment and behavioural control

Gender-based violence that is perpetrated by staff employed by mental health inpatient units raises further concerns for women's safety in these settings. This is complicated by how treatment in the units is conducted, particularly when the treatment is involuntary and involves practices such as seclusion and restraint.

Six participants in this study described gender-based violence perpetrated by male staff members employed at mental health inpatient units, and these incidents mostly occurred in the context of treatment. For Olivia, however, it was the attention paid to her by male staff members that was unnecessary and experienced as gender-based violence:

> There were two male staff members and I think it was my first night in there, actually. They looked at me and you can just tell when someone thinks you're attractive and then it wasn't long after they're knocking on my door and coming into it when I was having a shower like—so they nearly saw me basically naked … But I followed that up and just said what happened and I said don't have any of those two nurses come near my room again.

For the participants who identified treatment as a source of gender-based violence, the practices of restraint and seclusion were particularly contentious. Excessive physical force demonstrated by male staff members during restraint was raised by two participants. Marie, in particular, volunteered photographs detailing extensive bruising from the force used by a male security guard in restraining her:

> A security guard grabbed me by the one arm and then a [female] nurse decided to grab me by the other arm and I was flailing a bit which I think's a natural reaction, you don't just stand there. Then I was put down on a table and given an injection. I was put into Velcro. I think I fell asleep but I woke up with bruises all down my right arm and that's where the security guard had been "restraining" [Marie indicates inverted commas] me … I felt like it was overkill because I had it on my right arm and yet the nurse who restrained me on the left at least didn't leave a bruise.

Elizabeth also raised concerns about the use of force by male staff in restraint practices:

> They seemed to use their strength a lot more than the women—female nurses … They don't seem to consider their strength. I've had bruises and things like that all over my arms.

Elizabeth, who had experienced previous gender-based violence, further described the impact of having her underwear removed as part of being restrained and secluded:

> There was a stage there where they forcibly removed my underwear … They were worried about my safety because I was facing seclusion, I spent 27 hours in seclusion … It made my behaviour worse so I tried to kill myself in that unit, in that seclusion room … I have flashbacks of [the restraint] and the removing of my underwear and it's just—I just can't seem to move past it but at the same time I'm stuck 'cause I don't want to reach out to anybody 'cause I'm worried that all this stuff is just going to happen all over again.

For Amanda, restraint and seclusion were accompanied by verbal abuse and threats of sexual assault:

> I've survived a lot of trauma and assaults in the past and rapes in the past and it was like what they did was repeating the trauma of that because they tackled me to the ground, they pinned me on the ground and then they basically forced me into a room that I didn't want to be in with security guards who were threatening to sexually assault me and who were just standing over me and glaring at me and saying abusive things to me in the doorway.

Unlike with violence perpetrated by male consumers, women could do little to protect themselves from violence perpetrated by service providers. Women related that the active perpetration of gender-based violence was only one way in which they experienced gender-based violence. The active experience of violence was compounded and intersected with violence experienced by a lack of accommodating for women's specific needs. This was most clear in relation to the way trauma was responded to in the mental health inpatient units.

Lack of trauma-informed care

Lack of trauma-informed care manifested in three main ways:

1. a failure to respond to experiences of past trauma;
2. a failure to respond to trauma caused in the inpatient setting; and
3. a failure to ensure that trauma was managed and responded to after exiting the inpatient setting.

Past trauma

Although the women were not asked specifically about their past experiences of trauma and abuse, seven offered this information. This correlates with previous studies that have identified past violence as a common characteristic of people diagnosed with mental illness (Brown & Anderson, 1991; Goodman, Rosenberg, Mueser, & Drake, 1997; Khalifeh et al., 2015). Moreover, there was a general awareness among the participants of a relationship between trauma and mental health problems. Olivia, a victim/survivor of domestic violence, observed of the mental health inpatient units:

> It's just a very volatile situation. I mean people are in there 'cause they're not well. Majority of women are in there because they've been raped in their life or had traumatic circumstances … Any girlfriend that I've met that I've stayed in contact with have had horrific childhood sexual abuse or been raped or both. It's the reason why they got their diagnosis, or whatever, at the hands of men and then they go through shit like that, you know?

This was corroborated by Megan:

> It can be hard enough in itself being in an inpatient setting where things can be quite elevated at times if you have a history of trauma which like obviously a lot of people in those settings do.

Megan further described how gender-based violence affected her mental health, which then contributed to unwelcome treatment by the staff:

> I struggled with disassociation so it impacted quite a lot and so I was dissociating a lot and staff were getting quite angry about that and so a male staff member like dragged me across the floor because I was dissociating …

> They knew that when I wasn't feeling safe I would like sit underneath things and that was fine, it was kind of like the thing I would do just because it felt safe … The doctor was there to see me and because I wouldn't manage to get myself out from underneath the table because I was scared he dragged me across the room, which did not help the fear.

Responses to traumatic events

The women described seeking support from staff at the mental health inpatient unit, as well as pursuing other external options such as legal and counselling support. Seven women reported an incident of gender-based violence to the staff at the mental health inpatient unit. Of these, three women reported an incident to the police. Four women made no reports.

The responses varied in how they were experienced by women. Positive responses were common and, as the experiences detailed below show, vital in addressing the ongoing harm and reducing the impact of trauma. Unfortunately, negative responses were also common, starkly illustrating the importance of competent and well-trained staff who are skilled in gender-sensitive practice.

Positive mental health inpatient unit responses

Three participants reported positive responses from staff to reports of gender-based violence at a mental health inpatient unit in which they had stayed. For example, Megan appreciated being able to take her meals away from the mixed-gender space when she felt unsafe; although, she pointed out that it was unfair that she was the one who had to change her behaviour, not the male consumer making her feel unsafe:

> [There was a] male who was quite elevated and often would be threatening or just say kind of like sexually inappropriate things to everyone. So, they knew that I was quite nervous around meal times and stuff and so even though you weren't supposed to they would ask me if I wanted to have my meal either in my room or a female lounge room … I mean like it would have been I guess nicest if nobody was sexually harassing people at the dinner table.

The participants highlighted the work of specific service providers who responded proactively and with empathy. Ann said that after she reported that she had been sexually assaulted:

> There was one guy who was an orderly. He approached me and said, 'look, I'm really, really sorry to hear this has happened to you' and 'are you okay?' But he was not in a position to be able to do anything about it. The majority of the other staff just plied me with more Valium and said 'you'll be right love'.

These experiences are a small illustration of the potential for mental health services, providing clear evidence that despite the challenges faced in ensuring women's safety, good practice is already present in some areas and can be scaled up. This is also reflected in the, albeit limited, literature (e.g. Fletcher, Buchanan-Hagen et al., 2019; Fletcher, Hamilton, et al., 2019; Fletcher et al., 2017; Hamilton et al., 2016).

Negative mental health inpatient unit responses

Unfortunately, participants reported more examples of negative responses to their complaints. The effect of this ranged from being ignored and having to manage situations individually, to the failure to address a perpetrator's behaviour resulting in further harm to women. This is discussed above as a failure to intervene, but it is also included here to illustrate how a failure to intervene does not only allow the trauma to occur but can compound it through breaching trust and inhibiting the healing process.

The experience of not being taken seriously was raised numerous times. Megan described seeking help from a nurse about a man who was threatening sexual assault:

> He said that on the first afternoon that I arrived and then the nurse who I had been assigned said that he was just like that and that we just had to ignore it and kind of accept it and move on sort of. That was what was said kind of every time it happened.

Olivia said that having a mental illness, compounded by a lack of staff expertise and/or empathy, meant that her concerns were ignored:

> I didn't feel the majority of staff members cared a lot for me anyway. Some of them were really green around the ears, some of them were students and I think the worst thing is … you're put in a box, you're nuts, you're psycho, you're buttholey or whatever when you may or may not really be that.

For Ann, it took 2 days for her to be moved to the female section after she had been sexually assaulted in her room located in the men's section.

Elizabeth outlined the response she received when she raised what was happening with staff:

> The first time I was sitting out in this gazebo and he touched me down my thigh. I went straight to a nurse and the response was 'I will talk to him but he is harmless' … It made me feel like what I was saying wasn't validated. Made me feel like I had made it up or something like that and they didn't believe me and they didn't believe the seriousness of it.

A second incident occurred:

> I told the nurse. Basically, they said we didn't see it so we don't believe you.

A third incident occurred:

> Again, I told them again. It was the same thing. We didn't see it.

A fourth incident occurred:

> I didn't tell anybody because I didn't think—I didn't think—you know? What was the point?

Eventually, Elizabeth—as discussed above—was raped by this male consumer. She described the response she received:

> [After the rape] he had gone and laid back down on the couch, common area, and I walked out and I went to the nurse, I went there and I knocked on the door. There was a lady nurse there and she said 'don't be silly, look at him, he's over there asleep on the couch'. Those words to this day, they just—they sit with me … They didn't believe me so I just—my behaviour, it just seemed pretty bad but I was banging and I was really wanting to get out of there and get away from him. It took them about an hour. Another nurse finally like sort of listened and they did give me a piece of paper and they said 'oh you're going to need to go to the bedroom and you'll have to write—should write down everything that's happened'. So yeah, I did, I got to write all that down but they wouldn't let me call anybody. I asked to call somebody and they—oh no, we're just going to leave this piece of paper down for the nursing unit manager in the morning … He's still in the common area … and a little bit later he's trying to get into my bedroom … I had the door locked. I can see his face in the window of the door and the lock turning and turning and turning 'cause he's trying to get in. He wasn't removed 'til apparently hours and hours later.

The following day Elizabeth met with the chief psychiatrist, the police were called and forensic evidence was taken:

> At that point I was still in shock, really. All this happened and no-one believed me until it was too late.

Elizabeth made a statement a few months later but the perpetrator was never spoken to due to his mental illness:

> All I wanted was that he was spoken to by the police 'cause I understand that justice might not be something that happens but more that I would like him to be spoken to.

Elizabeth was later readmitted and then saw the perpetrator again:

> There was no offer of the other hospital … I would think that's what they might consider. There's another lady in there who had been assaulted by him who he was told to stay away from … They just told me that 'oh he's been told to stay away from you. To avoid you if he sees you'. And I'm like okay, I still don't feel safe.

Not everyone felt able to raise that they were being victimised. For example, Zoe did not report the sexual assault in her room to the staff:

> Firstly, I was in a very, very bad way. I'd just escaped an abusive relationship and I was already in a headspace where I wasn't able to really talk about stuff. And then

> the staff were a big factor. They didn't want to have one bar of you and they just would lock themselves up in their office and not speak to anyone.

For Ann, it was the experience of her assault not being taken seriously that impacted her decision to pursue a formal complaint:

> Yeah, they really treated it as if it was a joke, as if it wasn't—it really wasn't taken seriously. Yeah then in the end they said to me 'oh well maybe it's just because of your mental health issues'. I thought well it's not really but yeah, I must admit in the end after the meeting that we had with the head of the Department and the Director of Nursing I just let the complaint slide because it was too much of a hassle to keep it going. I didn't think it was going to go anywhere anyway.

This paints a complex picture, with trust being a precious commodity which is quickly expended, that has implications for women's overall response to mental health treatment.

Ongoing trauma

Essentially, for the participants of this study, there was no coherent or coordinated ongoing response to their experiences of trauma while in inpatient settings. The absence of a coordinated and structured response meant that the trauma experienced stayed with the women, with no examples of good support and healing processes identified in this study.

The participants described how the gender-based violence they experienced in mental health inpatient units affected them subsequently. Catherine, who had transacted sex for somewhere quiet to sleep, said that after being released from the unit:

> I just felt like I couldn't tell my husband and I was so ashamed … At the time [trading sex] just was logical and then looking back I can't believe how I would do that for something so simple and I never told anyone … I just felt so lonely and I carried it for 18 months just by myself and I'd think about it all the time.

For Elizabeth, her trust in the mental health system was broken and she did not believe it was capable of keeping her safe from gender-based violence:

> I don't trust anybody [in mental health services] so the change of that is like I don't feel like I can go and talk to—reach out for help. I don't talk to anybody, I can't bring myself to go and talk about anything, I can't tell them if I feel or don't feel safe, I can't—I just don't feel like I can do it.

Amanda was worried about the implications for her if she brought attention to the gender-based violence by making a report, based on previous verbal complaints she had made to staff:

> I can't [take action about the staff abuse because] it's the same hospital that I still see regularly so if I take legal action against them or if I challenge anything then that actually comes back to me … I've made complaints verbally and it's come back to me … like even denying me a service permanently, like them being afraid that I'm going to sue them over what's happened, them saying that I'm not eligible to be seen by their service, that I don't meet the criteria to be eligible to receive any support.

Elizabeth spoke about the impact the gender-based violence continues to have on her life:

> I get flashbacks every time I go to a bathroom … and I have to avoid using public toilets … Anywhere that I visit I can't use their bathroom, I have to come home. I don't go out on my own at all.

These accounts only reinforce the need for immediate action to ensure women's safety in mental health inpatient units. Despite the longstanding nature of this issue, women generally saw it as preventable, as discussed in the next section.

Participants' solutions

Women were all asked what would have prevented their experiences of gender-based violence. Their responses can be grouped into two main areas:

1. built environment solutions; and
2. staffing solutions.

Built environment solutions

The built environment and the facilities of mental health inpatient units arose consistently as issues in the interviews.

Gender-segregated inpatient units

There was strong support for fully gender-segregated mental health inpatient units. Eight women specifically said that these were essential for providing safety from gender-based violence perpetrated by male consumers: "I think that would be a really good idea because it would make people feel a lot safer" (Elizabeth).

In addition to safety, Olivia said it would make the units a more peaceful place:

> There'd be no men in a ward, there'd be women … Full-on 24/7 [having women] in the same place with men in a situation like that—it's a recipe for disaster with people on different psych drugs … So a female gendered-only inpatient unit would be just so much safer, so much more quiet, so much more peaceful generally speaking.

The participants were clear that their preference for segregated units included all the facilities. As Amanda stated, "I don't believe that they should be mixing males and females in the same levels or just even in the same building".

Megan indicated that fully segregated units were necessary because shared spaces for meals and other activities were still locations where gender-based violence could occur:

> I've been in wards where there's been like [separate] male-female bedroom areas. I found that to be relatively common but it's still difficult because when you go to … the meal areas and the group areas, you're still I guess interacting and if there is violence and harassment that can be difficult.

Only one woman, Jen, expressed that she did not want to stay on a women-only unit; although, she stated that segregation would likely have prevented the gender-based violence that was perpetrated against her:

> Oh, what would have prevented it? Probably nothing. To be really honest, probably just a segregated facility, a male facility and a women's facility, but I don't know that would be a good idea … 'Cause the two people I had the most in common with, that I learnt the most from were both men so I would have really hated being stuck with a bunch of girls and one of whom, like I said, scared the shit out of me—she scared some of the men. So I think violence can go both ways—the women aren't always the recipients of it.

Nonetheless, Jen did raise concerns about bedrooms being in mixed areas and/or men having access to the designated women's areas:

> I think it's important if you're going to put women down behind a locked door, you should give them key passes to their rooms … I know people take them home but maybe you should just order more.

Three participants also specifically stated that not only were women-only units necessary, they should be provided and staffed solely by women.

Other physical aspects

The physical setting of mental health inpatient units and how they are managed are critical in providing women with a safe space. Mental health inpatient units can differ greatly according to size, location and age. In Victoria, units provide support for men and women; however, there is variation in how they are located in the space. The women described a range of environments and management of the resources within the units. These can be communal. There can also be a separation of men and women that can be managed in a variety of ways; this could include separate corridors, lounges and/or bathrooms. The provision of separate areas, however, does not necessarily result in gender segregation.

Even when separated areas were available, demand for beds can often override this, with women reporting that a lack of beds resulted in them being placed in the men's area. Conversely, the women described men being placed in the women's area:

> Because there were so few women and so many men they had to put men in those beds so that the women's section wasn't really a women's section at all, it had men in it so that's a bit of a contradiction in terms. (Jen)

The condition of the amenities in the units can further expose women to danger. In the women's section, locks on doors may be broken, or keys unavailable so doors are left open. Jen stated:

> The door [to the women's section] was broken so anyone could go in, it wasn't locked at all … You had to have a key back to get through the door and not even all the women had them.

Ann stayed in a room that was located in the men's section. This was left unlocked at night following an hourly nurse's check, resulting in a male patient entering her room:

> About 10 minutes later I heard the door click and thought, 'oh, that's odd, they're normally hourly checks' and rolled over to face the door to see a man in my room. I sat up and asked him to leave and he didn't so I got out of bed and asked him again to leave and he didn't and then in the end I screamed at him to go and the nurses heard and came in and they escorted him out and I reminded them politely that they really need to relock the doors if this is going to happen.

Even where doors were locked, male consumers were still able to enter the women's section. As described above, Zoe was sexually assaulted after a male patient entered the locked ward by following others in on several occasions.

Furthermore, Marie was threatened over the telephone while she was in her room by a male consumer she had met in the common area:

> He was quite young and had that glamourised violence sort of attitude to him. Every now and then he'd say something, which would make me feel quite uncomfortable but then I thought maybe it's all just hot air … He rang me and said … 'you have to give us ten dollars otherwise we're going to bash you' … I said 'listen, don't play that game with me because my cousin [is an ex-outlaw bikie] so you bash me, you're going to be in so much trouble'.

Where there were women's sections, people commonly still had to share other facilities such as bathrooms and meal areas. These were locations where gender-based violence occurred, and the women described actively avoiding them:

> A lot of the bathrooms didn't even have locks that worked and you'd be in the shower and men would go 'oh I'm having a shower' … I would say I'm not having a shower 'cause the locks don't work and then I'd get in trouble for not showering 'cause that's a sign of mental illness. (Catherine)

Experiences of gender-based violence meant that Megan tried to evade any areas where men were located:

> It made it very I guess difficult to want to be anywhere except for like inside my room with the door locked so I didn't want to go and eat, I didn't want to go to groups, I didn't want to go to the bathroom 'cause the bathroom was outside the room. I think—I mean a lot of the time when those kind of things happened it does become difficult especially if you feel like you've been targeted by someone.

Shared space not only contributes to the occurrence of gender-based violence, they can be spaces that are actively avoided by women. This reinforces the male domination of shared spaces, making them potentially less safe. It is also an equity issue, with women unable to access communal televisions or participate in activities.

Staffing

Various aspects of staffing the mental health inpatient units were also raised as an area for consideration. Four participants described the mental health inpatient units as under-staffed, leaving women vulnerable to gender-based violence due to staff not being able to observe what was happening in the units. The lack of supervision was raised:

> Just more staff supervision 'cause there was really a lack of supervision from the staff. (Zoe)

> I just think better staffing, more supervisory nurses. (Jen)

Ann commented that the evening was a time when inadequate staffing was most noticeable:

> I think staffing issues are definitely an issue, especially of an evening. There tends to be less available staff and less security on of an evening which is really unfortunate.

This was confirmed by nurse unit managers in the workshops and is discussed below.

Staff training

In addition to the matter of staffing levels, the women suggested that staff receive specific training in how to respond to gender-based violence. Issues that were raised included interpersonal and practical support. As discussed above, many of the participants described feeling as though their concerns were dismissed or ignored. The women emphasised the importance of being believed when they raised concerns about men's behaviour or disclosed having been victimised.

The negative responses to disclosures of gender-based violence in mental health inpatient units were understood by some of the women as the staff not being sufficiently trained in how to respond appropriately. For Zoe, this was expressed through lack of compassion displayed by the staff, she stated, "I don't think they'd had proper training either … They just didn't have any compassion or empathy or you could just tell they didn't actually understand mental illness".

Ann stated that the lack of training and accompanying dismissal of women's concerns needed to change to include training in being proactive in responding to gender-based violence:

> I also think that some of the staff really need to have some retraining as to how to deal with [incidents] of aggression and rather than just fobbing people off and saying 'no, you'll be right', to actually be able to explain to patients that they are proactively going to do something about it, they're not just going to ignore it.

Amanda further suggested that staff should be trained to ask on admission if there was anyone in the woman's life who made her feel unsafe and whom she did not want contact with during her stay.

Four participants called for greater understanding of the impact that past trauma continues to have on their lives and how this can be further triggered by experiencing gender-based violence in mental health inpatient units. As Elizabeth stated, she wanted "to have my past taken into account".

Further, Zoe indicated that staff needed to be aware of past trauma in order to provide appropriate support:

> I think one thing that would help is if they kind of took the time to hear your own history, to know like if you've experienced abuse before so that they're aware of that.

Central to this is taking a person-centred approach, as described by Amanda who stated, "Believing people and having safety, like asking people what helps people to feel safe and then trying to build that around that for the person".

The use of restraint on women was raised as an area that can be experienced as gender-based violence due to excessive force being used by some male staff members. Megan suggested that it was not simply a matter of training staff in their use of restraint, but rather the practice more broadly needed to be re-evaluated so that it was no longer a normal event:

> More training about ways to minimise restraint practices and sort of maybe ways to kind of de-normalise restraint. Like if it isn't seen as being such a normal part of routine maybe it won't be seen as normal for those practices.

Megan also drew attention to touching by staff in a more general sense. She suggested that touching should only occur in an emergency and that if all touching were documented this would mean that staff would be held accountable and would also think about what they were doing:

> I think maybe if there were stronger boundaries around like no touch without consent unless it's an emergency and like clear meaning around what emergency means so like people have to justify their reasons that they're touching without consent … if you have to actually like take time to either write down or note like why you touch someone without consent in this instance and what the emergency was in that situation.

Jen suggested that policies of no touching between consumers needed to be better reinforced:

> Making it crystal clear to people on admission and throughout their stay that there is to be no touching, there is a no touching policy. Like, I think they've got that written in the literature somewhere that you're supposed to sign but when people come in and they're unwell, like it should be stuck up—in people's bedrooms—on posters, like the rules.

Connected with this is Elizabeth's suggestion that if a sexual assault has occurred, the woman should have immediate access to a sexual assault service. Amanda suggested, more generally, that women should have access to counsellors who specialise in institutional abuse. She stated, "I've never found an institutional abuse counsellor which I would like to see for people who survive lots of trauma in institutions".

Two participants highlighted the impact of having a disability or chronic illness, and the importance of staff understanding how this might impact their experience in a mental health inpatient unit. Specialist training was suggested by Amanda, who felt that the staff did not understand the impact her neurological condition had on her experience in the ward:

> Training on disability as well as trauma because they don't really have like any knowledge or awareness about disabilities or people with chronic illnesses when the majority of people living with disabilities are also living with mental health issues.

Concern was raised by participants about entering unsafe conditions when they were discharged from the mental health inpatient unit. At the time of her admission, Olivia was involved with a violent partner and Amanda was homeless, a situation that had exposed her previously to gender-based violence. Amanda suggested that housing was never addressed on discharge and that this needed to change. Amanda stated, "I know that my mental health issues are way more extreme because of my homelessness".

Elizabeth made the suggestion of being able to transfer to another mental health inpatient unit, even if the distance was great, if there had been an experience of gender-based violence at the current unit.

Peer support and consumer advocacy

Some participants suggested that peer support workers be employed to provide support to women who had experienced gender-based violence. Peer support workers were perceived as ideally placed to understand the impact of gender-based violence on women living with mental illness. Amanda said, that otherwise, women would only receive a clinical response:

> They should really also be employing more peer workers and the people who are living with mental illness … If they're just like employing people who are … mentally well and haven't lived any trouble then they don't really have any understanding and they just take a really clinical perspective.

Catherine reflected on her positive experience working with peer support workers in another state, although she raised a concern about the pressure it would put on peer support workers if they were expected to respond to incidents of sexual assault:

> People with lived experience were so lovely like they were the only people that you could just have a conversation with … I love the idea of peer workers but the ones I met just couldn't—and they'd say 'yeah, sexual abuse happened to me too', like they're traumatised.

Zoe, who had been sexually assaulted when a male consumer was able to enter her room stated, "it would have been helpful if there was like a consumer advocate to talk to".

Workshops with mental health professionals

Four initial workshops were undertaken with a total of 42 staff from NorthWestern Mental Health (NWMH) services across Melbourne. The participants were presented with four scenarios (see Appendix G) based on composite and de-identified data collected through interviews with women who had experienced gender-based violence in a Victorian mental health inpatient unit in the past 5 years. Two further workshops were held with a total of 21 NWMH allied health staff to consult on the draft Guidelines. Workshop discussions were documented but not transcribed verbatim.

This section summarises the key recommendations and feedback received from NWMH staff in response to the scenarios presented. These findings should be interpreted with the understanding that there is no evidence that NWMH services are any less safe for women than other public Victorian mental health services. NWMH have undertaken a number of initiatives to improve the experience of women in their inpatient units, including "Safewards" (Hamilton et al., 2016). Their partnership and participation in this project reflect their willingness to engage with this difficult issue.

The issues described in the findings from the workshops are consistent with the literature (e.g. MHCC, 2018; Quinn & Happell, 2015; VMIAC, 2008; VWMHN 2008, 2009), the experiences of women described in the section above, and with project partners across Victoria. The participants overwhelmingly felt that the experiences of women presented in the scenarios were not appropriate and were representative of several contextual issues. This was underpinned by a consensus that mental health services have a duty to eliminate gender-based violence. While participants acknowledged that the scenarios were "appalling" to read, they nonetheless understood how it would be possible for such events to occur in the current context. In general, the findings from the workshops are consistent with the findings from the experiences of the women, with no jarring differences of opinion. The findings do differ in perspective, as is to be expected, focusing on the barriers to providing a safe environment rather than the experience of gender-based violence. Professionals tended to focus less on the ways that services can perpetuate gender-based violence but did not dispute that this occurred. The main barriers identified by professionals can be roughly grouped under four areas:

- resourcing;
- the physical environment;
- staff culture; and
- service responses to family violence.

Key themes across these areas were:

- that staff would assess gender-based violence as either delusions or paranoia;
- the lack of understanding of the dynamics of gender-based violence, particularly in relation to trauma-informed care;
- family violence and sexual assault; and
- issues of capacity.

Resourcing

Resourcing was a common theme across all discussion areas but was mainly raised in relation to staffing ratios and the lack of appropriate available beds.

Staffing

Participants consistently identified that low staffing ratios contributed to a lack of women's safety. Several participants described mental health inpatient units as dynamic places that operated at a fast pace. One group suggested that while a ratio of 1:4 staff to consumer ratio is considered ideal, in reality, it is more likely to be a ratio of 1:6, decreasing throughout the day and lowest during the night. This means that there is often not the time needed to complete a thorough intake, which if done "properly" could take "3 hours" to do. One participant suggested that "staffs' backs are against the wall" and that the case study given was "just the tip of the iceberg". Similarly, when a person was assessed by staff as requiring 1:1 nursing this was often not available.

Three related issues were identified. Firstly, inadequate numbers of staff mean that it is "very difficult to keep track of everyone on the ward". Adequate staffing means that safety can be more closely monitored. Secondly, participants in

every group identified the need for a specialist role such as a social worker, occupational therapist or peer worker whom nursing staff could call upon to support, and advocate for, women with safety concerns. Some participants suggested that having someone whose role included gender-based safety would result in more proactive responses to concerns. In addition, there was support for a protocol with Centres Against Sexual Assault (CASAs) to be established for specialist crisis intervention and support co-ordination. Finally, women-only units with all women staff was another way of promoting a sense of safety for women. Some participants felt that this was the only way of ensuring gender safety, while others felt that it would go a long way to addressing the issues raised.

Bed pressure

A consistent theme in the groups related to a shortage of gender-specific beds. While beds may be designated to men or women, it was widely acknowledged that women can be placed in men's sections, and vice versa, when demand exceeds supply. This was described as a common occurrence by many participants, although there was significant resistance to this practice in some groups.

Multiple workshop groups described informal processes for making the best use of their limited women-only beds. One participant said it was accepted that they could not accommodate all women in the women-only beds, so staff would informally identify women who they considered to be "vulnerable". Vulnerability was linked to young age or to women who have been victims/survivors of a "recent" sexual assault. These women would be allocated this limited resource, while other women would have to be placed in the men's section. Another participant described advising women who were placed in the men's section to keep their bedroom doors locked at all times.

It should be noted that this practice is not occurring in all units; however, managers of units where it is not occurring described immense pressure from various stakeholders to accommodate men in women's spaces and vice versa. This was particularly the case where a person, usually a man, could not be accommodated in any other space, and may already be waiting in an ambulance outside the unit or in a state of imminent harm to himself or others.

These resourcing issues are clearly linked to limitations of the physical environment, where inflexible and inappropriate accommodation fails under the pressure of a resource-scarce system. For example, one participant described the impossibility of monitoring a long corridor-like ward, while others identified that shared communal areas were being locked and left unused as it was not possible to supervise them.

The physical environment

Participants pointed to ways mixed gender units could be dealt with through improved and creative design. Several suggested that unit spaces needed to have in-built flexibility such that boundaries could be changed. One participant gave the example of installing two sets of unit entry/exit doors so that the female section could be lengthened or shortened as needed. This meant that if a man had to be admitted to the women's section, the boundary could be changed and the integrity of the female area maintained. Others were less convinced that women-only units were the answer and suggested that improved design of unit spaces could address safety concerns. A number of professionals had worked in women-only units, both in Australia and overseas. These professionals overwhelmingly supported gender-segregated units, while warning that this would not in itself create safe spaces for women.

Other issues with the physical environment were raised in relation to amenity. Everyday items that contribute to amenity, such as headscarves, mirrors, photographs in frames, hairdryers and televisions, were often prohibited for safety reasons. The absence of televisions in rooms was identified as forcing women into shared spaces where they were less safe. Shared rooms also posed significant challenges, mainly due to the lack of privacy and noise disturbance. There was universal agreement that women should have access to rooms that can be locked from the inside for their personal sense of safety, however, this was not always done, particularly with shared rooms.

The built environment contributed to a lack of safety in multiple ways. Staff identified that some activity rooms were not used as they could not be supervised. Other difficult to supervise areas such as outside, the laundry or at the end of corridors meant staff could not ensure women's safety in these spaces.

Staff culture and organisational policies

All groups raised the importance of workplace culture and organisational policies in shaping attitudes towards gender safety. Some participants indicated that a gendered lens was almost completely absent in their service, while others said they had invested a significant amount of time in improving the service response to gender-based violence and trauma. One group of participants indicated that they worked from the assumption that everyone had experienced some kind of trauma; however, this approach was not identified by any other groups.

One participant suggested that gender "blindness" among staff could hinder understanding and responding to women's concerns about male consumers or male staff. A number of participants discussed how responding to the issue of gender-based violence could be considered a "new thing", noting that it was not necessarily a focus of staff. One group suggested that the attitude of staff was "really important" and "starts at the top" referring to the importance of leadership. All groups highlighted that the scenarios reflected a lack of attention to trauma-informed care and gender sensitivity, which was considered unacceptable but not unusual in practice. Some participants did assert that their practice was already trauma-informed but acknowledged that this was an ongoing process.

Two clear patterns emerged from the workshops to explain this: firstly, mental health was "different" as women were understood to often lack decision-making capacity or would delusionally accuse people of gender-based violence; and secondly, that staff tended not to have training in issues of gender. These cultural issues were illustrated in a number of ways, shaped by the scenarios presented to the workshops. These included:

- believing women who reported incidents;
- the practice of observations and restraint;
- communicating rights and responsibilities; and
- the practice of mandatory reporting of sexual incidents.

Believing women

Reflecting feedback from the women interviewed, workshop participants suggested that women can be afraid to "speak up" about their concerns or fears relating to men on the unit due to intimidation and power or control strategies used by some men. All groups acknowledged that women's concerns in the case studies should not have been dismissed when reported. Participants felt strongly that regardless of a woman's presentation, she should be believed, taken seriously and receive an appropriate response. Some groups related practices of investigating, often using video footage, to determine if an allegation was based on a delusion, while others indicated that this was irrelevant as the experience for the woman was the same. Other participants identified that while a police report would be made, a referral to specialist sexual assault services would only be made if the staff believed a sexual assault had occurred.

Participants acknowledged that resourcing issues and the physical environment might make appropriate responses difficult or impossible, so distinctions between the impact of staff culture and resourcing can be difficult to make.

Workshop participants noted issues of workplace culture in the case studies relating both to the responses of staff and to the way the physical environment was used. This was specifically raised in how issues of sexual harassment might be responded to, and how these responses would be limited by the available options. For example, if there were no other beds available for a woman and she was assessed as requiring inpatient care, she might be placed in a male section of the unit. If that room had a broken lock, it might take some time to organise for the lock to be fixed. This meant that she would be in an unlockable room in a male area for a period of time. This would be seen as unfortunate and requiring some oversight but would not be viewed in itself as an incident of gender-based violence, although it may be experienced as such by the woman. Several participants reported that an unlockable door would not be accepted and that procedures are in place in some services to ensure that this does not occur, such as a 24-hour maintenance service.

Observations

In addition to the staffing measures outlined above, the workshop groups suspected a lack of attention to policy and procedures in the case studies discussed. For example, if a woman needed to be subjected to regular observations which might need to be conducted by male staff, this should have been discussed with her beforehand and an agreement reached about how these would be undertaken (e.g. a staff member to announce themselves before entering).

There was wide agreement that searching and other intimate contact with women should be done by a female staff member. One participant highlighted that a request to remove clothing should not be made unless authorised by the appropriate psychiatrist.

Restraint

One scenario presented to the workshops involved an experience of restraint. The workshop participants emphasised two aspects of the scenario they felt could have been prevented by different staffing arrangements. However, there were several views on what prevention would look like. One participant suggested that restraint should be a "nursing intervention not a security guard intervention" thus pointing to the possible relationship between professional training/skills and outcome. Others felt that the professional role was less important than the gender of the worker and suggested that any restraint should be undertaken by female staff. One participant suggested that best practice would also include an opportunity to debrief, an apology and provision of information on available complaints processes. In addition, this participant highlighted the responsibility of the nurse unit manager to follow up on this and to complete an incident report.

Rights and responsibilities

Some participants reflected that all consumers should be informed of their rights and responsibilities throughout their stay. Again, the importance of the workplace culture to ensuring that this happens was supported. The workshop participants identified that if a woman felt her rights were being respected then she was more likely to engage in positive relationships with staff, which would be conducive to trauma-informed care and improve communication. This, in turn, would help staff address and respond to gender-based violence.

Mandatory reporting

All workshop groups raised the issue of mandatory reporting. Participants widely agreed that the mandatory reporting of sexual interactions was a positive move, while also acknowledging that many women did not want to make reports. All participant groups identified that their practice was consistent with policy that requires all sexual contact, including consensual contact where both parties could be assessed as having decision-making capacity, was reported to either the Office of the Chief Psychiatrist or police irrespective of the wishes of the woman involved. Generally, the decision to proceed or not with a criminal investigation would be left to the police. Women would not automatically be referred for sexual assault counselling.

Some participants highlighted how some women may change their view on sexual incidents once they leave the unit, so mandatory reporting ensures that the option to pursue a legal and/or complaints process remains open. Others indicated that staff had a "duty of care" to report to police because women in inpatient units did not have "capacity to give informed consent". Despite this appearing to remove the choice about reporting sexual assault from the victim/survivor, multiple participants reported their understanding that it instead ensured that they retained choice, as it meant that if they wanted to pursue legal action later they could do so.

Several participants identified that a shortfall of this process was the lack of any follow-up with the woman to ensure that she is aware of her options and for support to pursue legal or complaints processes. This is consistent with the women interviewed, who also identified a lack of a structured follow-up process.

Responding to domestic and family violence

While certainly an aspect of staff culture, the theme of service responses to domestic and family violence was so

heavily featured in the workshops that it is presented here as a discrete issue. While conceptually domestic and family violence has been understood in this research as a subset of gender-based violence, the workshop participants indicated that it required a different set of responses to gender-based violence perpetrated by men who were other consumers in the unit. The discussion was particularly focused on how information was shared with, or gained from, a perpetrator of domestic or family violence.

Contacting next of kin

The importance of updating next-of-kin was seen as relevant in situations where the next-of-kin was a potential perpetrator of family violence. The general consensus was that this should be done in consultation with the woman, but some participants gave examples where they had assessed that a described experience of domestic violence was instead a paranoid delusion, and they had decided to go against the women's wishes and contact the next-of-kin.

All groups identified an issue with processes to ensure that next-of-kin information stored on patient files is accurate and up-to-date. Everyone agreed that it is the responsibility of staff to ensure that such information is current, but highlighted several ways in which confusion about data accuracy might be fostered. Firstly, patient intake forms all require information on next-of-kin, but these may be "pre-filled" during the admission process based on existing information. It is possible that pre-filled information is not double-checked with the consumer. As a consequence, and post-intake, staff are likely to assume the information is correct.

Documentation of family violence

Some participants reported that there was the option within patient records to add an "alert" where there is a known history or occurrence of domestic or family violence. Participants acknowledged, however, that whether or not this was done really depended on individual staff members—that is, it was not done as part of standard procedure. Some services identified much more rigorous processes for collecting this information. Further, participants suggested that if a history of family violence was to be recorded, it was less likely to happen in the "fast-paced environment" of a mental health inpatient unit. Consequently, participants felt that staff are likely to depend on this being entered or picked up by staff in the emergency department or by community treatment teams. One workshop group highlighted how useful it would be if a copy of any current Intervention Orders and Parenting Orders could be included in patient files.

The difference between information gathering and sharing

Some participants felt that there needed to be a distinction drawn between the purposes for which staff may contact next-of-kin. In one situation, staff were gathering information on the patient for the purposes of establishing patient history and background data, and in the other, staff were sharing information on the wellbeing of the patient with next-of-kin. Many participants felt that contacting the partner for information gathering may be relevant, despite the history of family violence. However, others felt strongly that the history of family violence should preclude this from happening in any case, given the risk contacting the perpetrator could pose in terms of disclosing the whereabouts of the woman. None of the groups felt that it would be appropriate to contact a perpetrator for the purposes of sharing information about a victim's/survivor's care. However, only a small minority of participants identified that collecting information from a perpetrator could allow him to perpetrate violence against her, by framing her response to his violence as a mental illness. In one group, this was identified as stemming from a general lack of understanding of the dynamics of family violence among mental health clinical staff.

Several participants indicated that they may need to contact a perpetrator to gather information on the woman's mental health history and that this need for information might outweigh her request not to contact him. Indeed, one group suggested that this practice was "not unusual" regardless of a person's request. Others, however, felt that a reasonable process would be to call other family members or contacts and then re-assess whether the perpetrator needed to be contacted for more "collateral" information. In any case, most participants agreed that any decision to contact the perpetrator should be discussed with the woman rather than undertaken without her knowledge and despite her request.

This was essentially based on the assumption that the veracity of a woman's account of her situation may be questioned based on her mental illness. While participants acknowledged that this is not best practice, they specified that clinical staff may make judgements about a woman's account of events. Despite acknowledging this practice, the vast majority of participants stated that regardless of her presentation, a woman should be believed and taken at her word.

Conclusion

Across both the women who were interviewed and the service providers who participated in the workshops, two main themes were consistent. The first is that women's safety is not assured in mental health inpatient units, and the second is that staff are not always able to prevent violence.

These conclusions led to a general consensus that women should not be required to share any spaces with men. While it was generally agreed that this would not solve all issues, particularly those arising from experiences of restraint, the provision of women-only units staffed by women would be a necessary precursor to ensuring women's safety. Other considerations are also required, but they are supplementary to the separation of men.

Discussion

Mental health inpatient units are dynamic spaces and they can be experienced and perceived in different ways by consumers. For those who feel safe, who develop therapeutic relationships with staff, and who interact comfortably with other consumers, mental health inpatient units can offer many benefits (Muir-Cochrane, Oster, Grotto, Gerace, & Jones 2013). Conversely, they can also be frightening places if these aspects are not present (Muir-Cochrane et al., 2013). Rather than being a sanctuary for mental wellbeing, our study showed that women can experience mental health inpatient units as unsafe sites because of their exposure to gender-based violence. This situation is not unique; many other local and international studies have highlighted gender-based violence as a problem facing mental health inpatient units (e.g. Clarke & Dempsey, 2008; Frueh et al., 2005; Kulkarni & Gavrilidis et al., 2014; Leavey et al., 2006; Lucas & Stevenson, 2006; Mezey et al., 2005; Motz, 2009; Nibert et al., 1989; OPA, 2017; Wood & Pistrang, 2004). Not only is gender-based violence a violation of women's rights and autonomy, it compounds problems associated with poor mental health and impedes mental wellbeing (Ellsberg et al., 2008; Mullen, Walton, Romans-Clarkson, & Herbison, 1988; Oram, et al., 2013). A safe environment that is free from the harm of others is crucial for a therapeutic experience; this includes providing a safe place to talk through issues with consumers knowing that they will be listened to and respected (Hegarty, Tarzia, Fooks et al., 2017; Hopkins, Loeb, & Flick, 2009).

This section discusses key issues arising from the findings, relating to:

- the physical environment;
- the risks associated with mixed-gender spaces;
- staffing and workplace culture and practices; and
- the need for improvements in trauma-informed care.

The physical environment

The physical environment of mental health inpatient units was identified by women and service providers as contributing to the lack of safety from male perpetrators. This supports previous studies from the UK that also singled out built environments, particularly those that do not offer gender-separated areas, as pivotal in compromising women's safety (Bonner & Wellman, 2010; Cutting & Henderson, 2002; Hawley et al., 2013; Krumm et al., 2006; Leavey et al., 2006; Mezey et al., 2005; Motz, 2009; Noble & Rodger, 1989; Thomas et al., 2009; Wood & Pistrang, 2004). Victorian mental health inpatient units can be fully mixed, partially mixed with some women's only areas or corridors or completely divided by gender. Partially mixed arrangements may involve rooms being located on separate corridors and the segregation of communal spaces, such as lounges, bathrooms and dining rooms. The limited availability of beds, however, undermines provisions put in place to provide gender segregation because allocating beds is prioritised over women's safety.

The mixed-gender environment of units was a particular concern that was raised by the women and service providers with whom we spoke. The shortage of gender-specific beds was outlined as a constant challenge for service providers, which meant that the designation of single-gender rooms and spaces was often dependent on supply and demand. Service providers described placing men in beds designated for women and vice versa as a common occurrence when there were bed shortages. The women interviewed emphasised how they were vulnerable to gender-based violence when they were accommodated in rooms in male areas, or men were placed in female areas. Even where women's rooms were located in locked areas, it was often still possible for men to access them, highlighting the persistent threat of gender-based violence experienced by women. The workshop groups were acutely aware of, and frustrated by, these systemic barriers to providing safe spaces for women and protecting them from gender-based harm.

To reduce the risk of gender-based violence there was strong support articulated by women for gender-segregated units, with only one woman expressing a preference for mixed-gender units. Among the service providers, there was some ambivalence expressed about whether such changes would address this issue; however, overall the advantages of segregation were acknowledged. Scepticism about the benefits of gender-segregation seemed to emerge mostly because of a concern that changing the design of the units was only one part of the solution. Many service providers expressed a desire for broader systemic change, including improving staff-to-patient ratios and increasing the availability of

beds. There were certainly concerns raised about the layout of the wards and suggestions were made about how they could be redesigned to be safer, such as having moveable ward boundaries to accommodate different gender ratios at any given time and removing long corridors that are difficult to supervise.

The provision of lockable doors was nominated as one way of providing private and safe space for women. Lockable bedroom doors have been recognised to "greatly increase consumer's sense of safety and security" (Canberra Hospital and Health Services, ACT Health, 2017); however, maintenance issues and availability of keys were identified by both the women and the workshop participants as a particular problem. Having designated women-only units that could not be compromised by a lack of beds elsewhere and lockable spaces would make available private spaces for all women.

In sum, our study supports Kulkarni and Galletly's (2017) contention that the upgrading of existing mental health inpatient units that includes the option of gender-segregation must be prioritised so that women's safety is not compromised. Similarly, any planning for future sites must also incorporate this option (Kulkarni & Galletly, 2017). These issues of the built environment, however, are not independent of workplace culture, as discussed below.

Staffing issues and workplace culture

Previous research has indicated that resourcing and resistance to change within mental health inpatient units compounds the challenges presented by the physical environment (Copperman & Knowles, 2006; Clark & Fileborn, 2011). As Kulkarni and Galletly (2017, p. 193) argue, "mental health professionals are inured to the issue because this is how wards have been structured and run for decades; change is too difficult". In our study, both the women and the workshop groups highlighted the critical nature of workplace culture and practices in managing and responding to gender-based violence. Based on the case studies, the workshop groups emphasised the need for changes to be implemented throughout organisational structures. Staff indicated that these changes needed investment from leadership within mental health services. Systems that disempower women need to be dismantled, otherwise, women are denied autonomy and choice (Clark & Fileborn, 2011). This is crucial for any sustained institutional change to occur.

Women discussed the need for staff to receive training in how to respond to, and manage, different forms of gender-based violence, to understand the different circumstances in which it occurs, and also to work actively to prevent abusive behaviour. In Victoria, "Safewards", a model for reducing and containing conflict in mental health services, is the main response to improving inpatient safety (Fletcher, Buchanan-Hagen, et al., 2019; Fletcher, Hamilton, et al., 2019; Fletcher et al., 2017; Hamilton et al., 2016). As mentioned in the literature review above, "Safewards" aims to identify and address conflict and causes of conflict in both staff and people who are in inpatient units. While it has been found to reduce incidents of violence, neither the training nor the evaluation includes a specifically gendered approach. This is a noteworthy gap and signifies the lack of a gendered lens on this issue.

There was a concern expressed by both the women interviewed and the workshop groups that the capacity of staff to respond effectively to reports of gender-based violence was compromised because of present staffing allocations, putting both women and staff at risk. Under-staffing made observation difficult, particularly of those women who were identified as "vulnerable" to gender-based violence. Improvements in staffing ratios would deliver safer environments for women by providing adequate supervision and monitoring of changing gender dynamics within the ward. Increased staffing alone, however, would not address the issue of women being co-located with men, as many of the examples of gender-based violence outlined in this report could not have been prevented solely by observation.

A further suggestion from both the women and the workshop groups was that segregated units should be staffed by women, at least at night or at least with female nurses. Some policies reviewed did allow for searches or other intimate interactions to be conducted by a person of the same gender or of their choice of gender, usually subject to the availability of staff. In Victoria, for example, a search is required by law to be

undertaken by a person of the "same sex" as the person searched, but only insofar as it is "reasonably practicable in the circumstances" (*Mental Health Act 2014* (Vic) s 355(6)). In other jurisdictions, the requirements are different. Queensland, for example, requires that for "personal searches" and searches requiring the removal of clothing the "person carrying out the search must be the same gender as the person being searched" (Queensland Chief Psychiatrist, 2017).

Documentation and information

The workshop groups highlighted the benefits of posting an alert on consumer files to identify those at risk of gender-based harm and those who have a history of harming others. Files can be marked with an alert to staff about histories of gender-based violence. Many of the policies, procedures and guidelines included in the project policy analysis underscore the importance of including women's histories that document experiences of gender-based violence. The benefit of gathering this information in intake assessments is already established (Xiao et al., 2016); yet, the workshop groups indicated that this responsibility was typically taken on by individual staff members rather than being systematic.

Moreover, the "fast-paced environment", combined with staffing pressures of mental health inpatient units, is not conducive to the consistent collection and collation of information on gender-based violence. Integrated and coordinated service provision for women who have experienced trauma involves the clear delineation of roles (Hegarty, Tarzia, Rees et al., 2017). The workshop groups stated that they rely on the identification of those at risk or those who may pose a risk to others being picked up during intake assessments, within emergency departments or through contact with community treatment teams. These risk assessments are not always completed or may be completed using outdated information. This means that issues may be overlooked or missed, leaving women at greater risk of gender-based violence.

While it may be helpful in terms of the provision of treatment and care to collect extensive histories that include experiences of trauma, it is also a women's right not to disclose such information. Mental health practices should acknowledge this right and internal processes should reflect the fact that all women may have experienced violence or be at risk of violence. To ensure that this information is collected appropriately, staff must be required to collect it, be adequately resourced to spend the time necessary to complete intake and risk assessments properly, and to revisit these assessments over the period of inpatient stay. Women need control over if and when they disclose abuse. Furthermore, service providers need to be supported so they are equipped to do this sensitive work (Hegarty, Tarzia, Rees et al, 2017).

Improving procedures around the collection of information and updating files are needed to provide for women's safety. The interviews with women highlighted how women's safety could be compromised when information was shared with people who posed a threat to them. This was a particular risk in the context of family and domestic violence. The exposure of women to family or domestic violence could occur through the contact details for support people or next-of-kin information being out-of-date, or women's details being shared with people without first consulting them. Problems also arise when next-of-kin information is "pre-filled" on admission based on existing patient information and/or it is not checked and updated with each admission. The possibility of including current intervention violence orders within women's files was suggested by staff as a way of minimising the risk to women who had a history of exposure to family violence. This would be dependent on an intervention order being taken out, and women being willing to share it with the treating team.

A significant tension between a service's need for information about a person and the right of a person to privacy and protection was identified. Responding to domestic and family violence in the context of providing care and support is covered by some policies (e.g. Victorian Chief Psychiatrist, 2017), yet no definitive means of navigating this tension is offered in most jurisdictions. There was a suggestion from the workshop groups that there should be a distinction made between information gathering and information sharing. The workshop groups identified ethical concerns about balancing their duty of care for gathering information about a patient's mental health condition with her potential exposure to, and experiences of, gender-based violence. There was substantial

disagreement amongst the workshop group members about the ethical implications of contacting a perpetrator of violence for background information, and how reliable this information might be. Sharing information without women's consent, to violent partners/ex-partners for example, is potentially harmful, both in terms of breaching trust with the mental health service and in terms of making the perpetrator aware of sensitive information. Furthermore, it could also place women at further risk of harm by alerting perpetrators to their whereabouts. Developing systems that require consistent updating of information and engagement with individual women will help to protect women from the threat of family and domestic violence. Screening for domestic and family violence, in particular, offers circumstances for women to disclose abuse and consequently receive assistance (Ghandour, Campbell, Lloyd, 2015; Spangaro, Zwi, Poulos, & Mann, 2010). Moreover, it will promote trust and rapport, which is essential to experiences of safety and the promotion of good mental health in the units.

Institutional violence and coercion

The interviews with the women victims/survivors exposed gender-based violence perpetrated by male staff members through physical violence, sexual harassment and threats of sexual assault. There were no reports of violence perpetrated by female staff members. This highlights further concerns for women's safety, and the capacity of mental health inpatient units to provide safe environments; yet, abuse of consumers of mental health services by professionals, in general, is an area that has received little attention (Melville-Wiseman, 2012). In addition to imbalances in power that already exist in gendered-based hierarchies, staff members are inevitably in a position of control. It raises questions about how and from whom women are able to seek support if they are victimised by staff or experience re-traumatisation. If gender-based violence occurs in the course of treatment, it can make it difficult to identify the intent to harm and for women to make a complaint.

Restraint and seclusion practices undertaken in mental health inpatient units are especially contentious and can be experienced by women as gender-based violence (Fish & Hatton, 2017). Many policies identified the need for consideration of the gender of staff involved in bodily searches (e.g. Queensland Chief Psychiatrist, 2017), and the use of restraints or seclusion (e.g. NSW Ministry of Health, 2012). Yet, the women we spoke to described men being involved in these practices. The workshop groups made several suggestions about how restraint, in particular, could be better managed. This included ensuring that restraint is a nursing intervention and not the domain of security staff. Alternatively, as workshop participants pointed out, any restraint of female patients should be undertaken by female staff members. Further, a report should be made following an incident. In order to better inform and engage women following restraint, a suggestion was made to take time to debrief and provide information on the complaints process. An additional suggestion that came from the interviews was that consent should be sought for any physical touching by a staff member and that all touching should require an explanation and be recorded. Nonetheless, of central importance is respecting women's experiences; if a woman experienced treatment as gender-based violence then this must be acknowledged and support offered accordingly.

The link between trauma and mental health problems has been well-established (Ellsberg et al., 2008 Mullen et al., 1988; Oram, et al., 2013). Given the prevalence of gender-based violence globally, in addition to what is occurring in mental health inpatient units, it makes sense that trauma-informed approaches are applied as standard. Sensitivity to differences in experiences of trauma according to gender is essential. Power disparity based on gender that contributes to violence must not be replicated and reinforced through systems of care that should be ameliorating these problems (Hegarty, Tarzia, Fooks et al., 2017).

This study accentuated the importance of implementing trauma-informed approaches in mental health inpatient units with regard to gender-based violence, supporting previous research examining sexual violence specifically that highlighted the need to embed such models of care in mental health settings to assist both women and practitioners (Hegarty, Tarzia, Fooks et al, 2017). Gender-based violence triggered memories of past experiences of trauma for women interviewed for this research and the importance of applying

trauma-informed care was distinguished by both women and the workshop groups. Although not necessarily named as "trauma-informed care", women expressed a desire for responses from service providers that incorporated aspects that were consistent with this approach, such as being believed, feeling heard, and the impact of experiencing gender-based violence being acknowledged and understood. One way of acknowledging past trauma that was identified by women was to have their experiences of past traumatic events, such as gender-based violence, included in their health records so that staff were aware of their circumstances.

Managing incidents

Mandatory reporting of "sexual interactions" was viewed by the workshop groups as a positive response to managing aspects of gender-based violence that occurs in mental health inpatient units. This is a systematic response that is perceived to provide options to women, whereby staff do not have to make judgments about the degree of seriousness of the incident. Despite policies highlighting the need to follow up with those involved in a sexual safety incident, there is some indication that this is not happening. Furthermore, little is known about what happens to a report once a woman is discharged; or, how situations that involved gender-based violence that is not sexual are managed. Very little prevalence or any other data is released by any jurisdiction. The interviews with women did not yield any evidence of their awareness of mandatory reporting, or what this would entail.

The workshop groups identified the need to have people in specialist roles, such as social workers, occupational therapists or peer support workers, who would be available to support nurses in responding to reports of gender-based violence and to provide support and advocate for women. Moreover, there was particular interest in establishing a protocol with Centres Against Sexual Assault (CASAs) to provide prompt support and advocacy for incidents of sexual assault. This would align the support offered to consumers with other women who, in the case of a recent sexual assault, can access 24-hour support from a counsellor/advocate at a crisis care unit in different Victorian locations to assist with making informed decisions such as contacting the police, seeking medical attention and being referred to counselling (CASA Forum, 2014).

Consumers supported the idea of having specialists available to provide support, but they expressed a preference for peer support workers because of their capacity to better empathise due to their lived experience of mental illness. Additionally, if peer support workers were to be employed in this capacity, measures would need to be taken to support them and not overburden them when they potentially have their own lived experiences of gender-based violence.

One strategy to keep individual women safe when there was "bed stress" that was discussed in the workshop groups, was to identify women who were "vulnerable", due to youth or a recent sexual assault for example, and to prioritise their placement in beds designated for women. In Victoria, the Department of Health (2012) guidelines *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* require the assessment and identification of those potentially at risk of gender-based violence and assigned a risk category (low, medium or high), and recommends the development of alert systems to help identify consumers with a history of sexually inappropriate behaviour. Furthermore, the guidelines state that an appropriate level of care should be provided according to a person's risk categorisation, including the provision of a personal alarm or duress systems to those considered to be at high risk. Presently, it seems, these practices and systems are being put in place on an ad hoc basis in individual units, rather than as standard practice across all mental health services. This also puts pressure on staff to identify vulnerable women, even though information may not be fully available, rather than systems being put in place that provide a consistent level of protection for all women regardless of their individual circumstances. The risk management approach is inherently problematic, particularly in light of the inability of mental health risk assessment tools to predict other behaviour such as suicide (Large, Chung, Davidson, Weiser, & Ryan, 2017; Large & Kapur, 2018). Even the best risk assessment tools for sexual offending have only a moderate predictive power (Hill et al., 2012), so risk assessment-based approaches to ensuring women's safety are at best harm minimisation strategies.

These practices highlight that some staff are attentive to how particular women may be more vulnerable to gender-based violence and put measures in place accordingly. Yet, they uncover environmental limitations and practical considerations that result in women's exposure to gender-based violence. In particular, it raises three main concerns:

- The structure of the physical environment and availability of beds limits the ability of staff to put in place consistent safety measures for all women regardless of perceived vulnerability.
- Individual staff are expected to make assessments about degree of vulnerability, which can rely on a woman having made a disclosure of recent gender-based violence.
- The onus is put on women to protect themselves by managing the gender dynamics of a male-dominated space.

Systems and practices designed to limit the risk to individual women based on their allocation to a risk category can be burdensome and can expose women who are missed to gender-based violence. System constraints and the mental health inpatient unit environments mean that women are perpetually at risk because of the potential for missed opportunities and oversights. All women should be deemed as potentially at risk from gender-based harm and the layout of inpatient units and staff practices need to reflect this.

Placing responsibility on women to manage gender-based violence

The presence of gender-based violence in the units, combined with a real and perceived lack of confidence in institutional responses, results in women needing to devise strategies to avoid violent situations. Current practices in mental health inpatient units can contribute to women feeling obliged to take responsibility for their safety in these settings. Gender-based violence was described by the women as something that needed to be endured, thereby placing pressure on women to manage the conditions of safety. Gender-based violence affects women's access and use of space in mental health inpatient units because they are unable to inhabit and enjoy gender-mixed spaces to the same extent as men due to safety fears. Instead, some women manage this by staying in their individual rooms rather than using the common areas.

The gendered power imbalance on mixed units can also be deployed through the strategy of relying on assistance from other male consumers to act as a disincentive to potential gender-based violence or to intervene if problems arise. Not only does this strategy rely on men to be available to women and to be able to provide support if violent situations arise, it puts undue pressure on male consumers to control other men's behaviours in the units. This also potentially places women in situations where they could be exploited for accepting this protection. Another strategy revealed in the interviews was the invention of a hypothetical male partner to deflect male attention. A further approach implemented by women was to not seek any support because to do so could result in provoking further gender-based violence. Women's fears that violence may intensify is not unreasonable, given the accounts in this study about the persistence and escalation of men's violent behaviour. From the perspective of the workshop participants, there was an awareness that women can be intimidated and controlled by men on the wards, and this could prevent them from seeking support from staff. Women have the right to feel safe and secure in their bodily integrity and should not be reliant upon real or invented male companions for security.

The risk, or experience, of gender-based violence can lead women to leave mental health inpatient units prematurely, whether through self-discharge or absconding. Feeling safe in mental health inpatient units is influenced by interactions with consumers and staff (Glasby & Lester, 2005; Muir-Cochrane et al., 2013; Wood & Pistrang, 2004). When consumers feel comfortable in the mental health unit, when they build therapeutic relationships with staff and when their interactions with other consumers are positive, they are more likely to perceive the environs to be safe (Muir-Cochrane et al., 2013). When the converse exists, they are more likely to abscond or attempt to do so (Muir-Cochrane et al., 2013).

Women may also prefer not to be readmitted to a mental health inpatient unit where they were previously exposed to gender-based violence. This indicates that, at times, the threat

of gender-based violence overrides consideration of their mental health and wellbeing. This clearly has implications for effective treatment. One strategy for managing this is giving women the option of being transferred or admitted to a different mental health inpatient unit, even if the distance is far away. While this could potentially limit the types of informal supports that might be available within their local area, it was an option raised by women in the study.

Conclusion

This study aimed to investigate women's experiences of gender-based violence that occurred during and due to stays in adult mental health inpatient units. Informed by a feminist methodology that valued women's experiences, women's voices were located at the centre of this research. Specific attention was given to women's narratives of gender-based violence and what they felt would need to occur to make mental health inpatient units safe.

In order to implement change, it is necessary to understand the current policy context. The State of knowledge review we produced showed that recognition of the importance of sexual safety and the need for gender sensitivity in mental health settings is evident within some policies across Australia; however, it also identified gaps within current policies, guidelines and procedures and structural limitations that prevent implementation of safety measures in practice. While many of the policies reviewed in this report acknowledge women's right to be free from the threat of violence within mental health inpatient units and recognise the need for safe spaces, this study highlights the structural and practical limitations of achieving this. Therefore, a further aim of our study was to produce the *Guidelines for ensuring women's safety in mental health units* that could be applied across all Australian jurisdictions. The suggestions made by women were central to developing the Guidelines.

The interviews with women provided insight into the nature of gender-based violence, the circumstances in which it occurs and its impact on women. Women's experiences of gender-based violence and their suggestions for change were then written up into composite case studies and used to facilitate discussion with mental health service providers about the ways and means of achieving institutional and practical changes for the protection of women.

Four workshops conducted with service providers were an opportunity to understand the barriers and limitations that mental health inpatient units face in providing safe environments for women. Service providers were also afforded an opportunity to outline changes that they believed would eliminate the risk of gender-based violence for women that could be implemented in practice and policy. The Guidelines were formulated from the interviews with women, the policy review and the workshops with service providers. In draft form, further consultation was sought from the project advisory panel, two further workshops with service providers and feedback from consumer advocates.

The Guidelines were developed according to the principles of safety, recovery, gender sensitivity, dignity, autonomy and choice, which are presented in Appendix A.

Finally, the findings of this project need to be viewed according to some of the limitations of the research. This includes the sample size of the consumer cohort. Due to difficulties with recruitment, this cohort is limited to eleven participants. Qualitative studies such as this do not rely on large sample sizes, however, this was not assessed as having reached saturation. In addition, given that the participants in this study do not reflect the diversity of Australian women, the study is also especially limited in its applicability to groups that were either not represented or were minimally represented in the study, such as Aboriginal and Torres Strait Islander women, women who identified as LGBTIQ and migrant women or women born outside of Australia, in particular those identified as CALD.

Areas for further research

More research is needed to understand how other barriers to seeking support are experienced by women, such as physical and intellectual disability, chronic illness, gender and sexual diversity, Indigeneity and cultural and linguistic diversity. Understanding how these groups experience and understand safety within mental health inpatient units is essential in order to avoid implementing policies and practices that may lead to further marginalisation. For example, some of the changes advocated within this report (such as women-only wards) may have an adverse impact on those who identify as trans or gender diverse. Moreover, this study was located in Victoria, so further national research would be beneficial. Gender-based violence in mental health inpatient units also has implications for the safety of staff working in those environments. Research that examines the experiences of gender-based violence and how this is managed is an essential part of assessing the changes required to make mental health

inpatient units safe for everyone. Finally, while this study only considered the mental health inpatient environment, the inability of staff to maintain safety in this environment should prompt consideration of alternatives that are safe, such as community-based responses. This is particularly relevant in the context of involuntary treatment and detention, given that the majority of women are prevented from leaving unsafe environments.

Implications and recommendations for policy and practice

This study must be read and located in the broader societal context of gender-based violence, and in how mental health services meet or do not meet the needs of women, both within inpatient units and in the community more broadly. Not surprisingly, the findings from this study have significant implications for policy and practice. Detailed recommendations for reforming inpatient units are summarised in this section and are comprehensively discussed in Appendix A, the Guidelines.

Failure to provide zero-tolerance of gender-based violence in mental health inpatient units is indicative of how women's safety is compromised at large. It is imperative that all women have the right to live free from violence, and mental health inpatient units are environments where consumers specifically rely on mental health systems for protection from abuse and oppression. Yet presently there is inconsistency in how policies address gender, with significant variation between jurisdictions. Where there are contrary and piecemeal policy approaches, service provision will be compromised. This speaks to how women's mental health is overlooked more generally (Kulkarni, 2014).

Drawing on the findings of this study and the consultation process, a number of clear recommendations emerge. The fundamental premise of these recommendations is the primary finding from this study, which is that women are not currently safe in mental health inpatient units. Accordingly, the recommendations are underpinned by the principles of safety, recovery, gender sensitivity, dignity, autonomy and choice.

Women's **safety** must be ensured in inpatient settings. Feeling unsafe is as important as the experience of being unsafe, and this needs to be recognised by service providers. Safety must be understood as defined by women themselves. Moreover, some women may have past and ongoing experiences of trauma and this will impact on their experiences of safety in mental health inpatient units.

Women have a right to **recovery**. Recovery is understood as a personal journey, different for each individual, and upholding the right of each individual to make their own choices, have their human rights upheld and to work in partnership with others to define their own recovery journey. An unsafe environment is counter-therapeutic, inconsistent with recovery and potentially traumatic.

Women's experiences of violence and abuse can be different from those of men and therefore require different understandings and responses particularly with regard to safety, trauma, abuse and power. Inpatient treatment and care must respond to women's individual needs, including an understanding that all (self-identifying) women are entitled to **gender-sensitive** and gender-appropriate responses.

All women have a right to **dignity**. Women in mental health services may require specific supports to ensure that this right is not violated. Any limitation of this right must be assessed on a person-by-person basis and be in accordance with the law. Women in mental health inpatient units should be afforded the same level of amenity as any other person. No person should be required to endure unsanitary, uncomfortable or undignified conditions as a consequence of an inpatient admission.

Autonomy is central to dignity and recovery. All women have the right to make decisions about their bodies, their recovery journey and to lead any responses to violations of their rights. Women in mental health inpatient units must be afforded the same rights as any other women. Victims/survivors of gender-based violence have the right to determine the response to their experience consistent with legal processes.

Women should both *have* **control** over their situation and *feel* that they have control over their circumstances. Women are the experts of their own experiences. Mental health service providers must demonstrate the dignity and worth of women by responding respectfully and with empathy, irrespective of their mental state.

These principles are embedded in the Guidelines and are reflected in each stage of the inpatient experience. **Promotion** of gender safety should ensure that gender-based violence never occurs. **Prevention** of gender-based violence requires that women are never required to share spaces with men. **Early intervention**, when gender-based violence does occur, requires trauma-informed and person-centred responses. Incident response must be led by women and conform with best practice in sexual assault service provision. **Incident reporting and recording** must be led by women and supported by staff. **Continuing care** must be provided to women who experience gender-based violence through ongoing and follow-up support. **Data collection** is needed to monitor incidence and prevalence of gender-based violence; this must protect women's privacy while ensuring that services are transparent and accountable. These data must inform **oversight and monitoring** mechanisms to ensure that the required changes are embedded in the mental health system.

References

Australian Bureau of Statistics. (2016). *Personal Safety, Australia, 2016* (cat. no. 4906.0). Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4906.0~2016~Main%20Features~Key%20Findings~1

Australian Institute of Health and Welfare. (2018a). *Family, domestic and sexual violence in Australia 2018*. Retrieved from https://www.aihw.gov.au/getmedia/d1a8d479-a39a-48c1-bbe2-4b27c7a321e0/aihw-fdv-02.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2018b). *Housing assistance in Australia 2018*. Retrieved from https://www.aihw.gov.au/reports/housing-assistance/housing-assistance-in-australia-2018/contents/housing-in-australia

Australian Institute of Health and Welfare. (2018c). *Mental health services Overview*. Retrieved from https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/overview

Australian Institute of Health and Welfare. (2019). *Mental health services in Australia, Prevalence and policies*. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia/prevalence-impact-and-burden

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington D.C: American Psychiatric Association.

Ashmore, T., Spangaro, J., & McNamara, L. (2015). 'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities. *International Journal of Mental Health Nursing*, *24*(2), 139–148. https://doi.org/10.1111/inm.12114

Bartlett, A., & Hassell, Y. (2001). Do women need special secure services? *Advances in Psychiatric Treatment*, *7*(4), 302–309. https://doi.org/10.1192/apt.7.4.302

Bauer, M., & Gaskell, G. (2000). *Qualitative researching with text, image and sound*. London: SAGE Publications.

Baumann, M. L., & Teasdale, B. (2018). Severe mental illness and firearm access: Is violence really the danger? *International Journal of Law and Psychiatry*, *56*, 44–49. https://doi.org/10.1016/j.ijlp.2017.11.003

Bonner, G., & Wellman, N. (2010). Postincident review of aggression and violence in mental health settings. *Journal of Psychosocial Nursing & Mental Health Services*, *48*(7), 35–40. https://doi.org/10.3928/02793695-20100504-05

Bowers, L., Alexander, J., Bilgin, H., Botha, M., Dack, C., James, K., … Stewart, D. (2014). Safewards: The empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing*, *21*(4), 354–364. https://doi.org/10.1111/jpm.12085

Bowers, L., Ross, J., Cutting, P., & Stewart, D. (2014). Sexual behaviours on acute inpatient psychiatric wards. *Journal of Psychiatric & Mental Health Nursing*, *21*(3), 271–279. https://doi.org/10.1111/jpm.12080

Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J., & McSherry, B. M. (2016). Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings. *Australian Health Review*, *40*(6), 599–604. https://doi.org/10.1071/AH15128

Brown, G. R., & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *The American Journal of Psychiatry*, *148*(1), 55–61. https://doi.org/10.1176/ajp.148.1.55

Brunt, D. (2008). The ward atmosphere of single-sex wards in a maximum-security forensic psychiatric hospital in Sweden. *Issues in Mental Health Nursing*, *29*(3), 221–241. https://doi.org/10.1080/01612840701869858

Bucci, N. (2016, December 5). Psychiatric nurse charged with raping two patients at Bundoora hospital. *The Age*. Retrieved from https://www.theage.com.au/national/victoria/psychiatric-nurse-charged-with-raping-two-patients-at-bundoora-hospital-20161205-gt4a2r.html

Canberra Hospital and Health Services, ACT Health. (2017). *Clinical guideline Dhulwa Mental Health Unit (DMHU): Practice sensitive to gender identity and sexual orientation*. Retrieved from http://www.health.act.gov.au/sites/default/files/2019-02/Dhulwa%20Mental%20Health%20Unit%20%28DMHU%29%20-%20Gender%20Sensitive%20Practice.docx

Carastathis, A. (2014). The concept of intersectionality in feminist theory. *Philosophy Compass, 9*(5), 304–314. https://doi.org/10.1111/phc3.12129

Carrez, J.-P. (2008). La Salpêtrière de Paris sous l'Ancien Régime: Lieu d'exclusion et de punition pour femmes. *Criminocorpus. Revue hypermedia*. Retrieved from http://journals.openedition.org/criminocorpus/264

CASA Forum. (2014). *Victorian centres against sexual assault: Standards of practice* (3rd ed.). Retrieved from https://www.casa.org.au/assets/Documents/victorian-casa-standards-of-practice-manual.pdf

Clark, H., & Fileborn, B. (2011). *Responding to women's experiences of sexual assault in institutional and care settings* (ACSSA Wrap No. 10). Retrieved from https://aifs.gov.au/publications/responding-womens-experiences-sexual-assault-institutional-and-care-se/defining-institutional-setting

Clarke, H., & Dempsey, J. (2008). Outrage becomes determination: Advocating to raise awareness of women's experience in mixed-sex psychiatric wards. *Health Issues*, *94*(Autumn 2008), 14–16. Retrieved from https://search.informit.com.au/documentSummary;dn=735710904497262;res=IELHEA

Cleary, M., & Warren, R. (1998). An exploratory investigation into women's experiences in a mixed sex psychiatric admission unit. *The Australian and New Zealand Journal of Mental Health Nursing*, *7*(1), 33–40.

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, New York, Dec. 10, 1984, *United Nations Treaty Series*, vol. 1465, p. 85. Retrieved from https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&clang=_en

Cooper, D. (2008). Intersectional travels through everyday utopias: The difference sexual and economic dynamics make. In E. Grabham, D. Cooper, D. Herman, & J. Krishnadas (Eds.), *Intersectionality and beyond: Law, power and the politics of location* (pp. 299–325). London: Routledge–Cavendish.

Copperman, J., & Knowles, K. (2006). Developing women only and gender sensitive practices in inpatient wards—current issues and challenges. *The Journal of Adult Protection*, *8*(2), 15–30. https://doi.org/10.1108/14668203200600010

Council of Europe. (2014). *Convention on preventing and combating violence against women and domestic violence: A tool to end female genital mutilation*. Retrieved from https://www.endfgm.eu/editor/files/2016/01/IstanbulConventionFGMguide_FINAL_ENGLISH.pdf

Craine, L. S., Henson, C. E., Colliver, J. A., & MacLean, D. G. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Psychiatric Services*, *39*(3), 300–304. https://doi.org/10.1176/ps.39.3.300

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(8), 139–167. Retrieved from https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Cutting, P., & Henderson, C. (2002). Women's experiences of hospital admission. *Journal of Psychiatric and Mental Health Nursing*, *9*(6), 705–712. https://doi.org/10.1046/j.1365-2850.2002.00516.x

Daley, A., Beresford, P., & Costa, L. (2019). *Madness, violence, and power: A critical collection*. Toronto: University of Toronto Press.

Davidson, J. (1997). *Every boundary broken: Sexual abuse of women patients in psychiatric institutions.* Sydney: Department for Women & Women and Health Inc.

Denzin, N. K., & Lincoln, Y. S. (2011). Introduction: The discipline and practice of qualitative research. In N.K. Denzin, & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 1–32). Thousand Oaks: Sage Publications Ltd.

Donald, F., Duff, C., Lee, S., Kroschel, J., & Kulkarni, J. (2015). Consumer perspectives on the therapeutic value of a psychiatric environment. *Journal of Mental Health*, *24*(2), 63–67. https://doi.org/10.3109/09638237.2014.954692

Efron, S. E., & Ravid, R. (2018). *Writing the literature review: A practical guide*. New York: The Guilford Press.

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *Lancet, 371*(9619), 1165–1172. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60522-X/fulltext

Etikan, I., Musa, S.A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1–4. https://doi.org/10.11648/j.ajtas.20160501.11

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. London: Routledge.

Felton, G., & Abu-Kmeil, S. (2012). Was the introduction of single-sex wards a mistake? *Mental Health Practice, 15*(5), 21–24. https://doi.org/10.7748/mhp2012.02.15.5.21.c8927

Fish, R., & Hatton, C. (2017). Gendered experiences of physical restraint on locked wards for women. *Disability & Society, 32*(6), 790–809. https://doi.org/10.1080/09687599.2017.1329711

Fletcher, J., Buchanan-Hagen, S., Brophy, L. M., Kinner, S., & Hamilton, B. (2019). Consumer perspectives of Safewards impact in acute inpatient mental health wards in Victoria, Australia. *Frontiers in Psychiatry, 10*(461). https://doi.org/10.3389/fpsyt.2019.00461

Fletcher, J., Hamilton, B., Kinner, S. A., & Brophy, L. M. (2019). Safewards impact in inpatient mental health units in Victoria Australia: Staff perspectives. *Frontiers in Psychiatry, 10*(462). https://doi.org/10.3389/fpsyt.2019.00462

Fletcher, J., Spittal, M., Brophy, L., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing, 26*(5), 461–471. https://doi.org/10.1111/inm.12380

Friedman, S. H., & Loue, S. (2007). Incidence and prevalence of intimate partner violence by and against women with severe mental illness. *Journal of Women's Health (2002), 16*(4), 471–480. https://doi.org/10.1089/jwh.2006.0115

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., … Hiers, T. G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*(9), 1123–1133. https://doi.org/10.1176/appi.ps.56.9.1123

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(1). https://doi.org/10.1186/1471-2288-13-117

Garling, P., & New South Wales Government. (2008). *Final report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals*. Retrieved from https://www.dpc.nsw.gov.au/publications/special-commissions-of-inquiry/special-commission-of-inquiry-into-acute-care-services-in-new-south-wales-public-hospitals/

Ghandour, R. M., Campbell, J. C., & Lloyd, J. (2015). Screening and counseling for intimate partner violence: A vision for the future. *Journal of Women's Health, 24*(1), 57–61. https://doi.org/10.1089/jwh.2014.4885

Glasby, J., & Lester, H. (2005). On the inside: A narrative review of mental health inpatient services. *British Journal of Social Work, 35*(6), 863–879. https://doi.org/10.1093/bjsw/bch222

González Cases, J., Polo Usaola, C., González Aguado, F., López Gironés, M., Rullas Trincado, M., & Fernández Liria, A. (2014). Prevalence and characteristics of intimate partner violence against women with severe mental illness: A prevalence study in Spain. *Community Mental Health Journal, 50*(7), 841–847. https://doi.org/10.1007/s10597-014-9703-1

Goodman, L. A., Rosenberg, S. D., Mueser, K. T., & Drake, R. E. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*(4), 685–696. https://doi.org/10.1093/schbul/23.4.685

Hamilton, B., Fletcher, J., Sands, N., Roper, C., & Elsom, S. (2016). *Safewards Victorian trial final evaluation report*. Melbourne: Centre for Psychiatric Nursing. Retrieved from https://www2.health.vic.gov.au/-/media/health/files/collections/research-and-reports/s/safewards-final-evaluation-report.pdf

Hawley, C. J., Palmer, M., Jefferies, K., Gale, T. M., & Vincent, J. (2013). The effect of single-sex wards in mental health. *Nursing Times, 109*(48), 20–22. Retrieved from https://www.nursingtimes.net/clinical/the-effect-of-single-sex-wards-in-mental-health-29-11-2013/

Health Ombudsman Act 2013 (Qld). Retrieved from https://www.legislation.qld.gov.au/view/pdf/inforce/2017-09-13/act-2013-036

Health Practitioner Regulation (National Uniform Legislation) Act 2010 (NT). Retrieved from http://classic.austlii.edu.au/au/legis/nt/num_act/hprula20102o2010642/

Health Practitioner Regulation National Law (ACT) Act 2010 (ACT). Retrieved from https://www.legislation.act.gov.au/a/2010-10

Health Practitioner Regulation National Law (NSW) 2009 No 86a (NSW). Retrieved from https://www.legislation.nsw.gov.au/#/view/act/2009/86a

Health Practitioner Regulation National Law Act 2009 (Qld). Retrieved from https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-045

Health Practitioner Regulation National Law (South Australia) Act 2010 (SA). Retrieved from http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/sa/consol_act/hprnlaa2010599/

Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas). Retrieved from http://www5.austlii.edu.au/au/legis/tas/consol_act/hprnla2010498/

Health Practitioner Regulation National Law (Victoria) Act 2009 (Vic). Retrieved from http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/consol_act/hprnla2009517/

Health Practitioner Regulation National Law (WA) Act 2010 (WA). Retrieved from http://classic.austlii.edu.au/au/legis/wa/consol_act/hprnla2010450/

Hegarty, K., Tarzia, L., Fooks, A., & Rees, S. (2017). *Women's input to a trauma-informed systems model of care in health setting (the WITH study): Key findings and future directions*. Sydney: ANROWS.

Hegarty, K., Tarzia, L., Rees, S., Fooks, A., Forsdike, K., Woodlock, D., … Amanatidis, S. (2017). *Women's input into a trauma-informed systems model of care in health settings (the WITH Study): Final report* (ANROWS Horizons 02/2017). Sydney: ANROWS.

Henderson, C., & Reveley, A. (1996). Is there a case for single sex wards? *Psychiatric Bulletin*, *20*(9), 513–515. https://doi.org/10.1192/pb.20.9.513

Hill, A., Rettenberger, M., Habermann, N., Berner, W., Eher, R., & Briken, P. (2012). The utility of risk assessment instruments for the prediction of recidivism in sexual homicide perpetrators. *Journal of Interpersonal Violence*, *27*(18), 3553–3578. https://doi.org/10.1177/0886260512447570

Hingley, S. M., & Goodwin, A. M. (1994). Living with the opposite sex: The views of long-stay psychiatric patients. *The British Journal of Clinical Psychology*, *33*(2), 183–192.

Hopkins, J. E., Loeb, S. J., & Flick, D. M. (2009). Beyond satisfaction, what service users expect of in-patient mental health care: A literature review. *Journal of Psychiatric and Mental Health Nursing, 16*(10), 927–937. https://doi.org/10.1111/j.1365-2850.2009.01501.x

Kennedy, J., & Fortune, T. (2014). Women's experiences of being in an acute psychiatric unit: An occupational perspective. *British Journal of Occupational Therapy*, *77*(6), 296–303. https://doi.org/10.4276/030802214X14018723138048

Khalifeh, H., Oram, S., Trevillion, K., Johnson, S., & Howard, L. M. (2015). Recent intimate partner violence among people with chronic mental illness: Findings from a national cross-sectional survey. *The British Journal of Psychiatry: The Journal of Mental Science*, *207*(3), 207–212. https://doi.org/10.1192/bjp.bp.114.144899

Klotzbaugh, R., & Glover, E. (2016). A lesbian, gay, bisexual and transgender dedicated inpatient psychiatric unit in rural New England: A descriptive analysis in demographics, service utilisation and needs. *Journal of Clinical Nursing*, *25*(23–24), 3570–3576. https://doi.org/10.1111/jocn.13253

Kohen, D. (1999). Specialised in-patient psychiatric service for women. *Psychiatric Bulletin*, *23*(1), 31–33. https://doi.org/10.1192/pb.23.1.31

Kohen, D., McNicholas, S., & Beaumont, K. (2013). Inpatient psychiatric services for women. In C. Henderson, C. Smith, S. Smith, & A. Stevens (Eds.), *Women and psychiatric treatment: A comprehensive text and practical guide* (pp. 47–67). New York: Routledge.

Krumm, S., Kilian, R., & Becker, T. (2006). Attitudes towards patient gender among psychiatric hospital staff: Results of a case study with focus groups. *Social Science & Medicine*, *62*(6), 1528–1540. https://doi.org/10.1016/j.socscimed.2005.08.004

Kulkarni, J. (2013, May 17). Sexual assaults in psych wards show urgent need for reform. *The Conversation*. Retrieved from http://theconversation.com/sexual-assaults-in-psych-wards-show-urgent-need-for-reform-14265

Kulkarni, J. (2014). Women's mental health: Still not a priority, still not good enough. *Australian & New Zealand Journal of Psychiatry*, *48*(8), 701–704. https://doi.org10.1177/0004867414541684

Kulkarni, J., & Galletly, C. (2017). Improving safety for women in psychiatry wards. *Australian & New Zealand Journal of Psychiatry*, *51*(2), 192–194. https://doi.org/10.1177/0004867416667234

Kulkarni, J., Gavrilidis, E., Lee, S., Van Rheenen, T. E., Grigg, J., Hayes, E., … Stafrace, S. (2014). Establishing female-only areas in psychiatry wards to improve safety and quality of care for women. *Australasian Psychiatry*, *22*(6), 551–556. doi:10.1177/1039856214556322

Large, M. M., & Kapur, N. (2018). Psychiatric hospitalisation and the risk of suicide. *The British Journal of Psychiatry*, *212*(5), 269–273. https://doi.org/10.1192/bjp.2018.22

Large, M. M., Chung, D. T., Davidson, M., Weiser, M., & Ryan, C. J. (2017). In-patient suicide: Selection of people at risk, failure of protection and the possibility of causation. *British Journal of Psychiatry Open*, *3*(3), 102–105. https://doi.org/10.1192/bjpo.bp.116.004309

Leavey, G., Papageorgiou, A., & Papadopoulos, C. (2006). Patient and staff perspectives on single-sex accommodation. *Journal of Health Management*, *8*(1), 79–90. https://doi.org/10.1177/097206340500800106

Lucas, M., & Stevenson, D. (2006). Violence and abuse in psychiatric in-patient institutions: A South African perspective. *International Journal of Law and Psychiatry*, *29*(3), 195–203. https://doi.org/10.1016/j.ijlp.2005.08.010

Maylea, C. (2019). The capacity to consent to sex in mental health inpatient units. *Australian & New Zealand Journal of Psychiatry*. https://doi.org/10.1177/0004867419850320

Melville-Wiseman, J. (2011). Professional sexual abuse in mental health services: Capturing practitioner views of a contemporary corruption of care. *Social Work and Social Sciences Review*, *15*(3), 26–43.

Mental Health Act 2014 (Vic). Retrieved from http://www5.austlii.edu.au/au/legis/vic/consol_act/mha2014128/index.html

Mental Health Complaints Commissioner. (2018). *The right to be safe—Ensuring sexual safety in acute mental health inpatient units: Sexual safety project report*. Retrieved from https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units

Mezey, G., Hassell, Y., & Bartlett, A. (2005). Safety of women in mixed-sex and single-sex medium secure units: Staff and patient perceptions. *The British Journal of Psychiatry*, *187*(6), 579–582. https://doi.org/10.1192/bjp.187.6.579

Mills, J. K., & Hamer, S. (2015). Transitioning to same-sex accommodation. *British Journal of Mental Health Nursing*, *4*(2), 83–86. https://doi.org/10.12968/bjmh.2015.4.2.83

Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, *48*(5), 330–337. https://doi.org/10.1177/070674370304800509

Motz, A. (2009). Hiding and being lost: The experience of female patients and staff on a mixed sex secure ward. *International Forum of Psychoanalysis*, *18*(1), 37–41. https://doi.org/10.1080/08037060802450746

Muir-Cochrane, E., Oster, C., Grotto, J., Gerace, A., & Jones, J. (2013). The inpatient psychiatric unit as both a safe and unsafe place: Implications for absconding. *International Journal of Mental Health Nursing*, *22*(4), 304–312. https://doi.org/10.1111/j.1447-0349.2012.00873.x

Mullen, P., Walton, V., Romans-Clarkson, S., & Herbison, G.P. (1988). Impact of sexual and physical abuse on women's mental health. *The Lancet, 331*(8590), 841–845. https://doi.org/10.1016/S0140-6736(88)91600-5

The National Health and Medical Research Council. (2007). *National statement on ethical conduct in human research (updated 2018).* Retrieved from https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018#block-views-block-file-attachments-content-block-1

Nibert, D., Cooper, S., & Crossmaker, M. (1989). Assaults against residents of a psychiatric institution: Residents' history of abuse. *Journal of Interpersonal Violence*, *4*(3), 342–349. https://doi.org/10.1177/088626089004003007

Nicholls, T. L., Brink, J., Greaves, C., Lussier, P., & Verdun-Jones, S. (2009). Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry*, *32*(1), 23–30. https://doi.org/10.1016/j.ijlp.2008.11.007

Nicholls, T. L., Ogloff, J. R. P., & Douglas, K. S. (2004). Assessing risk for violence among male and female civil psychiatric patients: The HCR-20, PCL:SV, and VSC. *Behavioral Sciences & the Law*, *22*(1), 127–158. https://doi.org/10.1002/bsl.579

New South Wales Government, Ministry of Health. (2012). *Aggression, seclusion & restraint in mental health facilities in NSW.* Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_035.pdf

New South Wales Government, Ministry of Health. (2013). *Sexual safety of mental health consumers guidelines.* Retrieved from https://www.mentalhealthcarersnsw.org/wp-content/uploads/2017/07/GL2013_012Sexual-Safety-of-Mental-Health-Consumers-Guidelines.pdf

Noble, P., & Rodger, S. (1989). Violence by psychiatric in-patients. *British Journal of Psychiatry*, *155*(3), 384–390. https://doi.org/10.1192/bjp.155.3.384

Northern Territory Government, Top End Mental Health Services. (2017). *Preventing sexual incidents TEMHS procedure.* Darwin: TEMHS.

Offer, K. (2015, March 11). Perth psychiatric nurse deregistered for sexual misconduct on Joondalup inpatients. *PerthNow.* Retrieved from https://www.perthnow.com.au/news/wa/perth-psychiatric-nurse-deregistered-for-sexual-misconduct-on-joondalup-inpatients-ng-756b88d0e21b23ab9831b29d0fcd858d

Office of the Public Advocate. (2017). *Community visitors annual report 2016–2017.* Retrieved from https://www.publicadvocate.vic.gov.au/our-services/publications-forms/442-community-visitors-annual-report-2016-2017?path=

Oram, S., Trevillion, K., Feder, G., & Howard, L. M. (2013). Prevalence of experiences of domestic violence among psychiatric patients: Systematic review. *The British Journal of Psychiatry*, *202*(2), 94–99. https://doi.org/10.1192/bjp.bp.112.109934

Owen, C., Tarantello, C., Jones, M., & Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services*, *49*(11), 1452–1457. https://doi.org/10.1176/ps.49.11.1452

Plato. (2015). *Timaeus* (D. J. Zeyl, Trans.). Retrieved from Overdrive digital library.

Queensland Health. (2016). *Sexual health and safety guidelines for mental health, alcohol and other drug services.* Retrieved from https://www.health.qld.gov.au/qhpolicy/html/index-m

Queensland Health. (2017). Chief psychiatrist practice guidelines: Searches and security. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0032/636845/pg_searches_security.pdf

Quinn, C., & Happell, B. (2015). Exploring sexual risks in a forensic mental health hospital: Perspectives from Patients and Nurses. *Issues in Mental Health Nursing*, *36*(9), 669–677. https://doi.org/10.3109/01612840.2015.1033042

Reinharz, S. (1992). *Feminist methods in social research.* New York: Oxford University Press.

Riecher-Rössler, A., & García-Moreno, C. (Eds.). (2013). *Violence against women and mental health.* Basel: Karger Publishers.

South Australia Health. (2017). *Sexual safety in mental health services policy guideline.* Adelaide: SA Health.

Soliman, A. E.-D., & Reza, H. (2001). Risk factors and correlates of violence among acutely ill adult psychiatric inpatients. *Psychiatric Services*, *52*(1), 75–80. https://doi.org/10.1176/appi.ps.52.1.75

Spangaro, J. M., Zwi, A. B., Poulos, R. G., & Mann, W. Y. N. (2010). Who tells and what happens: Disclosure and health service responses to screening for intimate partner violence. *Health and Social Care in the Community, 18*(6), 671–680. https://doi.org/10.1111/j.1365-2524.2010.00943.x.

Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Violent Behavior, 14*(3), 170–179. https://doi.org/10.1016/j.avb.2009.01.006

Tasca, C., Rapetti, M., Carta, M. G., & Fadda, B. (2012). Women and hysteria in the history of mental health. *Clinical Practice and Epidemiology in Mental Health*, *8*(7), 110–119. https://doi.org/10.2174/1745017901208010110

Theobald, J., Murray, S., & Smart, J. (2017). *From the margins to the mainstream: The domestic violence services movement in Victoria, Australia, 1974–2016*. Carlton: Melbourne University Press.

Thomas, N., Hutton, D. J., Allen, P., & Olajide, D. (2009). Changing from mixed-sex to all-male provision in acute psychiatric care: A case study of staff experiences. *Journal of Mental Health*, *18*(2), 129–136. https://doi.org/10.1080/09638230701879201

Tong, R. (2009). *Feminist thought: A more comprehensive introduction* (3rd ed.). Colorado: Westview Press.

Trotter, C. (2015). *Working with involuntary clients: A guide to practice* (3rd ed.). Sydney: Allen & Unwin.

United Kingdom Government. (2005). *The Kerr/Haslam inquiry report*. London: The Stationery Office.

United Nations General Assembly resolution 48/104, *Declaration on the Elimination of Violence against Women*, A/RES/48/104 (20 Dec. 1993). Retrieved from https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/48/104

Victorian Department of Health. (2011). *Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing.* Retrieved from https://www2.health.vic.gov.au/about/publications/policiesandguidelines/service-guideline-for-gender-sensitivity-and-safety

Victorian Department of Health. (2012). *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units - Chief Psychiatrist's guideline*. Retrieved from https://www2.health.vic.gov.au/about/publications/researchandreports/Promoting-sexual-safety-responding-to-sexual-activity-and-managing-allegations-of-sexual-assault-in-adult-acute-inpatient-units--June-2012

Victorian Department of Health and Human Services. (2016). *Safewards handbook: Training and implementation resource for Safewards in Victoria*. Retrieved from https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/training-resources

Victorian Department of Health and Human Services. (2017). *Victoria's mental health services annual report 2016–17.* Retrieved from https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report

Victorian Mental Illness Awareness Council. (2008). *Zero tolerance for sexual assault: A safe admission for women*. Retrieved from https://www.abc.net.au/reslib/201305/r1115028_13591277.pdf

Victorian Women and Mental Health Network. (2008). *Nowhere to be safe—Women's experiences of mixed-sex psychiatric wards*. Retrieved from https://wmhnv.org.au/wp-content/uploads/2016/11/Nowhere-to-be-Safe-Final-layout.pdf

Victorian Women and Mental Health Network. (2009). *Increasing safety and gender sensitivity in mixed sex psychiatric units*. Retrieved from http://wwda.org.au/wp-content/uploads/2013/12/vwmhn1.pdf

Walton, H. M., & Baker, S. L. (2017). Treating transgender individuals in inpatient and residential mental health settings. *Cognitive and Behavioral Practice*. In Press. https://doi.org/10.1016/j.cbpra.2017.09.006

Watson, J. (2018). *Youth homelessness and survival sex: Intimate relationships and gendered subjectivities*. London: Routledge.

Weller, P. (2019). OPCAT monitoring and the Convention on the Rights of Persons with Disabilities. *Australian Journal of Human Rights*, *25*(1), 130–149. https://doi.org/10.1080/1323238X.2019.1588056

Western Australian Department of Health. (2012). *Responding to an allegation of sexual assault disclosed within a public mental health service*. Retrieved from https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/Responding_to_Allegation_of_Sexual_Assault.pdf

Whelehan, I. (1995). *Modern feminist thought: From the second wave to 'post-feminism'*. Edinburgh: Edinburgh University Press.

Williams, M. (2015, January 1). Sexual violence soars in UK hospitals. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/dec/31/sexual-violence-soars-uk-hospitals

Williams, A., Cross, W., & Darbyshire, P. (2017). Mixed gender accommodation in acute care: Time to end another 'unfortunate experiment'. *Collegian*, *24*(2), 213–218. https://doi.org/10.1016/j.colegn.2016.01.005

Wood, D., & Pistrang, N. (2004). A safe place? Service users' experiences of an acute mental health ward. *Journal of Community & Applied Social Psychology*, *14*(1), 16–28. https://doi.org/10.1002/casp.755

Wright, M. (2017). *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*. Retrieved from http://www.health.nsw.gov.au/patients/mentalhealth/Documents/report-seclusion-restraint-observation.pdf

Xiao, C. L., Gavrilidis, E., Lee, S., & Kulkarni, J. (2016). Do mental health clinicians elicit a history of previous trauma in female psychiatric inpatients? *Journal of Mental Health*, *25*(4), 359–365. https://doi.org/10.3109/09638237.2016.1139074

Appendix A: Guidelines for ensuring women's safety in mental health inpatient units

These guidelines have been developed because women who use inpatient mental health services and the staff who work in them consistently identify that these environments are not safe for women and are common sites of gender-based violence. These guidelines provide direction for keeping women safe and to support the elimination of gender-based violence in mental health inpatient settings.

Principles

These guidelines are based on a set of interconnected principles clustered around preserving safety, recovery, gender sensitivity, dignity, autonomy and choice.

Safety

- Institutions, including mental health services, have a duty to eliminate gender-based violence and to reform systems that support environments in which it can occur.
- Sexist assumptions about women, women's behaviour and relationships make women unsafe.
- Gender-based violence occurs in spaces where women's safety is not protected.
- Feeling safe or feeling unsafe is determined by women themselves. Safety and lack of safety depend on a range of previous (trauma) experiences. Women's own judgment is paramount.
- Women in mental health services commonly have histories of trauma due to gender-based violence, including sexual assault. These histories must be acknowledged and responded to in their treatment and care.
- Safety must be integrated into all aspects of the inpatient environment, including transitions, advanced planning, assessment and treatment.
- Resourcing limitations and staffing requirements must not be used to justify the failure to provide for women's safety.

Recovery

- Women have a right to recovery. Recovery is understood as a personal journey, different for each individual and upholding the right of each individual to make their own choices, have their human rights upheld and to work in partnership with others to define their own recovery journey.
- Personal recovery is not defined as an absence of symptoms. These guidelines adopt a framework of personal recovery, not clinical recovery.
- Recovery is person-centred. No other person can determine the recovery journey of another person.
- An unsafe environment is counter-therapeutic, inconsistent with recovery and potentially traumatic.
- Recovery is hopeful and relational. Only by forming healthy and robust relationships can people support other people on their recovery journey.

Gender sensitivity

- Gender-based violence occurs in the broader societal context of gender (and other) inequalities and is both a consequence and foundation of gendered power disparities.
- Women's experiences of violence and abuse can be different from those of men and therefore require different understandings and responses particularly with regard to safety, trauma, abuse and power.
- Gender awareness requires recognition that gender is fluid and that providing safety for women must include all those who identify as women.

Dignity

- All women have a right to dignity. Women in mental health services may require specific supports to ensure that this right is not violated. Any limitation of this right must be assessed on a person-by-person basis and be in accordance with the law.
- Women in mental health services can have experiences of oppression arising from gender and the discrimination associated with mental distress and mental healthcare. These can be compounded by other intersectional factors such as race, culture, colonialism, ableism, poverty, socio-economic disadvantage and locality. This complex intersectionality must be responded to in mental health services.

- The preservation of dignity following a traumatic incident requires a timely, appropriate and measured response, particularly in responding to gender-based violence.
- Women in mental health inpatient units should be afforded the same level of amenity as any other person. No person should be required to endure unsanitary, uncomfortable or undignified conditions as a consequence of an inpatient admission.

Autonomy

- Gender-based violence is a violation of human rights.
- Autonomy is central to dignity and recovery. All women have the right to make decisions about their bodies, their recovery journey and to lead any responses to violations of their rights. Women in mental health inpatient units must be afforded the same rights as any other women.
- Victims/survivors of gender-based violence have the right to determine the response to their experience consistent with legal processes.

Choice

- Women should both *have* control over their situation and *feel* that they have control over their situation.
- Women are the experts of their own experiences. Mental health staff must demonstrate the dignity and worth of women by responding respectfully and with empathy, irrespective of their mental state.
- Capacity must be presumed, decision-specific and be supported. No decision should be made on behalf of women other than where required by law.

Based on these governing principles, the following guidelines reflect the process of the inpatient experience and service responses to issues of gender-based violence, including sexual assault.

Promotion

In an environment which is genuinely safe for women, there is no need to take specific action to prevent gender-based violence. Inpatient units should be spaces of safety, respect, affirmation and healing. Women who have histories of trauma, particularly of child abuse, domestic and family violence and/or sexual assault may feel unsafe in the presence of men. The importance of a safe, calm and predictable environment is vital in times of increased vulnerability, such as times of mental distress or while experiencing other traumatic events such as involuntary treatment and detention. Women's safety must be assessed on the basis of women's sense and experience of safety, not the assessment of staff:

- Staff must integrate trauma-informed practice in their work with women. This must be supported by organisational and departmental policy, procedures and training.
- Inpatient units must showcase a positive and supportive culture.
- Dignity, autonomy, agency and respect must be the basis for all inpatient care.
- Peer support should be easily accessible and integrated into all aspects of the inpatient setting. Peer support should be diverse to reflect the communities in which they work.
- Women must be provided with women-only treatment settings. There are many reasons why women may require women-only spaces, including for cultural, trauma and/or other reasons. Women must not be required to share any space with men without consent under any circumstances:
    - The difficulties in predicting, managing and responding to the potential harms or lack of safety in a mixed-gendered environment means that women-only environments must be offered as a default. Any mixed-gender spaces in inpatient units must be spaces of gender safety and women must not be forced into them. This includes treatment, activities, mealtimes and visiting.
    - Men must never be placed or allowed into women-only wards. Resourcing issues and increased demand for inpatient beds must never be used as justification for allowing women to be unsafe.

- Staffing requirements, preferences and demands must not take priority over the safety of women. Services must be adequately resourced to provide safe and appropriate treatment and care.
- Particular care must be given to women whose cultural needs require specific responses.
- The use of force or coercion by staff of any gender can be experienced as gender-based violence and is not acceptable.
- Women-only environments will not in themselves create entirely safe spaces for women, but are a necessary precursor for women's safety and will drastically reduce incidents of sexual assault.

Prevention

Both in women-only spaces and in mixed-gender areas, preventing gender-based violence is a key priority:

- Women should only be admitted to environments where they feel safe.
- The built environment must allow for women-only wards and be experienced as safe:
  - To promote recovery, inpatient units should be comfortable and pleasant. The level of amenity should be such that any person would feel safe and comfortable to stay.
  - All women must be able to lock their room and must not be required to share with others.
  - Women-only areas must not be accessible by men.
  - All rooms should have an en suite, tables, chairs and televisions. Rather than deny people in mental health units amenities, which are provided to people in general hospital settings, these amenities must be provided in a way that ensures they do not pose a safety risk. This may include building television cabinets in such a way as to eliminate ligature points. Assessment of risk that results in denying amenities must be determined on a person-by-person basis.
  - Where observation is necessary in acute units, locked observation ports accessible only by staff should be used and doors should not be opened without consent other than in emergency situations.
  - Protective environmental elements such as lockable doors must be supported by staffing practices which ensure they are used.
- Policies, procedures and practice must align to ensure that unsafe situations do not occur. For example, all contact information and consents must be kept updated to ensure that information is not shared with violent or abusive partners or family members.
- Staff should ensure that women are appropriately and adequately supervised and supported. The balance between a woman's right to privacy and right to safety through supervision should be led by the woman:
  - CCTV in private areas should only be used with consent.
  - Staff should closely monitor interactions between people in inpatient units, including visitors, to ensure safety while having regard to privacy.
- Transition management into and out of inpatient units must ensure that women are not placed in unsafe environments. Women should not be expected to stay in inappropriate or unsafe housing such as rooming houses or where they will be at risk of violence, abuse or homelessness.
- High dependency units and acute units require specific responses. These environments should not be less safe for women than any other part of the hospital.
- All treatment and care should be provided on the basis of free and informed consent unless legally required. Where consent is not able to be provided, staff must act consistently with principles of trauma-informed care.

Early intervention

Early intervention seeks to identify and address potential situations of gender-based violence and guide intervention to prevent escalation and ensure safety:

- All treatment and care must be trauma-informed. This both addresses the underlying causes of mental distress caused by experiences of trauma and limits the re-traumatisation which can occur in mental health services:
  - Staff must understand the trauma histories of women they work with. This includes experiences of gender-

based violence such as child abuse, domestic and family violence and sexual assault.
    - Screening for histories of gender-based violence must be undertaken for all women and responded to appropriately.
    - All disclosure by women must be based on their own consent. No information about a woman, or her trauma history, should be shared with any person, including staff, without her explicit and informed consent.
- Response to reports or observations of gender-based violence in all its manifestations should be prompt, assertive and affirm the women's experience:
    - Behaviour that makes women unsafe or uncomfortable should be responded to immediately and should not be minimised by staff.
    - De-escalation and other non-coercive approaches should be employed by staff often and early where women feel unsafe.
- Peer support should be easily accessible to promote trust and communication and early identification of any potential issues.

Incident response

Responding quickly and appropriately to all violence, including incidents of gender-based violence, such as sexual assault, can limit the potential for longer-term impacts of trauma. Clinical responses must be kept separate from investigative responses. It is not the role of mental health inpatient staff to investigate or interrogate women:

- The service response to incidents of gender-based violence should come from a position of trust and belief. The role of the service is to provide options and choices which put the woman in control of the process and then support her to make use of those options.
- External services and internal support should be offered wherever relevant, including legal and non-legal advocacy services.
- Specialist sexual assault services must be offered, and if necessary, made available in the inpatient setting. A timely response is vital in limiting ongoing trauma.
- Peer support should be offered.
- Alternative accommodation should be offered if required. Women must never be forced to remain in environments where a traumatic event has occurred.
- Applicable police and sexual assault codes of practice for responding to sexual assaults should be followed.
- All other rights, particularly to dignity and privacy, must be maintained throughout the process of responding to incidents of gender-based violence.
- Information should only be shared with consent or when required by law. Most sexual assault and other gender-based violence are perpetrated by people known to the victim/survivor. Staff should be alert to the potential for placing women at risk by sharing information about gender-based violence with family or carers who may blame the woman or use that information against her.

Incident reporting and recording

Women must be supported to have control over the service and legal responses to incidents of gender-based violence. In particular, women who have experienced a sexual assault must be supported to make decisions about the legal and medical responses she receives. Consequences and potential outcomes must be explained, but it is the woman who will decide if and how she wants to proceed:

- Where a crime has potentially been committed, evidence gathering and other forensic procedures must be based on the consent of the woman. Irrespective of the woman's assessed decision-making capacity, forced forensic medical examinations, interviews and other legal processes can be experienced as re-traumatising:
    - All care should be taken to ensure that women who chose not to make police or other reports are able to do so at a later date if they choose to do so. If possible and with consent, potential evidence should be preserved, including CCTV footage and clothing.
- All incidents of gender-based and other violence should be thoroughly documented and recorded internally, consistent with standard incident reporting policies.

- Mental health staff must never prevent a woman from exercising her right to make a police report irrespective of her assessed decision-making capacity or any judgement about the likelihood of legal success.

Continuing care

Women who have experienced gender-based violence in inpatient settings should be provided with continuing care and support:

- When necessary, a specific person or role should be identified to coordinate the response to incidents of gender-based violence. This person or role should be independent of the unit where the incident occurred.
- Ongoing support and appropriate and integrated care must be offered by someone of the same gender, including specialist counselling and/or peer support.
- Support must be provided to assist in making complaints of any nature, initiating legal action or making police reports. This support should be independent of the mental health service where the incident occurred. This may include independent advocacy or official and community visitors where such services exist.
- No woman should ever be required to return to an inpatient unit where a traumatic event has occurred. Alternative options should be organised in advance of future stays.
- Women who have experienced a traumatic event must continue to be protected from the perpetrators of violence.
- Transitions out of inpatient settings should always be into other places of safety.

Data collection

Without transparent, consistent and reliable data, gender-based violence in mental health inpatient units has historically been able to be ignored or dismissed by policy-makers:

- All incidents of gender-based violence should be de-identified and reported with other service performance data such as seclusion, restraint and mortality data. This should occur in addition to jurisdictional reporting requirements.
- Reported data should be made publicly available to ensure transparency and to allow comparison between units, hospitals, health districts and jurisdictions.
- Prevalence of trauma history should also be collected, de-identified and reported.
- The processes of nationally consistent measurement, recording and reporting of gender-based violence in inpatient units should be referred to the Mental Health Information Strategy Standing Committee (MHISSC) for advice and action.

Oversight and monitoring

Oversight and monitoring are essential to ensure policy implementation at all levels:

- The implementation and success of policies eliminating gender-based violence in mental health inpatient units require oversight and monitoring at the unit, service, district, state and territory and national levels.
- The National Mental Health Commission (NMHC) and the Safety and Quality Partnership Standing Committee (SQPSC) should prioritise women's safety in mental health inpatient units and coordinate the national response.
- Timelines for compliance and ongoing reporting should be developed.
- Data collection must be transparent and shared to allow for public scrutiny and identification of best practice.

Appendix B: List of policies reviewed

Australian Capital Territory Government, ACT Health. (2015a). *Canberra hospital and health services clinical procedure—Management of sexual assault within mental health, justice health and alcohol & drug services*. Retrieved from http://www.health.act.gov.au/sites/default/files/2019-02/Management%20of%20Sexual%20Assault%20within%20Mental%20Health%20Justice%20Health%20and%20Alcohol%20and%20Drug%20Services.docx

Australian Capital Territory Government, ACT Health. (2015b). *Mental health officer handbook*. Retrieved from http://www.health.act.gov.au/sites/default/files/2018-09/Mental%20Health%20Officer%20Handbook.docx

Canberra Hospital and Health Services, ACT Health. (2017). *Clinical guideline Dhulwa Mental Health Unit (DMHU): Practice sensitive to gender identity and sexual orientation*. Retrieved from http://www.health.act.gov.au/sites/default/files/2019-02/Dhulwa%20Mental%20Health%20Unit%20%28DMHU%29%20-%20Gender%20Sensitive%20Practice.docx

New South Wales Government, NSW Health. (2012a). *Aggression, seclusion & restraint in mental health facilities in NSW*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_035.pdf

New South Wales Government, NSW Health. (2012b). *Aggression, seclusion & restraint in mental health facilities—Guideline focused upon older people*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2012_005.pdf

New South Wales Government, NSW Health. (2013a). *Sexual safety of mental health consumers guidelines*. Retrieved from https://intranet.nnswlhd.health.nsw.gov.au/docs/GL2013_012-sexual-safety-of-mental-health-consumers-guidelines-v-001.pdf

New South Wales Government, NSW Health. (2013b). *Sexual safety—Responsibilities and minimum requirements for mental health services*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_038.pdf

New South Wales Government, NSW Health. (2015). *Same gender accommodation*. Retrieved from https://intranet.nnswlhd.health.nsw.gov.au/docs/PD2015_018-same-gender-accommodation-v-001.pdf

New South Wales Government, NSW Health. (2017). *Engagement and observation in mental health inpatient units*. Retrieved from https://intranet.nnswlhd.health.nsw.gov.au/docs/PD2017_025-engagement-and-observation-in-mental-health-inpatient-units-v-001.pdf

Northern Territory Government, Top End Mental Health Services. (2017). *Preventing sexual incidents TEMHS procedure*. Darwin: TEMHS.

Northern Territory Government, Top End Mental Health Services. (2018). *Response to alleged sexual incident(s) TEMHS procedure*. Darwin: TEMHS. Queensland.

Queensland Health. (2016). *Sexual health and safety guidelines—Mental health, alcohol and other drug services*. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0030/426828/qh-gdl-434.pdf

Queensland Government, Queensland Health. (2017a). *Chief psychiatrist practice guidelines—Searches and security*. Retrieved from https://www.health.qld.gov.au/system-governance/policies-standards/chief-psychiatrist-policies-and-guidelines

Queensland Government, Queensland Health. (2017b). *Guide to patient rights*. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0038/639866/Guide-to-Patient-Rights.pdf

Queensland Government, Queensland Health. (2017c). *Mechanical restraint policy*. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0033/465189/cpp-mechanical-restraint.pdf

Queensland Government, Queensland Health. (2017d). *Notification to chief psychiatrist of critical incidents and non-compliance with the Act*. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465212/cpp-notific-critical-incidence.pdf

Queensland Government, Queensland Health. (2017e). *Physical restraint policy*. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0027/465174/cpp-physical-restraint.pdf

South Australian Government, Department for Health and Ageing. (2014). *Same gender accommodation policy guideline.* Retrieved from https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/same+gender+accommodation+policy+guideline

South Australia Government, Department for Health and Ageing. (2015b). *Reporting and management of incidents of suspected or alleged sexual assault of an adult, or sexual misconduct by an adult, within SA Health facilities and services policy directive.* Retrieved from http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policiesporting+and+management+of+incidents+of+suspected+or+alleged+sexual+assault+of+an+adult%2C+or+sexual+misconduct+by+an+adult%2C+within+sa+health+facilities+and+services+policy+directiv

South Australian Government, Office of the Chief Psychiatrist. (2009). *Mental Health Act 2009—Plain language guide.* Retrieved from https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/plain+language+guide+mental+health+act+2009

South Australian Government, SA Health. (2015). *Restraint and seclusion recording and reporting chief psychiatrist standard.* Retrieved from https://www.sahealth.sa.gov.au/wps/wcm/connect/69dde780494d7b329ac7ba63e3a03091/Restraint+and+Seclusion+Recording+and+Reporting_July2015.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-69dde780494d7b329ac7ba63e3a03091-mMyPsfo

South Australian Government, SA Health. (2017). *Sexual safety in mental health services policy guideline.* Adelaide: SA Health.

Tasmanian Government, Department of Health and Human Services. (2014). *Preventing and responding to abuse in services policy.* Retrieved from https://www.dhhs.tas.gov.au/disability/publications/policies,_procedures_and_guidelines/preventing_and_responding_to_abuse_in_services_policy

Tasmanian Government, Department of Health and Human Services. (2017a). *Chemical restraint— Chief civil psychiatrist clinical guideline 10.* Retrieved from https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/252751/CCP_Clinical_Guideline_10_-_Chemical_restraint.pdf

Tasmanian Government, Department of Health and Human Services. (2017b). *Chief civil psychiatrist clinical guideline 9.* Hobart: DHHS.

Tasmanian Government, Department of Health and Human Services. (2017c). *Mechanical and physical restraint—Chief civil psychiatrist clinical guideline 10A.* Retrieved from https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/252752/CCP_Clinical_Guideline_10A_-_Mech_physical_restraint.pdf

Victorian Department of Health. (2011). *Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing.* Retrieved from https://www2.health.vic.gov.au/Api/downloadmedia/%7B6DED03D5-D320-4C93-B56F-DE4E08109909%7D

Victorian Department of Health. (2012). *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units—Chief Psychiatrist's guideline.* Retrieved from https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/promoting-sexual-safety-in-inpatient-settings/sexual-safety-in-inpatient-settings-service-response

Victorian Department of Health. (2014). *Restrictive interventions in designated mental health services.* Retrieved from https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Restrictive-interventions-in-designated-mental-health-services

Victorian Department of Health and Human Services. (2014). *Criteria for searches to maintain safety in an inpatient unit.* Retrieved from https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/criteria-or-searches-maintain-safety-in-inpatient-unit-for-patients-visitors-staff

Victorian Department of Health and Human Services. (2016). *Safewards handbook: Training and implementation resource for Safewards in Victoria.* Retrieved from https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/s/safewards-victoria-handbook-2016.pdf

Victorian Department of Health and Human Services. (2016). *Staffing requirements for safe practice where patients are in locked areas within mental health inpatient units.* Retrieved from https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/staffing-requirements-safe-practice-where-patients-in-locked-areas

Victorian Department of Health and Human Services. (2017). *Chief Psychiatrist's guideline and practice resource: Family violence*. Retrieved from https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/family-violence-guideline-practice-resource

Western Australian Government, Chief Psychiatrist of Western Australia. (2007). *The Chief psychiatrist's standards for the authorisation of hospitals under the Mental Health Act 1996*. Perth: Chief Psychiatrist of Western Australia

Western Australian Government, Chief Psychiatrist of Western Australia. (2015a). *Chief psychiatrist's standards for clinical care*. Retrieved from https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Standards_2015.pdf

Western Australian Government, Chief Psychiatrist of Western Australia. (2015b). *Clinicians' practice guide to the Mental Health Act 2014* (3rd ed.). Retrieved from https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/CPG_Edition-3_25112015.pdf

Western Australian Government, Chief Psychiatrist of Western Australia. (2018). *Policy for mandatory reporting of notifiable incidents to the chief psychiatrist*. Retrieved from https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2019/01/Notifiable-Incidents-Policy-Public-Mental-Health-Services-2018-040119.pdf

Western Australian Government, Department of Health. (2012). *Responding to an allegation of sexual assault disclosed within a public mental health service*. Retrieved from https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/Responding_to_Allegation_of_Sexual_Assault.pdf

Appendix C: Plain language information statement

Hello,

Researchers from RMIT University have asked selected service providers, including Victoria Legal Aid, to help with inviting women to participate in research about preventing gender-based violence in inpatient mental health units. The research is funded by Australia's National Research Organisation for Women's Safety Limited (ANROWS), an independent not-for-profit company funded by Commonwealth, state and territory governments to reduce violence against women and children.

The researchers would like to interview women who have experienced gender-based violence (physical or sexual assault by a man) during a stay in an inpatient mental health unit in the last 5 years.

This research aims to improve understanding of the current situation regarding gender-based violence in inpatient mental health units and take recommendations from consumers about how to improve safety for women in these environments. Information that is given by consumers will be used to develop practice and policy guidelines.

If you give initial consent to take part in the research project, we can pass your contact details to the researchers to then gain full consent to participate and, if you are agreeable, to arrange the interview. Prior to involvement in the research you will be required to sign the consent form.

If you participate in the research you will be involved in a face-to-face interview of up to one hour. You will be asked about your experiences of gender-based violence in inpatient mental health units and your suggestions for making these environments safe for women.

You will be provided with a $40 voucher as an acknowledgement of your time and expertise.

Participation in the research is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with services, the researchers or with RMIT University. Any information collected from you will be kept confidential.

If you are interested to participate in the research please let me know and I will advise the researchers of your preferred contact details (phone number or email address) and they will contact you to make arrangements to further discuss the project.

Or you can contact Chief Principal Investigator Juliet Watson directly on 03 9925 3477 or juliet.watson@rmit.edu.au to discuss your participation.

Thank you very much for considering participation.

Appendix D: Participant information sheet/consent form

Title
Preventing gender-based violence in inpatient mental health units

Protocol Number
2017.365

Project Sponsor
RMIT University

Coordinating Principal Investigator/ Principal Investigator
Dr Juliet Watson

Associate Investigators
Dr Chris Maylea, Associate Professor Russell Roberts, Ms Lisa Hebel

Location
NorthWestern Mental Health

Part 1
What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called 'Preventing gender-based violence in inpatient mental health units'. You have been invited because you are a woman who has used the services offered by NorthWestern Mental Health and they have suggested that you may be willing to contribute to this research.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

This research project aims to improve understanding of the current situation regarding women's experiences of gender-based violence occurring in inpatient mental health units in Australia and, subsequently, to provide recommendations on how to change policy and practice to make these environments safe for women. Women's experiences will form the basis of policy guidelines that will be developed and distributed to set out best practice for providing safety for women and will contribute to effective service responses.

This study is investigating:

- the circumstances in which women experience gender-based violence in inpatient mental health units;
- the changes that need to be made to inpatient mental health units to prevent gender-based violence and ensure the safety of women; and
- the range of services needed to support women who experience gender-based violence.

This research has been initiated by the chief principal investigator, Dr Juliet Watson. It has been funded by Australia's National Research Organisation for Women's Safety Limited (ANROWS). This research is being co-ordinated by RMIT University in partnership with the Mental Health Legal Centre, NorthWestern Mental Health and Charles Sturt University.

3 What does participation in this research involve?

Prior to involvement in the research you will be required to sign the consent form.

Capacity to consent to participate in this research project is assessed according to the *Mental Health Act (2014)*. Under this Act, a person has the capacity to consent if the person:

(a) understands the information he or she is given that is relevant to the decision; and (b) is able to remember the information that is relevant to the decision; and (c) is able to use or weigh information that is relevant to the decision; and (d) is able to communicate the decision he or she makes by speech, gestures or any other means.

If you participate in the research you will be involved in a face-to-face interview of up to one hour. You will be asked about your experiences of gender-based violence in an inpatient mental health service over the past five years. You will also be asked about the response you received if you sought support in response to the violence.

Your consent will be sought to audio record the interview in order to ensure the accuracy of the data collected.

If you agree, the location of the interview will be at the office of the service you have used. Or, if you prefer, the interview will take place at the nearest RMIT campus. This study will not require any home visits. If you agree to participate, the location will be confirmed at the time of making the arrangements for the interview.

To compensate you for your time and cover the costs of participating, you will receive a $40 supermarket gift voucher when we meet.

The person who interviews you is not employed by NorthWestern Mental Health and the findings of the project will be independent and not influenced by this organisation. Research team member Lisa Hebel is employed by NWMH, however, her role is as liaison between the research team and NWMH and she will not be involved in the interviews.

4 Other relevant information about the research project

In the first stage of the research we will be conducting interviews with up to 30 women who have experienced gender-based violence in inpatient mental health units. You have been invited because you have used the services offered by NorthWestern Mental Health. Pending ethics approval, in the second stage of the research we will be presenting the findings to mental health professionals through a series of workshops in order to develop guidelines to protect women in inpatient mental health units from gender-based violence. The research involves researchers from RMIT University in collaboration with Charles Sturt University. Charles Sturt University will be involved in running the workshops in the second stage of the research.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with NorthWestern Mental Health, the researchers, RMIT University or Charles Sturt University. If you decide not to participate this will not affect your access to services.

You may stop the interview at any time. Unless you say you want us to keep them, any recordings will be erased and information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

6 What are the possible benefits of taking part?

We cannot promise that you will receive any benefits from this research; however, you may appreciate contributing to knowledge. Possible benefits may include contributing to a better understanding of women's experiences of the mental health service system and ways to improve it for other women, including those experiencing gender-based violence. There will be no clear benefit to you for your participation in this research.

7 What are the possible risks and disadvantages of taking part?

You will be provided with a pseudonym to protect your identity. There is a small risk that aspects of your interview may be recognisable to the workshop participants in the second stage of the research. Your experiences will be turned into composite case studies through blending them with the experiences of other participants so that no single case study solely represents one person. It also means that information cannot be connected to any individuals. You may also choose what information you want to be shared in the workshops. If there is anything that you do not want to be included this will be omitted.

It is possible that talking about your experiences may be upsetting for you. If you become upset during the course of the interview and you do not wish to continue, the researcher will stop the interview immediately. If you prefer, you can have a support person or trusted family member or friend accompany you in the interview. You will also have the support of the service that suggested your participation. Alternatively, you can call trained counsellors on Lifeline 24-hour anonymous phone counselling services (phone number 13 11 14) or 1800RESPECT 24-hour sexual assault and family violence counselling service (1800 737 732). Members of the research team are available to refer you to appropriate services.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team. You have the right to have any unprocessed data withdrawn and destroyed, providing it can be reliably identified.

9 Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons. These may include reasons such as unforeseen circumstances causing the lead investigators to be unable to continue their participation.

10 What happens when the research project ends?

The findings from this research will be published as a report for Australia's National Research Organisation for Women's Safety Limited (ANROWS). A summary of this report will be sent to you at the conclusion of the project, which is expected to be mid-2019. The findings may also be reported in journal articles and at conferences.

Part 2
How is the research project being conducted?

11 What will happen to information about me?

By signing the consent form you consent to the research team collecting and using personal information from you, collected during your interview, for the research project. Any information obtained in connection with this research project that can identify you will remain confidential.

If you agree to be audio recorded, the recording will be uploaded to a computer and deleted from the recording device. The audio recording will be professionally transcribed. All digital information will be kept on a password protected computer and written data will be kept securely at RMIT University in an office in a locked filing cabinet for seven years after completion of the project, before being destroyed. Only the researchers on the research team will have access to this material.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. As is the usual process, in any publication and/or presentation conducted by the researchers, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

Your information will only be used for the purpose of this research project and it will only be disclosed (1) to protect you or others from harm, (2) if specifically allowed by law, (3) you provide the researchers with written permission. Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored.

If you disclose a criminal act of violence perpetrated against you, such as a physical or sexual assault, we will not report this to the police as the choice to do this is yours. If you do decide to pursue your legal options we will provide a referral to a legal service for you to discuss your options.

12 Complaints and compensation

This study has been approved by the Melbourne Health Human Research Ethics Committee. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should contact the Principal Investigator named at the end of this document. If you have any concerns or questions about your treatment by the research team that you do not wish to discuss with the researchers listed in this document, then you should contact Melbourne Health's complaints contact person named at the end of this document.

13 Who is organising and funding the research?

This research project is being conducted by Dr Juliet Watson and her colleagues, Dr Chris Maylea, from RMIT University, Associate Professor Russell Roberts, from Charles Sturt University, and Lisa Hebel, from NorthWestern Mental Health. The research is being funded by Australia's National Research Organisation for Women's Safety Limited (ANROWS).

RMIT University will receive a payment from Australia's National Research Organisation for Women's Safety Limited (ANROWS) for undertaking this research project. No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

14 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). This research project has been approved by the HREC of Melbourne Health. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (The National Health and Medical Research Council [NHMRC], 2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researchers:

Name	Dr Juliet Watson
Position	Principal Chief Investigator
Telephone	
Email	juliet.watson@rmit.edu.au

Name	Dr Chris Maylea
Position	Associate Investigator
Telephone	
Email	chris.maylea@rmit.edu.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Melbourne Health (NorthWestern Mental Health) complaints contact person

Name	Director Research Governance and Ethics
Position	Complaints Manager
Telephone	03 9342 8530
Email	Research@mh.org.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	Melbourne Health HREC
HREC Executive Officer	Manager HREC
Telephone	03 9342 8530
Email	Research@mh.org.au

Appendix E: Consent form

Title
Preventing gender-based violence in inpatient mental health units

Protocol Number
2017.365

Project Sponsor
RMIT University

Coordinating Principal Investigator/ Principal Investigator
Dr Juliet Watson

Associate Investigators
Dr Chris Maylea, Associate Professor Russell Roberts, Ms Lisa Hebel

Location
NorthWestern Mental Health

Declaration by Participant

- ☐ I have read the Participant Information Sheet.
- ☐ I understand the information in the Participation Information Sheet including the purposes, procedures and risks of the research project.
- ☐ I am able to remember the information in the Participant Information Sheet and this has informed my decision to consent to participating in this research project.
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- ☐ I have been given reasonable time to make my decision to participate in the research.
- ☐ I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.
- ☐ I understand that I will be given a signed copy of this document to keep.
- ☐ I understand a summary of the project will be sent to me at the conclusion of the project

I consent to having my interview audio recorded and transcribed.

☐ Yes ☐ No

Name of Participant (please print)

_____

Signature

_____ Date _____

Declaration by Researcher†

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher† (please print)

_____

Signature

_____ Date _____

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Appendix F: Interview schedule

Client interview schedule—Preventing gender-based violence in inpatient mental health units

1. Please tell me a bit about yourself.
    a. Were you born in Australia? If not, where were you born?
    b. Are you Aboriginal of Torres Strait Islander?
    c. Where do you live? In particular, rural/metro/regional
    d. How old are you?
    e. Do you have a disability—other than mental health condition?
2. Do you have any concerns about starting the interview that we should discuss?
3. In the past five years, have you experienced gender-based violence while staying in, or as a result of staying in, an inpatient mental health unit? (e.g. sexual assault, sexual harassment, physical assault, touching, comments etc.)

Prompts:

- Gender-based violence includes...

4. What were the circumstances in which the gender-based violence occurred?

On this/these occasion/s, what kinds of support did you need?

Prompts:

- What immediate help did you need? (e.g. safety, legal, medical, advocacy)
- What type of help did you need in the medium to longer term?

5. On this/these occasion/s did you seek support? If so, from whom?
6. Why did you/didn't you choose to seek support?
7. On this/these occasion/s please describe any support or help you received, and what type of service provided it, and the extent to which it met your needs.
    - Were you satisfied with the response you received? Why/why not?
8. Did you receive help from this service, or any other service, after you left?
    - On this/these occasion/s to what extent did any help you received meet your support needs?
    - Were you satisfied with the response you received? Why/why not?
9. Do you think that the services you used were able to meet the needs of women who have experienced gender-based violence in inpatient mental health units? Did some types of services meet your needs better than others?
10. What do you think would have prevented the gender-based violence from occurring?
11. What are your suggestions for improving the help provided to women who have experienced gender-based violence due to stays in inpatient mental health units?
12. What are your suggestions for changing inpatient mental health units so that they are safe for women
13. If you were to be an inpatient in the future, what measures would make you feel safer on the ward?
14. What do you think about male and female wards being completely segregated?
15. Have you ever been restrained in an inpatient unit?
16. How do you think being a woman affected your experience of being restrained?
17. Is there anything else you would like to say about helping women who have experienced gender-based violence as a result of stays in inpatient mental health units?

Thank you very much for your time and contributions.

Appendix G: Workshop handouts

Information sheet

RMIT University has been funded by ANROWS (Australia's National Research Organisation for Women's Safety) to explore and document women's experiences of gender-based violence occurring in inpatient mental health units to inform how policy and practice can be improved to make these environments safe for women. Women's experiences will form the basis of policy guidelines that will be developed and disseminated that set out best practice for providing safety for women and will contribute to effective service responses. This research is taking place in Victoria but is aimed at a national impact.

The project is co-ordinated by RMIT University in partnership with the Mental Health Legal Centre (MHLC), NorthWestern Mental Health (NWMH), Victoria Legal Aid (VLA), and Charles Sturt University (CSU). This project is unique because it will use the suggestions made by women who have experienced gender-based violence in inpatient mental health units to provide the foundation for developing policy guidelines. The guidelines will be developed in collaboration with mental health professionals who work in inpatient mental health units. Consumers will be involved throughout the project including through the project advisory group.

The project has three stages:

1. Data collection consisting of interviews with 30 women who have experienced gender-based violence (including sexual assault) as a result of inpatient mental health stays
2. Development of policy guidelines through a series of workshops with mental health workers where the findings from the data will be presented
3. Dissemination and implementation of the policy guidelines

Ethics approval has been granted by Melbourne Health and RMIT University.

This focus group is aimed at ensuring the guidelines we develop are realistic and able to be implemented.

Page 2 lists four scenarios. Each scenario is a de-identified amalgam of actual events reported to the research team. Page 3 lists recommendations from women who have shared their experiences with the research team. Page 4 lists questions for consideration and discussion during the focus group. Please consider these questions and bring your answers to the focus group.

You will already be familiar with the OCP Guidelines on sexual safety, but as a refresher they are available here: https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/promoting-sexual-safety . These guidelines are currently under review by DHHS.

Scenarios

Scenario 1

Alice is 38 years old and was born in New Zealand. She has two children under the age of 10 and she separated from her husband, Sam, 6 months ago due to family violence. Alice currently has custody of the children. This is her first involuntary admission to an inpatient mental health unit since the separation, and her third admission in total. Ward staff want clarification about Alice's circumstances. Alice asks for her mother to be contacted for information because she was staying with her prior to the admission. Instead, Sam is called because he is listed on her medical record as next of kin. Sam is asked to offer his observations and opinion on Alice's behaviour. When Alice learns this, she specifically says that she does not want Sam contacted and that he will use any information provided against her to get custody of their children. The staff still do not call Alice's mother; however, the staff continue to provide Sam with regular updates on Alice's condition throughout her stay on the unit.

Scenario 2

Joanne is 43 years old and was born in Australia. She is allocated a bed on the mental health unit that is designated for men due to a lack of space in the women's area. Joanne's room is only accessible via a fob, but she is not given one because there are not enough to go around due to previous consumers taking them home. This means that Joanne's room is left unlocked. A man on the ward has been following Joanne around and asking her to be his girlfriend. One night he enters Joanne's room. Joanne speaks to staff and is told that he is harmless, but he will be spoken to about his behaviour. The next night the man enters Joanne's room and rapes her. Her mental health deteriorates and when she tells the ward staff about the rape the matter is reported to the police, although no charges are made, and the perpetrator is discharged. Joanne discharges herself early from the ward and subsequently avoids contact with mental health services.

Scenario 3

Eloise is 27 years old and was born in Mauritius. While waiting to be involuntarily admitted, Eloise is restrained by staff that include a male security guard and a female nurse. The security guard uses far greater force and this leaves Eloise with visible bruising. On the ward, a male staff member watches her in the shower and asks her to remove her underwear during a physical examination. These experiences trigger memories of past sexual assault and she experiences flashbacks during her stay. Eloise fears for her safety so she speaks with a female staff member about what has happened but she is told that she is imagining things. Eloise tries to abscond but she is caught. She subsequently becomes suicidal and she is required to remain on the ward for an extended period of time. Eloise is considering moving to another state to avoid the risk of being admitted to the same unit in the future.

Scenario 4

April is 33 years old and was born in Australia. She is living with a physical disability. On the ward, April is often propositioned by male consumers. This involves unwanted flirting, showing her pornography, and requests for sex. At times, April has also been verbally and physically threatened. April has a room in the women's area of the ward but she does not feel safe there because it is kept unlocked. One night a man comes into her room, so since then she sleeps in the communal living space. Another man sleeps in this space. He requests sex from her in exchange for the sofa and a blanket. She complies each night because she is exhausted from lack of sleep due to feeling scared in her room.

Women's recommendations

- Fully segregated areas
  - Segregated classes/group events
  - Separate violent consumers
  - Lockable doors
- Staffing
  - Increase staff levels/presence/security staff
  - Female only staff
  - Reminders for staff to ask for consent to touch
  - Staff training for de-escalation
  - Staff sensitivity training
- Trauma-informed practice
  - Acknowledgment by staff that assault has happened
  - Trauma specialist counselling
  - Contact onsite support immediately e.g. psychologist, counsellor
  - Support for/checking in with women when male is behaving inappropriately in general
- Peer support/advocacy
  - Consumer advocate/peer support worker
  - Access to Office of the Independent Advocate
  - Information provided about complaints process
- Implementation
  - Mandatory reporting by staff
  - Follow up existing protocols and procedures
- Other
  - Offer to go to another hospital
  - Allowed to make a phone call to someone
  - Make wards accessible for disability/specialised support
  - CCTV on wards
- Get consent before contacting partners

Focus group questions

1. What, should have been done differently in each of the scenarios. Consider:
   a. Before the incident
   b. During and immediately after the incident
   c. In response to the incident.
2. Of the recommendations on page 3, which do you think should be the highest priority? Which do you think should not be taken up?
3. How well are the OCP Guidelines working? What is working about them? What is not working?
4. What would make women safe in mental health inpatient units? Think about resourcing, culture, environment and other factors. What could be done this week, next year and in ten years?

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AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children