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Sexual Misconduct & Sexual Assault in Behavioral Health Settings

Challenges in Investigating Allegations

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Scope & Definitions

Sexual Misconduct

Any sexual behavior by a clinician toward a patient, regardless of consent. Includes sexual contact, exploitation of the therapeutic relationship, and boundary violations short of physical contact.

Sexual Assault

Non-consensual sexual contact. In behavioral health, encompasses assault by staff, by peers in residential settings, and facilitated assault.

Boundary Violation

Conduct that crosses professional, ethical, or therapeutic boundaries — including sexualized communication, inappropriate self-disclosure, and dual relationships.

Sexual Exploitation

Use of a professional relationship — including after termination — to engage in sexual activity with a former patient. Prohibited under most state licensing laws.

The Power Dynamic Problem

Why Behavioral Health Settings Create Unique Vulnerability

Therapeutic Dependency: Patients often rely on providers not only for treatment but also for emotional safety, stability, and recovery support — creating significant authority asymmetry.

Disclosure of Trauma: Patients share histories of abuse, sexual trauma, and vulnerability, which can be exploited by predatory providers.

Psychiatric Symptoms: Mental illness, substance use disorders, and cognitive impairments may affect a patient's ability to recognize or resist exploitation.

Institutional Power

In inpatient and residential settings, staff control access to privileges, medications, and discharge — coercive leverage.

Peer-on-Peer Risk

Residential settings create risk of patient-on-patient assault, compounded by limited supervision and inadequate screening.

Prevalence & Reporting Gaps

~12%

of mental health professionals report patient complaints of boundary violations in their career

1 in 20

therapists are estimated to have engaged in sexual contact with a patient (Gartrell et al.)

< 5%

of sexual misconduct incidents in healthcare settings are formally reported to licensing boards

80%+

of victims are women; majority have prior trauma histories that complicate disclosure

Why Underreporting Is Pervasive

Fear of disbelief or retraumatization during investigation

Shame, confusion, and misplaced self-blame by victims

Dependency on the perpetrator for ongoing care

Lack of awareness that the conduct is prohibited

Concerns about confidentiality and public disclosure

Prior negative experiences with reporting

Challenges: Credibility & Evidence

Credibility Assessments

- ▶ Avoid applying 'perfect victim' standards that are particularly harmful in mental health contexts
- ▶ Psychiatric diagnoses are wrongly used to undermine victim credibility — a illegally and unethical practice
- ▶ Inconsistencies do not equal fabrication; memory fragmentation from trauma is normal;
- ▶ Cognitive impairments or medication effects may affect reporting clarity without affecting reliability
- ▶ Investigators must distinguish between impaired credibility and impaired communication
- ▶ Prior sexual history and diagnosis history are not relevant to consent or misconduct

Evidence Scarcity

- ▶ Most incidents occur in private settings with no witnesses
- ▶ Physical evidence is rarely available, particularly for non-contact violations
- ▶ CCTV and monitoring are limited in clinical areas due to patient privacy rights
- ▶ Electronic communications (email, text, EHR messages) may constitute key evidence
- ▶ Delays in reporting often result in loss of forensic evidence
- ▶ Pattern evidence from multiple complainants is critical — identify prior complaints early
- ▶ Social media and personal device records may require legal process to obtain

Case Study



Challenges: Trauma, Confidentiality & Institutional Bias

Trauma Responses in Victims

- ▶ Victim-centered approach improve both accuracy and cooperation
- ▶ Delayed disclosure is the norm — not an indicator of fabrication
- ▶ Victims may minimize, recant, or protect the perpetrator due to trauma bonding
- ▶ Re-traumatization risk is high in adversarial investigation settings
- ▶ PTSD symptoms may cause non-linear or emotionally flat accounts
- ▶ Investigators must be trained in trauma-informed interviewing

Confidentiality Tensions

- ▶ HIPAA limits what can be disclosed during investigation without patient authorization
- ▶ Substance-abuse treatment has heightened barriers
- ▶ Mandatory reporting obligations may conflict with victim confidentiality preferences
- ▶ Law enforcement requests and subpoenas require careful legal review
- ▶ Balancing transparency with staff and protection of victim identity is complex

Institutional Bias

- ▶ Board governance failures often precede major misconduct scandals
- ▶ Organizations often protect high-performing or long-tenured employees
- ▶ Complaints against founders or senior clinicians face suppression pressure
- ▶ Fear of reputational damage and liability can shape investigative findings
- ▶ Witnesses and colleagues are influenced by loyalty and fear of retaliation
- ▶ Prior complaints that were dismissed create liability and pattern evidence

Best Practices: Investigation & Response

Intake & Preservation

- › Immediately separate the accused from the victim and any potential witnesses
- › Preserve all records, communications, and access logs before any notification
- › Document the complaint in detail; use the victim's own words without paraphrasing

Trauma-Informed Investigation

- › Use trained investigators — ideally external — with trauma-informed interviewing skills
- › Do not assess credibility through lens of victim's diagnosis or behavior
- › Offer victim advocacy support throughout; ensure access to independent counsel

Parallel Process Management

- › Understand and follow mandatory reporting timelines; document compliance
- › Coordinate with law enforcement early; avoid contaminating criminal investigation
- › Keep licensing board investigation separate from employment action track

Findings & Action

- › Document findings in writing objectively; avoid conclusory language
- › Do not offer neutral references or confidential settlements that protect future victims
- › Report to licensing board regardless of employment outcome; this is often mandatory

Key Takeaways

Power & Vulnerability

Behavioral health settings create conditions for exploitation that require heightened vigilance and proactive safeguards.

External Oversight Matters

Organizational investigations are prone to institutional bias. External investigators and mandatory board reporting are essential safeguards.

Diagnosis ≠ Uncredible

A patient's psychiatric history is not a basis for discounting their account. Investigators must be trained to recognize and reject this bias.

Trauma Shapes Disclosure

Non-linear, delayed, or emotionally flat accounts are expected in trauma victims. Trauma-informed interviewing is not optional.

Documentation Is Evidence

Clinical records, EHR audit logs, staffing schedules, and communications are critical investigative resources — preserve them early.

Coordination Is Complex

Multi-agency investigations require careful sequencing and legal guidance to avoid compromising criminal, civil, or licensing proceedings.

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