Supporting patients who make disclosures of sexual violence on inpatient wards

A practical guide for mental health professionals

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Who is this document for?

This document is produced by a mental health nurse who has experience working on inpatient wards in two London NHS Foundation Trusts. She is also training to become an Independent Sexual Violence Advisor, something that was born out of the realisation that staff of all disciplines lacked the knowledge and confidence to respond to allegations that had been made to them.[1]

As well as educating about sexual violence and the terminology you may come across, practical advice will be given in terms of the actions to take immediately and in the days and weeks after an incident of sexual violence has occurred. You will also be introduced to key partner agencies and organisations.

You will notice that in most instances the person that has reported the incident will be referred to as victim or survivor, as oppose to alleged victim. This is a deliberate move in order to reinforce that this guide is not for the purposes of investigating individual incidents but to provide a tool to ensure that the response to any allegation is both timely and effective. This also takes into account that many of those who experience sexual assault, particularly those with mental health diagnosis' have historically not been taken seriously, or have been disbelieved, this in itself can cause as much harm as the event itself and is often referred to as secondary traumatisation.

In order to support you, there will be writing in italics throughout this document. This denotes hypothetical accounts from both inpatient survivors and mental health professionals in order to prompt further thinking.

This guide focuses on adult inpatient mental health services, although some of the material will be transferrable. It does not replace local or national policies, nor does it apply to all settings and individual circumstances.

[1] Care Quality Commission (2018) Sexual Safety on Mental Health Wards. https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

Definitions

Alcohol/Drug Facilitated Sexual Assault: Alcohol or other drugs are used to make the victim incapable of consenting. Some of the more common are Rohypnol, GHB and Ketamine. Alcohol remains the most common substance used to subdue victims.

Child Sexual Abuse: When a perpetrator intentionally harms a minor physically, psychologically, sexually, or by acts of neglect. Sexual touching between children can also be sexual abuse when there is a significant age difference (often defined as 3 or more years) between the children.

Child sexual exploitation (CSE): Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person

Comfort Suites: Comfort suites are dedicated rooms where victims of rape and serious sexual assault can talk to the police in privacy and comfort. The rooms are designed in a way to be less intimidating than a regular interview room. These are often located in police stations.

Consensual sexual activity: Sexual activity that occurs after mutual sexual consent has been provided by those involved.

Consent: To voluntarily agree to engage in sexual activity. When a person consents that consent does not automatically carry over to future encounters and consent to one act does not mean agreeing to all sexual acts, for example a person can consent to one type of sexual activity but not another e.g. oral but not vaginal sex, or consent to penetration but with conditions such as wearing a condom. Consent can be withdrawn at any time. A person is not capable of consenting to sexual activity when incapacitated by alcohol or drugs, unconscious, or when another person abuses a relationship of trust, power, or authority.

Crown Prosecution Service: The CPS is responsible for the preparation and presentation of criminal prosecutions in the UK. They work closely with the courts, the police, and other agencies in the criminal justice system

Cyberviolence: online behavior that constitutes or leads to harm against the physical, psychological and/or emotional state of an individual. This can include cyberstalking, unwanted advances, online harassment, non-consensual sharing of sexual images.

Date rape: Unwanted, coerced and/or forced sexual penetration that occurs between people who are known to each other who are in a dating relationship, a blind date or “hook up.”

Disclosure: The act of making information known for the purpose of seeking support and/or information.

First responder: The police officer(s) that take a victims first account

Forensic medical examination: Depending on the circumstances of sexual assault, a sexual offence examiner may take swabs from both intimate and non-intimate parts of the body. They will also document any physical injuries and may photograph non-intimate injuries and/or request to take the clothing that a person was wearing at the time of the assault.

Gender based violence: Gender-based violence is violence that affects women disproportionately. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.

Hepatitis B vaccination: The hepatitis B vaccine is recommended for adults at high risk for and gives lifetime protection against a preventable chronic liver disease.

Independent Sexual Violence Advisor: An ISVA is trained to offer emotional and practical support. They understand how the criminal justice process works and will provide a person with information to support them to make informed decisions about what happens next.

Intermediary: An Intermediary is a communication specialist who helps vulnerable witnesses to give evidence to the police and to the court in criminal trials. They work with people who may find it difficult to give evidence because of their age, a learning, mental or physical disability.

Intimate Partner Sexual Violence. When rape/sexual assault occurs between two people who have or have had consensual sexual. It is a crime just as any other types of sexual violence are.

LGBT+: encompasses people who identify as lesbian, gay, bisexual, transsexual and all spectrums of sexuality and gender.

Officer in Case: An officer in the case (OIC) is a plain clothes police constable who has specialist training in the investigation of rape and serious sexual offences.

Patient safety: the avoidance of unintended or unexpected harm to people during the provision of health care.

Perpetrator: a person who has carried out sexualised behaviour or activity that has involved another individual directly or indirectly. This can also be known to as the suspect.

Post-exposure prophylaxis (PEP): PEP refers to the use of antiretroviral drugs for people who are HIV-negative after a single high-risk exposure to stop HIV infection. It must be started as soon as possible to be effective – always within 72 hours of a possible exposure – and continued for 4 weeks.

Professional Sexual Exploitation: Inappropriate use of sexual actions or words by a professional or volunteer within a helping context. Any sexual interaction between professionals and clients/patients, current or former, is sexual violation (even if the victim sees it as consensual.)

Rape: The legal definition of rape is 'penetration with a penis of the vagina, anus or mouth of another person without their consent'. The invasion is often committed by force, or threat of force or coercion, such as that caused by fear of violence, duress, psychological oppression, or abuse of power. It can also include taking advantage of a coercive environment, or violence committed against a person incapable of giving genuine consent.

Released under investigation means that the Police will continue to investigate the allegations against a suspect, but the suspect is not on Police Bail and that no bail conditions apply.

Re-traumatisation – delayed onset or reactivated symptoms related to something traumatic experienced in the past. Usually triggered by something that reminds the person of the original traumatic incident.

Revenge porn: The distribution of nude and/or sexually explicit photos and/or videos of an individual without their consent

Sexual assault referral centre: SARCs are specialist medical and forensic services for anyone who has been raped or sexually assaulted. They are multi-functional, providing a private space for interviews and/or forensic examinations. Most SARCs provide services to victims/survivors of rape or sexual assault regardless of whether the person chooses to report the offence to the police or not.

Sexual assault: the intentional touching of another person of a sexual nature where the other person does not consent to the touching.

Sexual harassment: any unwelcome or unwanted sexual behaviour.

Sexual health clinic: A sexual health or genitourinary medicine (GUM) clinic specialises in sexual health and can provide tests and treatment for many STIs. Testing for chlamydia and gonorrhoea usually requires only a urine sample or a self-taken swab for a woman. Testing for HIV and syphilis requires a blood sample.

Sexual safety: This can mean different things for different people, but in general, it means the right to feel and be kept safe from sexual harm.

Sexual violence: The general term used to describe any kind of unwanted sexual act or activity. It includes non-consensual completed or attempted sexual contact; non-consensual acts of a sexual nature such as voyeurism, grooming or sexual harassment and acts of sexual trafficking or online exploitation.

Sexually disinhibited behaviour: Impulsive behaviour of a sexual nature, whereby sexual thoughts, impulses, or desires are expressed in a direct or disinhibited way, in inappropriate situations; at the wrong time; or with the wrong person.

SOIT: A Sexual Offences Investigation Trained Officer may be involved in the response to an allegation of a sexual offence. They will gather evidence and information from the victim in order to support a criminal investigation.

Survivor centered/trauma informed approach: The survivor/trauma centered approach aims to create a supportive environment in which a survivor's rights are respected, and they are treated in a way that promotes their recovery. This involves empowering the person to identify and express their needs and reinforcing their capacity to make decisions about possible interventions. The professional recognizes that many aspects of an inpatient environment such as restraint, seclusion, enforced medication can be re-traumatizing and actively resist this.

Systemic Sexual abuse: Organised form of sexual abuse often involving numerous perpetrators and victims. Victims may be 'initiated' with the perpetrator using the guise of spiritual expression, initiation into a gang, or a secret or selected group.

Trauma informed: This recognises the high prevalence of trauma and its impact on emotional, psychological, social well being. Trauma aware staff understand trauma, its effects, and adaptations.

Victim or Survivor: Many are unsure which term to use when referring to someone that has experienced sexual violence. Both terms are applicable, and it is often best to use the terms that the person prefers.

What is sexual violence and who may be a victim

Sexual violence is any behaviour of a sexual nature that is unwanted and without consent. It can affect anybody, regardless of age, race, gender, and sexuality. Marginalised groups face challenges that place them at greater risk and less likely to seek help. These groups include lesbian, gay, bisexual and transgender individuals, those from a black or Asian minority ethnic background, those with learning disabilities, sex workers, the prison population and those with mental health difficulties. Another group that can find reporting sexual violence especially difficult are men. It can be difficult to talk about what happened because of the commonly held view that sexual crimes do not happen to men, or that they should be able to protect themselves.

The attitudes of mental health staff reflect those of the general public, with the majority thinking that perpetrators are strangers, who attack an individual in a public place, and using force. In reality, most victims are assaulted in private by someone that they are known to and injuries are rare.

An Overview of Sexual Offending in England and Wales, (2013) the first ever joint official statistics bulletin on sexual violence released by the Ministry of Justice (MoJ), Office for National Statistics (ONS) and Home Office, revealed that:

- Approximately 85,000 women and 12,000 men (aged 16 - 59) experience rape, attempted rape or sexual assault by penetration in England and Wales alone every year.
- Only around 15% of those who experience sexual violence report it to the police
- Approximately 90% of those who are raped know the perpetrator prior to the offence [1]

The relationship between sexual violence and mental illness is both complex and bi-directional [2]. This means that both men and women with severe mental illness are more likely to have experienced, and/or to go on to experience sexual violence. A study by University College and Kings College London (2015), found of those with severe mental

illness, 40% of females are survivors of rape and 12% of men. This is compares to 7% of the female general population and 0.5% of the male general population [3].

Conditions such as mania, psychosis, and dementia often cause reduced awareness, impaired judgment, and hypersexuality and as many as 1 in 10 of inpatients engage in sexually challenging behaviours during the first two weeks of admission[4]. A patient's vulnerabilities, the disinhibited behaviors of others, the potential for abuse of the power imbalance between staff member and patient are all reasons that sexual harm can and does occur in inpatient environments. Whilst there have been estimates about the prevalence of such incidents [5] these should be taken with caution.

[1] Ministry of Justice, Home Office, and Office for National Statistics (2013). An Overview of Sexual Offending in England & Wales, Joint publication. https://webarchive.nationalarchives.gov.uk/20160106113426/http://www.ons.gov.uk/ons/rel/crime-stats/an-overview-of-sexual-offending-in-england---wales/december-2012/index.htm\

[2] O'Dwyer C, Tarzia L, Fernbackher S, Hegarty K (2019) Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units *BMC Health Serv Res* 19, 839 (2019). https://doi.org/10.1186/s12913-019-4683-z

[3] Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., . . . Howard, L. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine, 45*(4), 875-886. doi:10.1017/S0033291714001962

[4] Bowers et al (2013) *Sexual behaviours on acute inpatient psychiatric units* doi:10.1111/jpm.12080

[4] Care Quality Commission (2018) Sexual Safety on Mental Health Wards. https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

The law and sexual violence

There are a range of crimes that are considered as sexual offences, these include rape, sexual assault, stalking, female genital mutilation, crimes against children including child sexual abuse or grooming, and crimes that exploit others for a sexual purpose, both in person and online.

There are two critical stages of the criminal justice system; the police investigation stage and the prosecutor stage. Contact with a police officer is usually the first step towards prosecuting a crime. The goal for the police is to build a strong case of evidence and recommend to prosecutors that a case is filed.

The Crown Prosecution Service (CPS) prosecutes criminal cases that have been investigated by the police. The survivor themselves plays an important role in the investigation process, and many cases only go forward if they participate.

In rape and sexual assault cases, consent is a fundamental issue. The prosecution is required to prove that the victim did not consent to an act and that the suspect did not have a reasonable belief that the victim had given their consent.

In a court case, the prosecutor will consider consent in two stages; first whether the complainant had capacity to consent i.e were they impaired in some way such as through drink or drugs, mental illness, or learning disability, secondly they will consider if the complainant was free to make the decision without coercion, for example whether they were threatened with violence before the request for sex was made.

With cases regarding children, it is only necessary to prove that the act took place.

The significant passage of time does not prevent the effective prosecution of sexual offences. Crimes that took place prior to May 2004 may be heard under the Sexual Offences Act 1956 or the Indecency with Children Act 1960.

Promoting sexual safety in the inpatient environment

"I was asked about my history of experiencing sexual abuse or trauma on admission. The nurse asked in such a sensitive manner and told me that my response would be confidential between me and my care team. It meant that I felt more confident to discuss my sexual safety when I felt that it was being compromised by a visitor on the ward."

The ward environment does not always promote sexual safety, nor do those that use services always feel that they are kept safe from unsolicited sexual behaviour. Whilst sexual violence in the inpatient environment is not entirely avoidable, it is preventable.

There are initiatives such as the national Sexual Safety Collaborative [2] which aims to produce a set of standards around sexual safety, a library of resources and undertake work to improve sexual safety through quality improvement initiatives.

There are also steps that can be taken locally. These include carrying out regular risk assessments of the environment, identifying individual risk factors among the patient population, ensuring that incidents are recorded and investigated and working to build a culture where conversations around sexual health and sexual violence, safety and sexual safety are normalised. Ideas for promoting sexual safety are most successful if they are owned by the ward and with patients involved throughout. Ideas can include:

- Building staff and patient confidence to talk about sexual health and sexual safety[3]. This could be through the use of models such as 5 A's Framework [4] which moves people from a place of avoiding conversations about sexual health to a place of acknowledging their importance and being ready to have them. The STARTER model [4] was produced specifically for mental health staff to support them in overcoming personal and professional barriers to including sexual health in their practice.

- Role playing scenarios, whereby staff practice difficult conversations in a safe space.

- Panic alarms that are available for both staff and patients, either individually or in communal areas.

- Bedroom doors that are lockable from the inside.

- Sensory motion detectors that can alert staff if a patient leaves their room at night.

- Displaying posters that emphasise behavioural expectations, with an emphasis on safety and sexual safety.

- Shared learning from incidents of sexual violence.

- Regular audits of the ward environment, including bathrooms, gardens, courtyards, bedrooms and communal areas with clear actions taken when a need is identified.

- Having a zero-tolerance approach to sexual violence whereby staff work with the police to ensure the strongest possible action is taken when as incident occurs.

- Educating patients about sexual health and sexual boundaries through individual and group exercises. These can include through awareness days, film & discussion nights, art therapies, community meetings and 1:1 discussion with nursing staff. They can also be extended to include families and the wider community.

- Improving partnerships with the police and sexual assault services to ensure that patients have the confidence that incidents are taken seriously and treated without prejudice.

- Ensuring that care plans are up to date and risk assessments are conducted with emphasis on those patients who have a history of sexually disinhibited or assaultive behaviour, and those who have been identified as being vulnerable due to their presentation or risk history.

- Co-produced staff training that includes trauma informed care and defining, recognising, and managing sexual violence.

- Developing the role of sexual safety champions and mentors so that staff and patients who are more confident to have such conversations are able to role model.

- Conducting regular surveys of patients, staff, visitors to assess subjective feelings of sexual safety as well as asking them for recommendations for how the environment can be improved.

- Having a clear visitor policy, with any visitors that display unacceptable behaviour removed and reported to the police if a crime has taken place.

- Having transparent ‘professional boundaries’ policies and ensuring that these are part of the induction process for all staff and regularly updated.

"There was an emphasis on the ward on safety. This included sexual safety. As a newly qualified nurse being asked to co-facilitate a group called 'Lets Talk About Sex' with 20 grown men was rather daunting! I was encouraged to use the STARTER model to help 'start' the conversation and it helped me to understand the importance of giving people permission to talk about sexual health and sexual violence as well as acknowledging my own barriers to having these conversations. I can't believe that it's only a few months since and now I am the ward's sexual safety champion. This involves supporting patients to have sexual health and sexual safety care plans. Another initiative =was arranging for the police to come and do a session around consent. That proved extremely popular, you wouldn't believe how few of these men had ever had any sexual health education."

[1] Crime Prosecution Service (2020) Sexual offences. https://www.cps.gov.uk/crime-info/sexual-offences

[2] Care Quality Commission (2018) Sexual Safety on Mental Health Wards. https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

[3] NSW Government (2013) Sexual Safety of Mental Health Consumers Guidelines. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2013_012.pdf

[4] Quinn C, Happell B, Welch A (2013) The 5-As framework for including sexual concerns in mental health nursing practice. *Issues in Mental Health Nursing*. 34, 1, 17-24. doi: 10.3109/01612840.2012.711433

[5] Luby R (2020) Using the STARTER model to talk about sex in mental health nursing practice. Mental Health Practice. doi: 10.7748/mhp.2020.e1457

Responding to sexual violence: What everyone needs to know

Appendix 1

"I informed my named nurse that another patient had came into the room and sexually assaulted me. He wrote 'alleges' he has been sexually assaulted on my notes. What will happen if these medical records are used in court? No one will take me seriously!"

Being informed of an incident of sexual violence, whether it be recent or historical; involve assault, harassment, or abuse can be an upsetting, daunting and unfamiliar experience. Unfortunately, this is one that is often not covered by specific policy, or training which can leave staff feeling unprepared*.

In every encounter that a person has, they bring with them their own beliefs, values, and cultural experiences. It is vital therefore, that those that work in inpatient environments are aware how these can influence their response to sexual violence, and take steps to be as sensitive, objective and non-judgemental as possible.

The reaction of the first person to whom an incident is disclosed is critical in terms of giving the survivor a perception of how they will be treated, whether they will be believed, or whether they will be held responsible.

Those that work in mental health are not experts in this area, nor are they expected to be able to provide everything that a patient who has experienced sexual harm needs. They do, however, have a vital role in improving the immediate and long-term outcomes for survivors, and it is important that they do their best to get it right.

"I overheard nurses talking about another patient who had the same diagnosis as me. They said that she was attention seeking and told lies. It meant that I felt unable to report what had happened to me. There was no way that I was going to be believed".

Negative responses include minimising or dismissing, blaming, focusing on a person's diagnosis, or trying to avoid the conversation altogether. Helpful responses include empathising and believing the person's disclosure, listening to them, understanding that distress is subjective to that person; what is inconsequential to one person can cause significant trauma to another and validating their experience.

"I really didn't know what to do. However, I thought about what I would need if the sexual assault had happened to me. Then it just kind of came naturally. I told her I believed her, that I thought she was brave for telling me, and that I would do my best to make her feel and keep her safe."

Those that have survived sexual violence say that what they need most from professionals is:

- To be believed
- To be treated with dignity
- To be reassured that what happened was not their fault
- To be made to feel safe
- To be allowed to be in control of what happens next
- To be informed of their choices
- To be able to speak to someone that is independent about what happened. [2]

"The first thing that the nurse said when I told her about what had happened was 'I believe you'. That was probably the most important thing I heard in the days and weeks after the assault."

Some of the phrases that can be helpful are:

- It took a lot of courage to tell me this
- Thank you for sharing this for me
- You did not do anything to deserve what happened to you
- You are not to blame in any way
- I care about you and I am here to help in any way I can
- I am sorry this happened
- You can tell me as much or as little as you feel comfortable
- I will support you with this [1]

"I was only about half way through telling him. I had got to the moment where he came into my room and turned the light off… Then there was an incident elsewhere on the ward and the health care assistant that I was talking to went off to respond to it. In that moment I knew I would never speak about what happened to me again. When he came back and asked me to continue, I told him that it wasn't anything important. The moment was lost"

The way that you react to a disclosure can influence everything that happens next; whether the victim makes a report to the police, whether they access services to help them with their healing, and whether they get a conviction. Whatever the situation, it is essential to create an environment that makes it easier for the survivor to share their story[2].

1: Support the disclosure

- Provide a quiet and confidential space for the patient to continue the conversation. Acknowledge that it may be difficult to speak about what happened.
- Provide an interpreter if English is not the person's first language (do not use a family member or friend).
- Allow the patient to go at their own pace, they may need some time, or breaks.
- Ask non-threatening, open questions, and reframe them as not to attribute blame e.g. 'where would you like to start?' 'Would you like to tell me what you are able to remember?' 'What do you remember saying at the time?'
- Be non-judgemental, supportive, and empathetic.

Active listening skills

1) Look at the speaker directly, put aside distracting thoughts, do not mentally prepare a response. Avoid being distracted by external factors. 'Listen' to the person's body language.
2) Show that you are listening; nod occasionally, give the person permission to continue with verbal comments such as 'yes' 'oh' 'uh huh'.
3) Provide feedback: Reflect on what has been said by paraphrasing. Ask questions if certain points need clarifying, summarise periodically.
4) Defer judgement: Allow the survivor to finish before asking further questions. [3]

- Pay attention and listen carefully, ensure that you are not distracted by what is going on around you. Make sure you do your best not to lose focus. Try not to interrupt, but be prepared to comment, question, or recap what is being said in order to communicate that you are listening and interested.
- Take immediate steps to ensure that no further contact between the victim and the perpetrator takes place, regardless of who the alleged perpetrator is. If there is reason to believe that the alleged perpetrator poses ongoing risks to the patient, or other patients, take all reasonable steps to minimise such risk[1]
- Ensure that any cctv footage that could aid an investigation is retrieved.

"I didn't know how to explain that I had sustained physical injuries. The nurse came with a pen and paper and so I could write it down. If they hadn't done that I am not sure if I would have been able to tell them, or get the treatment I needed in A&E".

2. Assess for physical injuries

- Ask the person if the have any physical injuries, if they do ensure that they are supported to see the ward or duty doctor or attend A&E (it can be helpful to phone in advance in order to ensure that the person does not have to spend a long time waiting around which can add to their distress.)
- Ask them if they would prefer you to ask questions that require yes or no answers, or if they would like to write down their responses.
- Only ask questions about symptoms, injuries, or relevant past medical history.
- Ensure that any medical treatment is provided as a priority.

"So I had barely finished speaking about what had happened. I needed some time just to process things. Next thing the police are on the ward. All the other patients are looking, wondering what I had done wrong. I wasn't even ready to speak to them."

3. Ask the person what they want to happen next

- It is important to let the person have as much control as possible. This means resisting the temptation to take over and instead supporting him/her to explore their options and make their own decisions.
- Ask the patient if they want family contacted, and if they want the incident to be reported to the police. If the patient does not want to speak to the police, but local policy dictates that they must be informed, explain this to the patient.
- *Do not ask the police to attend the ward without checking that this is what the patient wants.* For those that are not ready to make a crime report themselves, ensure that you emphasise that there is no time limit on reporting crimes.
- Inform the patient that they can access an Independent Sexual Violence Advisor who can help them better understand their options. *(It is helpful to know how these can be accessed in your local area; it may be via your service, Victim Support, the police, Rape Crisis Centres or third sector services.)* The role of the ISVA is to provide information and support particularly around the criminal justice process, liaise with work or educational settings and provide therapeutic input.

4. Arrange for police involvement, and inform the patient of their right to attend a SARC if they have been sexually assaulted

"The ward doctor explained what was likely to happen when the police were contacted. It helped me to feel prepared for when they arrived. I requested that at least one of the officers that attended was female and this was facilitated. It meant that I felt safe enough to tell them what had happened to me."

- If the patient does want to report a sexual assault to the police, ensure that this happens as soon as possible. It is recommended that they do not wash, brush their teeth, eat, drink, or urinate if possible. Try and make them comfortable whilst they wait for the police but do not stop them from toileting, showering or bathing if, despite knowing the above, they still wish to.
- Give the patient the option of writing down what happened whilst it is still fresh in their mind.
- If the police do not offer facilitate this, the patient can be supported to self-refer to a SARC. *(Details of your local SARC can be found at: https://www.nhs.uk/service-search/other-services/Rape-and-sexual-assault-referral-centres/LocationSearch/364).* The SARC looks for evidence of injuries and takes samples of things such as blood, saliva, urine, semen and hair and test for the DNA of the perpetrator. The examination is relatively short, but the whole process can take several hours.
    - Within a week the patient should receive a telephone call to see how they are doing.
    - Two weeks after the incident they will contact again to offer a follow up appointment. During this test for sexually transmitted infections and pregnancy tests can be carried out.

    - The police will ask questions that will try and help them establish

      What has happened?
      Who did it?
      Where did it happen?
      When did it happen?

They may arrange for a further interview with a specially trained officer.

They may also arrange for an intermediary[2]. An intermediary is a specialist who helps vulnerable witnesses and complainants to give evidence to the police and to the court in criminal trials. The specially trained officer will take a further account of what happened, identify any potential witnesses, identify any suspects and discuss options for receiving support. Once the police have finished their investigation, they may pass the information on to the CPS who will decide whether to bring a charge against the alleged perpetrator.

The police will be expected to give the patient:

- Written confirmation of the crime that has been reported including a crime reference number
- The contact details for the police officer that is dealing with the case
- A needs assessment, to find out what support is required
- The details of victim support organisations.
- Updates on their investigation, including informing the survivor if the suspect is arrested or charged, released on bail.

5. Ensure that sexual health/medical needs are accounted for:

- With the help of the medical team, evaluate the risk of pregnancy, arrange for **emergency contraception** to be prescribed and administered. This can be effective up until 5 days after the incident has occurred. If it is too late, ensure that you offer pregnancy testing on the first day of the missed period.
- If indicated, arrange for **PEP** (**post exposure prophylaxis**) to be prescribed. This is a combination of HIV drugs that can stop the virus from taking hold if a person may have been exposed to it [4]. To work PEP must be taken within 72 hours (three days) and ideally within 24 hours.
- **Hepatitis B vaccination** may also be indicated. In some situations, the patient will also need an injection of antibodies called specific hepatitis B immunoglobin (HBIG) along with the hepatitis B vaccine. This should ideally be given within 48 hours but can still be given up until a week after exposure.
- Assess the wish or need for referral for further assessment and screening, particularly for sexually transmitted infections, this is usually two weeks post possible exposure. (If this can not be facilitated on the ward, the NHS website offers details of local sexual health services by postcode.)

"I knew that it was possible that the police or the court would ask for the progress notes. So, I ensured that I documented what he had told me exactly as he had told me it. I also got the ward psychiatrist to undertake a mental capacity assessment, I thought it was important to do that right away. I wasn't entirely sure how to raise the safeguarding alert, so I called the trust's lead, and they were very supportive throughout."

6. Ensure accurate documentation

- Keep detailed and accurate records including; the date and time of the report, a mental state assessment, any visible bruises, scratches or other injuries, what has been said about the assault and assailant, the outcome of any risk assessment, all actions taken.

- Write a detailed narrative, be careful not to use words that imply consent.

- Use the survivor's exact words and place those in quotation marks.

- Explain to the survivor how you will do your best to ensure confidentiality, but that there will be circumstances in which this can not be maintained such as if someone is at significant risk, if you are required to share information by law, and with agencies that may be supporting the patient.

- Follow local protocols for reporting incidents and referring to safeguarding.

6. Whatever the patient chooses to do, support them!

*The author recommends that senior leaders work with frontline staff, survivors, and those that use services to address this, although it is hoped in the meantime that this document goes some way of 'filling the gap'.

[1] Sara Payne MBE (2009) Rape: The Victim Experience Review. Home Office

[2] NHS Health Scotland (2019) *Rape and sexual assault: what health workers need to know about gender based violence*. www.healthscotland.scot/media/2463/gbv-rape-and-sexual-assault-march2019-english.pdf

[3] Mind Tools (2020) Active Listening. https://www.mindtools.com/CommSkll/ActiveListening.htm#:~:text=Becoming%20an%20Active%20Listener.%201%201.%20Pay%20Attention.,4.%20Defer%20Judgment.%205%205.%20Respond%20Appropriately.%20

[4]Terrence Higgins Trust (PEP post exposure prophylaxis for HIV) (2020) https://www.tht.org.uk/hiv-and-sexual-health/pep-post-exposure-prophylaxis-hiv

Helping patients to come to terms with what happened to them

Some survivors of sexual violence will recover with minimal external support; however, most are likely to experience some or many of the following after the event:

- fear and anxiety
- shock and anger
- hyper or hypo arousal
- disrupted sleep
- rumination
- increased need for control
- denial of the experience
- feelings of detachment; blanks or inconsistencies in memory
- emotional constriction
- feelings of betrayal
- a sense of shame, or blaming themselves for the assault

Reactions to sexual violence are unique to the individual and to not have any trauma responses is also not uncommon; particularly if the perpetrator was in a position of trust or authority, if the survivor thought that they were in a relationship with them, or if they had been groomed.

Some of the questions that you may be asked, or statements you may hear following the incident and some example answers are considered below:

Question	Sample answer
Why didn't I fight him off?	Fighting is rare. You should not feel guilty for not fighting the person off. You had little control over how you responded, this is because your responses to danger are automatic. Some people refer to these as fight or flight, but there is also freeze, flop, and friend[2].
Was I asking for it?	Many people who have been in similar situations feel that they may have provoked the person. This is often because of the myths in society around sexual violence. However, people do not ask for this kind of

	thing to happen to them. You did not deserve it.
Why do I blame myself for what happened?	This was not your fault. Sexual violence can happen to anyone, and it is often more common than we realise.
When will I stop remembering?	You are strong and you are courageous for being able to tell me about this. You will heal in your own time and your own way and it is okay to remember. We are here to help you with those memories.
Why am I so angry?	Many people are angry. This is a healthy response. However, if you are struggling to express yourself, we can look at ways that you can express it together?
No one understands how it feels to be me.	You are correct, I can not understand your personal situation, but I do not that you are not alone and that these are common feelings of people that have survived sexual violence. You are not alone.
Why do I keep having flashbacks?	Some people experience anxiety, flashbacks, and nightmares after a sexual assault. These are normal reactions to trauma. It is helpful to talk about these and the way the are affecting you. We can explore things that may help.
I do not know why everyone is making a big deal out of it!?	Just pretending what happened or ignoring it can be unhelpful. However many people do not feel the impact of it straight away, however we are here if you do want to talk about it.
Why can't I remember what happened?	Many people find that painful, difficult memories and experiences are blocked until they are ready to process them. Some people do not ever remember the exact details. That is okay.
I am worried that he/she will get in trouble.	It is human to show concern for others, however, what happened was not your fault.

Avoiding re-traumatising the survivor

"I had experienced child sexual abuse before I came into hospital. I thought I had come to terms with what had happened. Then suddenly I was taken back to that place all over again when they held me face down and pulled down my trousers. I lost my trust in the team and I didn't feel safe again."

Mental health hospitals are typically viewed as physically and emotionally unsafe and disempowering settings for sexual trauma survivors. The power dynamic between a person that is seeking; or requiring help and the person that is offering it can be threatening to those that have experienced previous abuses of power over them.

Furthermore, the responses to distress can be traumatising or re-traumatising. Examples of such practices include prone or supine restraint, pat down searches, enforced intramuscular medication, seclusion, and enhanced observations. These events not only affect those that are directly experiencing them but those witnessing and carrying out the acts too.

With this in mind, we need to give greater attention to recognising how practices that use coercion and control contribute to re-traumatisation and take steps to eliminate or mitigate these incidents.

The following can support this process:

Additional strategies

1) If the previous sexual violence occurred in the ward environment offer the patient to be treated on a different ward/ by a different service.
2) Ensure that the alleged perpetrator and the survivor are not treated in the unit at the same time. If the alleged perpetrator was a staff member (and the allegations were found to be unfounded), ensure that they transfer to a different team when the alleged victim is admitted.
3) Work with patients to identify triggers and grounding strategies, ensure these are documented in the treatment plan.
4) Discuss strategies for keeping safe, with a focus on what staff and what the patient will do if an incident occurs.

Helplines and other resources

SurvivorsUK Helpline Web Chat
Web Chat
(Monday – Friday 10.30 – 21:00; Saturday – Sunday 10:00 – 18:00)

National Web Chat for adult male survivors of rape or sexual
Text: 020 3322 1860
Whatsapp: 07491 816 064
Website: **www.survivorsuk.org**

SupportLine
Helpline: 01708 765200

Confidential emotional support to children, young adults and adults
Website: **www.supportline.org.uk**

CISters (Surviving Rape and/or Sexual Abuse)
Telephone: 02380 338080

The helpline is available to female adult survivors of childhood rape/sexual abuse, and others can call if they have a concern about such issues.

Rape Crisis England and Wales
Freephone 0808 802 9999
12 noon – 2.30pm and 7 – 9.30pm every day of the year

Rape Crisis England & Wales to promote the needs and rights of women and girls who have experienced sexual violence
Website: www.rapecrisis.org.uk

Safeline
Male Helpline: 0808 800 5005
General Helpline: 0808 800 5008
Young people's Helpline: 0808 800 5007
Text Helpline and Online Advisors: 07860 027573

Monday 10am – 4pm|Tuesday 8am – 8pm|Wednesday 10am – 4pm|Thursday 8am – 8pm|Friday 10am – 4pm|Saturday 10am – 12 noon

Safeline is a specialised charity working to prevent sexual abuse and to support those affected in their recovery.
Website: www.safeline.org.uk

WEBSITES

Gallop

Free, confidential and independent service for all LGBT+ people who have experienced sexual assault, violence or abuse, however or whenever it happened.

Website: **www.gallop.org.uk**

NHS

The NHS website offers information for people who have experienced rape or sexual assault.

Website: www.nhs.uk/live-well/sexual-health/help-after-rape-and-sexual-assault/

Respond

Respond exists in order to lessen the effect of trauma and abuse on people with learning disabilities their families and supporters.

Website: **www.respond.org.uk**

Rape Crisis England & Wales

Rape Crisis England & Wales is a national feminist organisation that exists to promote the needs and rights of women and girls who have experienced sexual violence

Website: **www.rapecrisis.org.uk**

Help for the helpers

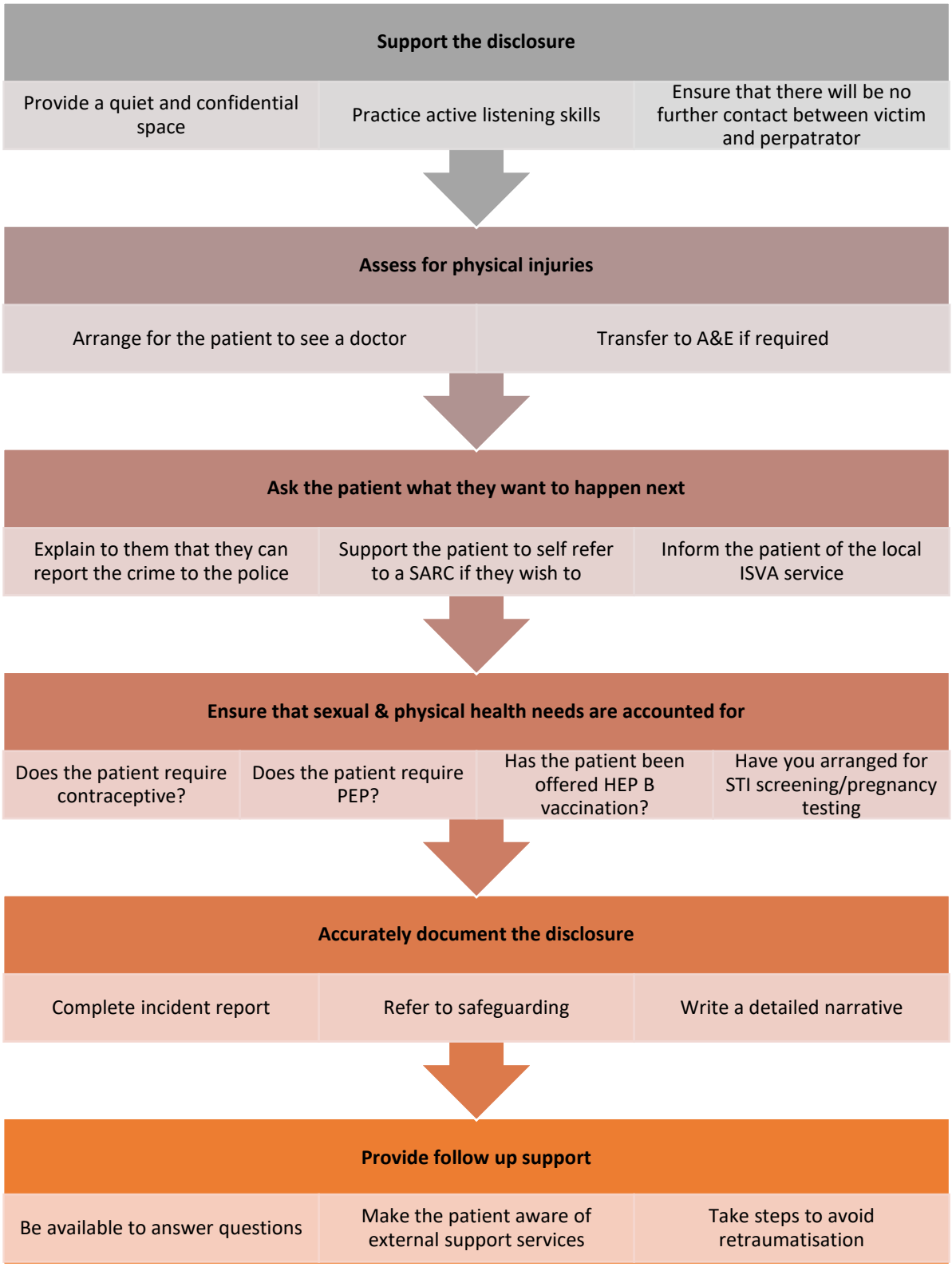
Working in environments where people have experienced sexual harm can cause distress. In some incidents this can lead to compassion fatigue. Symptoms include feeling exhausted, hypervigilant, unable to listen, avoidance, difficulty sleeping, physical ailments or guilt [1].

It can be difficult particularly, for those that have their own experiences of sexual harm. As well as utilising supervision processes, it can be important to reflect, to have self-care strategies that you practice yourself, to access occupational health or employee counselling services, or to contact some of the help lines that are detailed in this document.

If you are concerned about the behaviour of a colleague, do not be afraid to speak up. We owe it to those that we work with who are more vulnerable than we are.

[1] NHS Health Scotland (2019) *Rape and sexual assault: what health workers need to know about gender-based violence*. www.healthscotland.scot/media/2463/gbv-rape-and-sexual-assault-march2019-english.pdf

Appendix 1:


Support the disclosure
Provide a quiet and confidential space
Practice active listening skills
Ensure that there will be no further contact between victim and perpatrator
Assess for physical injuries
Arrange for the patient to see a doctor
Transfer to A&E if required
Ask the patient what they want to happen next
Explain to them that they can report the crime to the police
Support the patient to self refer to a SARC if they wish to
Inform the patient of the local ISVA service
Ensure that sexual & physical health needs are accounted for
Does the patient require contraceptive?
Does the patient require PEP?
Has the patient been offered HEP B vaccination?
Have you arranged for STI screening/pregnancy testing
Accurately document the disclosure
Complete incident report
Refer to safeguarding
Write a detailed narrative
Provide follow up support
Be available to answer questions
Make the patient aware of external support services
Take steps to avoid retraumatisation

Further reading:

Sexual assault survivor's guides

College of Saint Benedict and Saint Johns (2020) Sexual Assault Survivor's Guide. https://www.csbsju.edu/chp/sexual-assault-survivors-guide

Taylor J (2020). *Free self-development course. Caring for yourself after sexual violence*. Written and presented by Jessica Taylor. https://www.victimfocus.org.uk/free-caring-for-yourself-after-sexual-violence

Sexual safety in inpatient units:

Bowers et al (2013) *Sexual behaviours on acute inpatient psychiatric units*

doi:10.1111/jpm.12080

Care Quality Commission (2018) *Sexual Safety on Mental Health Wards.* https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

Eaton, J. (2019) *Why I stopped encouraging women to disclose to police of doctors after rape*. https://victimfocusblog.com/2019/01/17/why-i-stopped-encouraging-women-to-disclose-to-police-or-doctors-after-rape/

Jackson, H (2020) *It's time to speak up: sexual safety on inpatient mental health units.* https://blogs.bmj.com/ebn/2020/08/30/its-time-to-speak-up-sexual-safety-on-inpatient-mental-health-units/

Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., . . . Howard, L. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine, 45*(4), 875-886. doi:10.1017/S0033291714001962

NHS Health Scotland (2019) *Rape and sexual assault: what health workers need to know about gender-based violence*. www.healthscotland.scot/media/2463/gbv-rape-and-sexual-assault-march2019-english.pdf

NSW Government (2013*) Sexual Safety of Mental Health Consumers Guidelines.* https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2013_012.pdf

O'Dwyer C, Tarzia L, Fernbackher S, Hegarty K (2019) Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units *BMC Health Serv Res* **19,** 839 (2019). https://doi.org/10.1186/s12913-019-4683-z

The Conversation (2020) *They wouldn't let me call anybody': women in mental health wards need better protection from sexual assault*. https://theconversation.com/they-wouldnt-let-me-call-anybody-women-in-mental-health-wards-need-better-protection-from-sexual-assault-131998

Willitts, P. (2018). *There's an epidemic of sexual assault on psychiatric wards*. globalcomment.com/theres-an-epidemic-of-sexual-assault-on-psychiatric-wards/

Trauma informed care:

Sweeney, A., Clement, S., Filson, B., and Kennedy, A., (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, 21(3), pp.174-192

Blueknot (2020) *Trauma informed care* https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care-and-practice#:~:text=Trauma%2DInformed%20Practice%20is%20a,Hopper%20et%20al.%2C%202010)

National Association for People Abused in Childhood (2020) *Trauma Informed Practice* https://napac.org.uk/trauma-informed-practice-what-it-is-and-why-napac-supports-it/

Taylor J (2020). *Free self-development course. Caring for yourself after sexual violence*. Written and presented by Jessica Taylor. https://www.victimfocus.org.uk/free-caring-for-yourself-after-sexual-violence

Criminal Justice

Crime Prosecution Service (2020) *Sexual offences*. https://www.cps.gov.uk/crime-info/sexual-offences

Ministry of Justice, Home Office, and Office for National Statistics (2013). *An Overview of Sexual Offending in England & Wales, Joint publication.* https://webarchive.nationalarchives.gov.uk/20160106113426/http://www.ons.gov.uk/ons/rel/crime-stats/an-overview-of-sexual-offending-in-england---wales/december-2012/index.htm\

NHS Health Scotland (2019) *Rape and sexual assault: what health workers need to know about gender based violence*. www.healthscotland.scot/media/2463/gbv-rape-and-sexual-assault-march2019-english.pdf

Payne, S MBE (2009) *Rape: The Victim Experience Review.* Home Office

Talking to patients about sexual health/ violence

Luby R (2020) Using the STARTER model to talk about sex in mental health nursing practice. *Mental Health Practice.* doi: 10.7748/mhp.2020.e1457

Mind Tools (2020) *Active Listening.* https://www.mindtools.com/CommSkll/ActiveListening.htm#:~:text=Becoming%20an%20Active%20Listener.%201%201.%20Pay%20Attention.,4.%20Defer%20Judgment.%205%205.%20Respond%20Appropriately.%20

Terrence Higgins Trust (2020) (*PEP post exposure pophylaxis for HIV)* https://www.tht.org.uk/hiv-and-sexual-health/pep-post-exposure-prophylaxis-hiv

Quinn C, Happell B, Welch A (2013) The 5-As framework for including sexual concerns in mental health nursing practice. *Issues in Mental Health Nursing*. 34, 1, 17-24. doi: 10.3109/01612840.2012.711433