



# Preventing gender-based violence in mental health inpatient units

*Key findings and future directions*

ANROWS

AUSTRALIA'S NATIONAL RESEARCH  
ORGANISATION FOR WOMEN'S SAFETY  
*to Reduce Violence against Women & their Children*

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ANROWS Research to policy and practice papers are concise papers that summarise key findings of research on violence against women and their children, including research produced under ANROWS's research program, and provide advice on the implications for policy and practice.

This is an edited summary of key findings from the ANROWS research project *Preventing gender-based violence in inpatient mental health units*. Please consult the ANROWS website for more information on this project and the full project report: Watson, J., Maylea, C., Roberts, R., Hill, N., & McCallum, S. (2020). *Preventing gender-based violence in mental health inpatient units* (Research report, 01/2020). Sydney, NSW: ANROWS.

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ANROWS research contributes to the six *National Outcomes of the National Plan to Reduce Violence against Women and their Children 2010-2022*. This research addresses National Plan Outcome 4 - Services meet the needs of women and their children experiencing violence.

### **Acknowledgement of Country**

ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge.

### **Acknowledgement of lived experiences of violence**

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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IN BRIEF

# Preventing gender-based violence in mental health inpatient units

## KEY FINDINGS

- Women in mental health inpatient units experience gender-based violence in many forms.
- Women are not safe in mixed gender spaces, and even gender-specific areas are not always safe.
- Trauma-informed care is not consistently embedded in service provision.
- Institutional violence and coercion (including restraint and seclusion) can be experienced as gender-based violence.

## IMPLICATIONS FOR PRACTITIONERS AND SERVICE PROVIDERS

- Ensure that care is trauma-informed.
- Recognise that the practice of restraint can be experienced as gender-based violence.
- Keep clinical responses to incidents of gender-based violence separate from investigative responses.

## IMPLICATIONS FOR POLICYMAKERS

- Women-only treatment settings are required.
- Consent and information-sharing should be informed by an understanding of domestic and family violence.
- Data collection and monitoring are required.

# Gender-based violence in mental health inpatient units

It is widely acknowledged that women are not safe in mental health inpatient units.

Around half of mental health inpatient admissions are involuntary, that is, people are admitted against their will because they are identified as posing a risk of harm to themselves or to others. Mental health inpatient units need to manage this increased risk in conditions that can be difficult.

Most mental health units are mixed-gender wards, and this co-location of men and women contributes to gender-based violence perpetrated by male consumers<sup>1</sup>. Some facilities have women-only areas, but even there women may experience gender-based violence perpetrated by staff and by other men they know such as intimate partners and ex-partners.

The process of involuntary treatment can be traumatic, and can lead to increased lateral violence. Practices such as restraint and seclusion can be experienced as gender-based violence, compounding existing trauma.

In recent years in Australia there have been some efforts, particularly in Victoria, to address the issue of gender-based violence in mental health inpatient units. A number of Australian jurisdictions (including Victoria, Tasmania and Queensland) have adopted the Safewards model, an international approach to reducing violence in mental health inpatient units. Notably, however, the Safewards model lacks a gender lens. Notwithstanding multiple studies reflecting the success of the model, there has been little interrogation of the nature of gender-based violence in the mental health inpatient unit setting.

Mental health inpatient units need to do more to prevent gender-based violence and to respond appropriately to incidents of gender-based violence when they occur. Women's voices should be at the centre of any strategy that is developed<sup>2</sup>.

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<sup>1</sup> The term "consumer" is used here to describe a person of any gender who elects to use or who is forced to use mental health services

<sup>2</sup> See the ANROWS project [Women's Input into a Trauma-informed model of care in Health settings: The WITH Study](#) for a trauma-informed model of care based on the input of women who had experienced sexual violence and mental health issues.

## THE ANROWS RESEARCH PROJECT

*Preventing gender-based violence in mental health inpatient units*

by Juliet Watson, Chris Maylea, Russell Roberts, Nicholas Hill  
and Susan McCallum.

This project addressed 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 practice?

Based in Victoria, the study involved in-depth interviews with 11 women who had experienced gender-based violence during a stay in a mental health inpatient unit. Quotes from these interviews are included in this Research to Policy and Practice paper (the page numbers given refer to the full research report).

The study also involved workshops held with a total of 42 service providers, and an analysis of relevant policies from across Australia.

To read the full research report (including detail on research methodology), visit [anrows.org.au/publication/preventing-gender-based-violence-in-mental-health-inpatient-units](https://anrows.org.au/publication/preventing-gender-based-violence-in-mental-health-inpatient-units)

See Appendix A of the full report for *Guidelines for ensuring women's safety in mental health inpatient units* that were developed as part of this research project.

# Key findings

## KEY FINDING

### Women in mental health inpatient units experience gender-based violence in many forms

- Women are exposed to a range of behaviours including threats, harassment, sexual and physical violence.
- Transactional sex also occurs in mental health inpatient units. In contexts where negotiating power is unequal, this constitutes a form of gender-based violence.
- Perpetrators of violence are mostly male consumers but also include male staff members and other men known to the women, such as partners/ex-partners who visited the unit.



*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'. - Catherine\*, p. 37*

*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 - Olivia, p. 45.*

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\*All names given are pseudonyms.

## KEY FINDING

**Women are not safe in mixed gender spaces, and even gender-specific areas are not always safe**

- Mixed gender spaces including lounges, dining rooms and bathrooms contribute to women's experiences of gender-based violence.
- Fear of violence limits women's access to common spaces.
- Gender-specific areas do not always provide safety:
  - pressure on bed availability means that women are placed in men's sections or vice versa;
  - broken locks remain unrepaired;
  - men can gain access to women-only areas by following others who have swipe card access.



*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, p. 36*

*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. - Jen, p. 52*

*About 10 minutes [after the hourly nurse's check] 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. - Ann, p. 53*

*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. - Amanda, p. 41.*

## KEY FINDING

### Trauma-informed care is not consistently embedded in service provision

- Women's past history of trauma is not consistently taken into account by staff.
- Staff lack understanding about how women's past trauma could be triggered by experiences of gender-based violence on the unit.
- Staff are often unable to prevent gender-based violence in a mixed gender environment, and even where they might be able to intervene they do not always do so.
- Women reported being ignored or not having their experiences taken seriously when they reported incidents of gender-based violence to staff.
- Women may be re-admitted to units where they have previously been assaulted, sometimes with the perpetrator once again on the ward at the same time.
- Policies do not emphasise the importance of victims-survivors having control over the process of response to a sexual assault. Some policies require mandatory reporting to police, even without the woman's consent, while many others implicitly or explicitly allow for service providers to deny access to police reporting.



*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.*  
- Zoe, p. 55

*He [threatened sexual assault] 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.* - Megan, pp 47-48.

*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.* - Megan, p. 42.

*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.* - Elizabeth p. 49

## KEY FINDING

## Women's care plans are informed by the perspectives of family members, including those who had perpetrated violence

- Next-of-kin – including perpetrators of domestic and family violence – are sometimes contacted for their perspectives on a woman's mental health to inform treatment and care planning.
- Service providers agreed that contacting next-of-kin should be done in collaboration with women, however in some cases a woman's description of domestic violence was assessed as being a paranoid delusion, and staff then contacted the next-of-kin against the woman's wishes.
- In other cases, abusive former partners were contacted inadvertently because next-of-kin information had not been updated on the woman's file.



*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. - Vanessa p. 40*

## Institutional violence and coercion (including restraint and seclusion) can be experienced as gender-based violence

- Involuntary treatment, particularly the practices of restraint and seclusion, can be experienced as gender-based violence.
- Restraint can involve excessive physical force by male staff members, including security guards who are sometimes called to assist clinical staff. Restraint can trigger traumatic memories of previous sexual assault.



*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. - Marie, p. 45*

*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. - Amanda, p. 45*

# Principles for ensuring women's safety in mental health inpatient units

These principles are abridged from the *Guidelines for ensuring women's safety in mental health inpatient units*. For the complete Guidelines see Appendix A of the Research report at [anrows.org.au/publication/preventing-gender-based-violence-in-mental-health-inpatient-units](https://anrows.org.au/publication/preventing-gender-based-violence-in-mental-health-inpatient-units)

## SAFETY

- Institutions have a duty to eliminate gender-based violence.
- A woman's own judgment of her safety is paramount. Feeling safe or feeling unsafe will depend on a range of previous (trauma) experiences.
- Gender-based violence occurs in spaces where women's safety is not protected. Resourcing limitations must not be used to justify a 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.
- An unsafe environment is counter-therapeutic, inconsistent with recovery and potentially traumatic.

## 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.
- 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.
- The preservation of dignity following a traumatic incident requires a timely, appropriate and measured response, particularly in responding to gender-based violence.

## AUTONOMY

- Autonomy is central to dignity and recovery. 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.
- Assessment of capacity must be decision-specific and decision-making must be supported. No decision should be made on behalf of women other than where required by law.

# Implications for practitioners and service providers

## 1. Ensure that care is trauma-informed

- It is essential that staff:
  - have an understanding of gendered trauma;
  - provide trauma-informed responses regardless of whether clients have disclosed past experiences of gender-based violence;
  - address the past trauma experiences that underlie current mental distress; and
  - limit the re-traumatisation which can occur in mental health services.
- In responding to reports or observations of gender-based violence, staff should:
  - respond from a position of trust, and validate the woman's experience;
  - respond promptly and assertively; and
  - not minimise any behaviour which makes women feel unsafe or uncomfortable.

## 2. Recognise that the practice of restraint can be experienced as gender-based violence

- Understand the potential for re-traumatisation during restraint.
- Take action to mitigate the possibility of re-traumatisation if restraint must be used.

## 3. Keep clinical responses to incidents of gender-based violence separate from investigative responses

- After an incident of gender-based violence is disclosed, staff should provide options for the woman and support her to take control of the process. Staff may consult with specialist sexual assault services for guidance.
- Specialist sexual assault services should be offered. A timely response is vital in limiting ongoing trauma.
- Mental health staff should not investigate allegations of criminal behaviour.
- Staff must never prevent a woman from making a police report. The right to report must be upheld within mental health units, irrespective of a woman's assessed decision-making capacity or the likelihood of legal success.
- Staff should not gather evidence without the consent of the woman, irrespective of her assessed decision-making capacity. Forced forensic medical examinations, interviews and other legal processes can be experienced as re-traumatising.
- If possible and with consent, potential evidence including CCTV footage and clothing should be preserved to ensure that women who chose not to make police reports can do so later if they choose.
- All incidents of gender-based violence should be thoroughly documented and recorded internally, consistent with standard incident reporting policies.

# Implications for policy-makers

## 1. Women-only treatment settings are required

- The built environment should allow for women-only units, and these should be staffed by women only.
- Men must not be placed or allowed into women-only wards. Resourcing issues and increased demand for inpatient beds should not be used as justification for allowing women to be unsafe.
- Lockable doors to the women's corridor/section should be supported by staffing practices which ensure they are used.
- Any mixed-gender spaces in inpatient units must be spaces of gender safety, and women should not be forced into them. This includes spaces for treatment, activities, mealtimes and visiting.

## 2. Consent and information-sharing processes should be informed by an understanding of domestic and family violence.

- All contact information and consents should be kept updated to ensure that information is not inadvertently shared with abusive partners, ex-partners or family members.
- Information should only be shared with consent or when required by law.
- Where consent to share information is not provided, staff must still act according to principles of trauma-informed care.
- Following an incident of gender-based violence, staff should be alert to the potential for placing women at risk by sharing information about the incident with family or carers who may blame the woman or use that information against her.

## 3. Data collection and monitoring are required

- Data on all incidents of gender-based violence in mental health inpatient units should be collected, de-identified and reported publicly.
- Data on the prevalence of trauma history should also be collected, de-identified and reported publicly.
- The National Mental Health Commission (NMHC) and the Safety and Quality Partnership Standing Committee (SQPSC) should develop a coordinated national response to women's safety in mental health inpatient units, including timelines for compliance and ongoing reporting.
- 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.

# Further resources

Australia's National Research Organisation for Women's Safety. (2017). *Women's Input into a Trauma-informed systems model of care in Health settings (the WITH Study): Using a trauma-and-violence-informed framework in practice* [Factsheet]. Retrieved from [https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/02/19025247/WITH\\_Practitioner-Factsheet-Final-1.pdf](https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/02/19025247/WITH_Practitioner-Factsheet-Final-1.pdf)

EQUIP Health Care. (n.d.). TVIC Workshop. Retrieved from <https://equiphealthcare.ca/tvic-workshop/>

Victorian Mental Illness Awareness Council. (2019a). *About the Phoenix Project*. Retrieved from <https://www.youtube.com/watch?v=W7M-Q1pKbZo>

Victorian Mental Illness Awareness Council. (2019b). Phoenix Project: Trauma informed peer support. Retrieved December 3, 2019, from <https://www.vmiac.org.au/services/phoenix-project/>

# Sample policies

## **Policy with a strong focus on trauma-informed responses.**

State of Victoria, 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>

## **Policy with a strong focus on giving the woman as much control as possible throughout the process after a sexual assault is disclosed.**

State of 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](https://www.health.qld.gov.au/_data/assets/pdf_file/0030/426828/qh-gdl-434.pdf)

## **Policy with a strong focus on maintaining the ability of a woman to make a decision about proceeding with prosecution later, following allegations of sexual assault.**

State of Victoria, 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>

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